

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE# 0015651 Report Period Beginning: 10/1/04 Ending: 9/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 100,375

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3	170	Intermediate (ICF)	170	62,050	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	730	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
		8	SNF	1,010		440
9	SNF/PED					9
10	ICF	35,398	26,122	2,210	63,730	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,408	26,562	8,623	71,593	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.33%D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
MEALS ON WHEELSF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO I. On what date did you start providing long term care at this location?
Date started 2/13/65J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 103 and days of care provided 5,602Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/1/04 Fiscal Year: 9/30/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** # **0015651** Report Period Beginning: **10/1/04** Ending: **9/30/05****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	562,133	35,203	(75,841)	521,495		521,495	(29,913)	491,582		1
2	Food Purchase		571,619		571,619		571,619		571,619		2
3	Housekeeping	316,866	99,661	8,381	424,908		424,908		424,908		3
4	Laundry	124,785	12,945	610	138,340		138,340	(28,000)	110,340		4
5	Heat and Other Utilities			276,723	276,723		276,723		276,723		5
6	Maintenance	85,549	15,674	196,870	298,093		298,093		298,093		6
7	Other (specify):*										7
8	TOTAL General Services	1,089,333	735,102	406,743	2,231,178		2,231,178	(57,913)	2,173,265		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,658,534	638,055	100,876	5,397,465		5,397,465		5,397,465		10
10a	Therapy	82,399	183	439,488	522,070		522,070		522,070		10a
11	Activities	122,122	3,973	31,064	157,159		157,159		157,159		11
12	Social Services	86,303	160	26	86,489		86,489		86,489		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mission & Spiritual	69,821	2,606	1,634	74,061		74,061		74,061		15
16	TOTAL Health Care and Programs	5,019,179	644,977	573,088	6,237,244		6,237,244		6,237,244		16
	C. General Administration										
17	Administrative	117,131		210,744	327,875		327,875	(295,067)	32,808		17
18	Directors Fees										18
19	Professional Services			26,086	26,086		26,086		26,086		19
20	Dues, Fees, Subscriptions & Promotions			30,607	30,607		30,607		30,607		20
21	Clerical & General Office Expenses	254,138	30,921	423,743	708,802		708,802		708,802		21
22	Employee Benefits & Payroll Taxes			915,043	915,043	9,368	924,411	11,597	936,008		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,573	9,573		9,573		9,573		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,270	113,270	(9,368)	103,902		103,902		26
27	Other (specify):* Volunteers		786	2,917	3,703		3,703		3,703		27
28	TOTAL General Administration	371,269	31,707	1,731,983	2,134,959		2,134,959	(283,470)	1,851,489		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,479,781	1,411,786	2,711,814	10,603,381		10,603,381	(341,383)	10,261,998		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** #0015651 Report Period Beginning: 10/1/04 Ending: 9/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			650,683	650,683		650,683	29,898	680,581			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,444	60,444		60,444		60,444			35
36	Other (specify):*											36
37	TOTAL Ownership			711,127	711,127		711,127	29,898	741,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,662	2,662		2,662	(2,084)	578			41
42	Provider Participation Fee							149,470	149,470			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			2,662	2,662		2,662	147,386	150,048			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,479,781	1,411,786	3,425,603	11,317,170		11,317,170	(164,099)	11,153,071			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(29,913)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,598	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(64,925)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	126,984	X		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 63,744		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(227,843)	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (227,843)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (164,099)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BETHANY TERRACE NURSING CENTRE

ID# 0015651

Report Period Beginning: 10/1/04

Ending: 9/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	SPECIAL REVENUE	\$ (1,671)	17	1
2	HEALTH INFO MGT MISC INC	(628)	17	2
3	GIFT SHOP MISC INC	(2,084)	41	3
4	PROVIDER PARTICIPATION FEE	149,470	42	4
5	F/S AUDIT AJE	(1,700)	30	5
6	F/S AUDIT AJE	11,597	22	6
7	F/S AUDIT AJE	(28,000)	4	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	126,984		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE# 0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(29,913)	0	0	0	0	0	0	0	0	0	0	(29,913)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(28,000)	0	0	0	0	0	0	0	0	0	0	(28,000)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(57,913)	0	0	0	0	0	0	0	0	0	0	(57,913)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(295,067)	0	0	0	0	0	0	0	0	0	0	(295,067)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	11,597	0	0	0	0	0	0	0	0	0	0	11,597	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(283,470)	0	0	0	0	0	0	0	0	0	0	(283,470)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(341,383)	0	0	0	0	0	0	0	0	0	0	(341,383)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/04 Ending: 9/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	29,898	0	0	0	0	0	0	0	0	0	0	29,898 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	29,898	0	0	0	0	0	0	0	0	0	0	29,898 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(2,084)	0	0	0	0	0	0	0	0	0	0	(2,084) 41
42	Provider Participation Fee	149,470	0	0	0	0	0	0	0	0	0	0	149,470 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	147,386	0	0	0	0	0	0	0	0	0	0	147,386 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(164,099)	0	0	0	0	0	0	0	0	0	0	(164,099) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Methodist Hospital	Chicago, IL	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	Corporate Salary	\$ 148,606	Methodist Hospital of Chicago	100.00%	\$ 81,733	\$ (66,873) 1
2	V	Corporate Benefits	170,746	Methodist Hospital of Chicago	100.00%	71,713	(99,033) 2
3	V	Corporate Pro Fees	60,895	Methodist Hospital of Chicago	100.00%	33,492	(27,403) 3
4	V	Corporate Other	52,306	Methodist Hospital of Chicago	100.00%	28,768	(23,538) 4
5	V	Hospital Administrative	28,800	Methodist Hospital of Chicago	100.00%	17,804	(10,996) 5
6	V	Hospital Accounting	86,643	Methodist Hospital of Chicago	100.00%	86,643	6
7	V	Hospital Purchasing	47,158	Methodist Hospital of Chicago	100.00%	47,158	7
8	V	Hospital EDP	44,497	Methodist Hospital of Chicago	100.00%	44,497	8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 639,651			\$ 411,808	\$ * (227,843) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BETHANY TERRACE NURSING CENTRI # 0015651 Report Period Beginning: 10/1/04 Ending: 9/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** # **0015651** Report Period Beginning: **10/1/04** Ending: **9/30/05**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Methodist Hospital of Chicago
 Street Address 5025 N Paulina
 City / State / Zip Code Chicago, IL 60640
 Phone Number (773) 989-1465
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Corporate Salary	% to Total Cost	100	Various	\$ 594,425	\$	25	\$ 148,606	1
2	Corporate Benefits	% to Total Cost	100	Various	682,984		25	170,746	2
3	Corporate Pro Fees	% to Total Cost	100	Various	243,580		25	60,895	3
4	Corporate Other	% to Total Cost	100	Various	209,224		25	52,306	4
5	Hospital Administrative	% to Total Cost	100	Various	28,800		100	28,800	5
6	Hospital Accounting	% to Total Cost	100	Various	346,574		25	86,644	6
7	Hospital Purchasing	% to Total Cost	100	Various	205,035		23	47,158	7
8	Hospital EDP	% to Total Cost	100	Various	494,412		9	44,497	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,805,034	\$		\$ 639,652	25

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** # **0015651** Report Period Beginning: **10/1/04** Ending: **9/30/05**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$		\$		9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$		\$		14
15	TOTALS (line 9+line14)						\$	\$		\$		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
1. Real Estate Tax accrual used on 2004 report.		\$	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1" style="display: inline-table;"> <tr><td>2000</td><td style="text-align: center;">8</td></tr> <tr><td>2001</td><td style="text-align: center;">9</td></tr> <tr><td>2002</td><td style="text-align: center;">10</td></tr> <tr><td>2003</td><td style="text-align: center;">11</td></tr> <tr><td>2004</td><td style="text-align: center;">12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1" style="display: inline-table;"> <tr><td colspan="2" style="text-align: center;">FOR OHF USE ONLY</td></tr> <tr><td style="text-align: center;">13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</td></tr> <tr><td style="text-align: center;">14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td style="text-align: center;">15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td style="text-align: center;">16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2004 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$	<table border="1" style="display: inline-table;"> <tr><td style="text-align: center;">13</td></tr> <tr><td style="text-align: center;">14</td></tr> <tr><td style="text-align: center;">15</td></tr> <tr><td style="text-align: center;">16</td></tr> </table>	13	14	15	16
2000	8																										
2001	9																										
2002	10																										
2003	11																										
2004	12																										
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2004 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										
13																											
14																											
15																											
16																											

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BETHANY TERRACE NURSING CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0015651

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	183,600	1965	\$ 189,809	1
2	TERR LAND TRIANGLE		1996	92,064	2
3	TOTALS	183,600		\$ 281,873	3

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	275	1965	1965	\$ 1,332,134	\$ 1,705	40	\$ 1,705		\$ 1,332,134	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Item Remodeling	1973		23,592	369	32	369		23,592	9
10	Item Remodeling	1973		44,792	700	32	700		44,792	10
11	Improvements Fire Alarm System	1975		18,001	300	30	300		18,001	11
12	Improvements Lane Conversion	1975		42,023	700	30	700		42,023	12
13	Re-Wiring of Electrical Conduit	1985		59,165	1,448	20	1,448		59,165	13
14	Kitchen and Employee Dining Room	1985		392,466	9,606	20	9,606		392,466	14
15	Lindgren 1 Bathrooms	1986		1,307	34	19	34		1,307	15
16	Dental Suite and Chaplains Office	1986		4,260	112	19	112		4,260	16
17	Wheelchair Access	1986		4,907	129	19	129		4,907	17
18	Wheelchair Access	1986		4,908	129	19	129		4,908	18
19	Wheelchair Acces	1986		4,908	129	19	129		4,908	19
20	Electrical Work-Administrative Area	1986		5,065	133	19	133		5,065	20
21	Electrical Work-Administrative	1986		6,418	169	19	169		6,418	21
22	Electrical Work-Bendix	1986		15,975	420	19	420		15,975	22
23	Anderson Lane Resident Rooms	1986		16,532	435	19	435		16,532	23
24	Electrical Work-Glemaker	1986		17,030	448	19	448		17,030	24
25	Electrical Work-Wallenius I	1986		17,030	448	19	448		17,030	25
26	Electrical Work-Wallenius II	1986		17,030	448	19	448		17,030	26
27	Electrical Work-Asbury I	1986		17,030	448	19	448		17,030	27
28	Electrical Work-Asbury II	1986		17,030	448	19	448		17,030	28
29	Electrical Work-Anderson	1986		17,030	448	19	448		17,030	29
30	Electrical Work-Lingren II	1986		19,160	504	19	504		19,160	30
31	Electrical Work-Lingren I	1986		21,290	560	19	560		21,290	31
32	Heating/Cooling Lines	1986		44,252	1,165	19	1,165		44,252	32
33	Remodeling of the Nurses Station	1986		107,800	2,837	19	2,837		107,800	33
34	Dietary Remodeling	1986		166,018	4,369	19	4,369		166,018	34
35	Domestic Hot/Cold Water System	1987		1,420	39	18	39		1,420	35
36	Handrails-Allanes	1987		1,793	50	18	50		1,793	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Totals from Page 12, Carried Forward		\$ 2,440,366	\$ 28,730		\$ 28,730		\$ 2,440,366		37
38	Lingren Patio	1987	2,493	69	18	69		2,493		38
39	Lock Changes, All Lanes	1987	3,354	93	18	93		3,354		39
40	Gazebo Glenmaker Patio	1987	3,803	106	18	106		3,803		40
41	Add to Dietary Improvements	1987	4,547	126	18	126		4,547		41
42	Heating/Cooling Lines, Lindgren Lane	1987	7,888	219	18	219		7,888		42
43	Wheelchair Acc Bathrooms	1987	14,810	411	18	411		14,810		43
44	Heating/Cooling Lines, Anderson-Glemaker	1987	15,986	444	18	444		15,986		44
45	Improvement Snack Bar	1988	3,336	98	17	98		3,336		45
46	Remodeling Beauty Shop	1988	4,748	141	17	141		4,784		46
47	Improvement Alzheimer Unit	1988	7,338	216	17	216		7,338		47
48	Improvement Bendix Linen Rm	1988	7,512	221	17	221		7,512		48
49	Wallenius Utility Room	1988	8,916	262	17	262		8,916		49
50	Soffits Rebuilt in House	1988	9,558	281	17	281		9,558		50
51	Rotunda Remodeling	1988	157,446	4,631	17	4,631		157,446		51
52	Faucets for Resident Rooms	1989	1,422	44	16	44		1,422		52
53	Conversion of Tub Rms to Linen Closets	1989	1,977	62	16	62		1,977		53
54	Utility Rooms Lindgren	1989	2,495	78	16	78		2,495		54
55	Rotunda Renovation	1989	22,188	693	16	693		22,188		55
56	Interior Design Main Dining Room	1989	30,672	958	16	958		30,672		56
57	Remodeling Alzheimer Triangle	1989	30,809	963	16	963		30,809		57
58	Remodeling Bendix Lane	1989	101,675	3,177	16	3,177		101,675		58
59	Additional Terrace Remodeling	1989	114,204	3,569	16	3,569		114,204		59
60	Add to the Bendix Remodeling	1990	2,275	76	15	76		2,272		60
61	New Fire System	1991	1,112	75	15	75		1,075		61
62	Remodeling Closet No. 908	1992	650	25	13	25		650		62
63	Shed for Storage 14'x10'	1992	2,450	164	15	164		2,205		63
64	Remodeling Terrace Lobby	1992	2,991	115	13	115		2,991		64
65	Remodeling Lindgren II	1992	137,324	5,282	13	5,282		137,324		65
66	Alzheimer Project	1992	1,132,621	43,562	13	43,562		1,132,621		66
67	Install Electrical Plug Mold	1993	600	30	20	30		375		67
68	Electrical Work for Dock Garage	1993	1,000	50	20	50		625		68
69	Homeier Exit Door Alarm	1993	1,600	107	15	107		1,334		69
70	TOTAL (lines 4 thru 69)		\$ 4,280,166	\$ 95,078		\$ 95,078		\$ 4,279,051		70

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 4,280,166	\$ 95,078		\$ 95,078		\$ 4,279,051		1
2	Lobb/Offices	1993 4,300	179	12	179		4,300		2
3	Remodeling Dietary	1993 32,370	1,349	12	1,349		32,370		3
4	Remodeling Asbury II	1993 37,106	1,546	12	1,546		37,106		4
5	Remodeling Asbury I	1993 37,464	1,561	12	1,561		37,464		5
6	Remodeling Lindgren I	1993 49,201	2,050	12	2,050		49,201		6
7	Physical Therapy/Sensory Room	1993 61,250	2,552	12	2,552		61,250		7
8	Water Heater 240W/40Gal	1994 550	36	15	36		422		8
9	6" Concrete Pad for Compactor	1994 2,560	176	15	176		2,032		9
10	New Heating & A/C Unit	1994 17,500	875	20	875		10,063		10
11	Repair - Roof	1995 697	35	10	35		697		11
12	Labor & Cable for Phone Interface	1995 738	37	10	37		738		12
13	New Panic Bar Door	1995 950	47	10	47		950		13
14	New Roof Curbs	1995 1,370	68	10	68		1,370		14
15	Overbed Table	1995 2,623	175	15	175		1,837		15
16	Workforce Personel Lift Cap	1995 2,955	148	10	148		2,955		16
17	Phone Interface Unit	1995 3,024	151	10	151		3,024		17
18	Labor for Exterior Lighting	1995 4,100	205	10	205		4,100		18
19	Phone Interface Unit	1995 6,000	300	10	300		6,000		19
20	Digital Telephone System	1995 7,000	350	10	350		7,000		20
21	Light & Power on Emergency Service	1995 8,030	401	10	401		8,030		21
22	Retube Boiler #1 & New Burner	1995 9,966	498	20	498		5,230		22
23	Heat Recovery & Evaporative Cooling	1995 32,000	1,600	20	1,600		16,800		23
24	Doors	1996 750	75	10	75		713		24
25	Hallway Door	1996 835	83	10	83		793		25
26	Electronic Ballast Reflectors	1996 1,017	101	10	101		966		26
27	Personnel Protection Station	1996 1,029	103	10	103		978		27
28	Receiving Door	1996 1,327	133	10	133		1,261		28
29	Bethany Terrace Roof	1996 4,950	495	10	495		4,703		29
30	Roofing	1996 5,300	530	10	530		5,035		30
31	A M H U Outpatient Clinic	1996 5,387	359	15	359		3,411		31
32	Whirl Pool & Lift Bath Trolley	1996 14,287	952	15	952		9,048		32
33	Terrace Remodel	1996 1,353,487	90,232	15	90,232		857,208		33
34	TOTAL (lines 1 thru 33)	\$ 5,990,289	\$ 202,480		\$ 202,480		\$ 5,456,106		34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 5,990,289	\$ 202,480		\$ 202,480		\$ 5,456,106	1
2	Building Renovation	1997	605	41	15	41		342	2
3	Refrigeration	1997	689	69	10	69		586	3
4	Electrical Lighting	1997	768	38	20	38		325	4
5	Roofing	1997	777	39	20	39		331	5
6	Building Renovation	1997	820	55	15	55		466	6
7	Architectural Building	1997	2,608	260	10	260		2,217	7
8	Refrigeration Unit Deep Freezer	1997	2,720	272	10	272		2,312	8
9	Exit Door System	1997	4,600	460	10	460		3,910	9
10	PT-Daycare-Parking	1997	1,372,256	34,306	40	34,306		291,601	10
11	Electrical	1998	530	27	20	27		199	11
12	Convactor Motor	1998	886	89	10	89		665	12
13	Water Cooler	1998	1,395	93	15	93		697	13
14	Acoustical Ceiling	1998	1,488	99	15	99		743	14
15	MBS Delayed Egress System	1998	1,643	110	15	110		822	15
16	Cabinets (Wall)	1998	2,274	152	15	152		1,138	16
17	Soil Pipe	1998	2,540	170	15	170		1,269	17
18	Plate Glass Replacement	1998	2,825	283	10	283		2,119	18
19	Terrace Remodeling	1998	178,041	8,902	20	8,902		66,765	19
20	Vinyl Flooring	1999	819	82	10	82		533	20
21	D336 Motor	1999	921	92	10	92		598	21
22	D 336 Motor	1999	1,058	106	10	106		689	22
23	New Piping for Heating Units	1999	2,400	120	20	120		780	23
24	Carpentry	1999	5,041	252	20	252		1,638	24
25	Gasline for Bi-Fuel Conversion	1999	6,500	325	20	325		2,113	25
26	Chapel Dining Hall Sound System	1999	8,550	855	10	855		5,558	26
27	Fuel Storage Tank Upgrade	1999	9,360	1,170	8	1,170		7,605	27
28	Inst New Doors	1999	9,679	645	15	645		4,193	28
29	Electro Magnetic Locking Devices	1999	10,658	1,066	10	1,066		5,863	29
30	Bi-Fuel Conversion System	1999	12,400	620	20	620		4,030	30
31	Door Replacement/Carpentry	1999	16,901	845	20	845		5,493	31
32	Mechanical Insulation	1999	22,595	1,130	20	1,130		7,345	32
33	Chapel Renovation	1999	98,934	4,947	20	4,947		32,155	33
34	TOTAL (lines 1 thru 33)		\$ 7,773,570	\$ 260,200		\$ 260,200		\$ 5,911,206	34

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12D

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 7,773,570	\$ 260,200		\$ 260,200		\$ 5,911,206		1
2	Emergency Generator	1999 184,029	9,202	20	9,202		59,809		2
3	Garbage Disposal General Parts Inv. 067360	2000 2,348	235	5	235		2,348		3
4	Fence Around Generator	2000 2,491	166	15	166		913		4
5	Software for Call Acct. System S.D.T. Invoice 10727	2000 3,214	321	5	321		3,214		5
6	Aluminum Floor in Walk In Coolers	2000 4,165	417	10	417		2,291		6
7	Convection Oven Edward Don Inv. 1351909	2000 4,792	479	10	479		2,635		7
8	Boiler Upgrade for Dual Fuel Source	2000 5,217	261	20	261		1,435		8
9	ID Card Reading System Advanced Fire Inv 005811	2000 5,831	583	10	583		3,207		9
10	Terrace Remodeling FY 2000	2000 284,128	7,103	40	7,103		39,067		10
11	Valve for Sprinkler System Nelson Fire Protection	2001 635	42	15	42		189		11
12	Bearing Assemb for Circ. Pump Johnstone Supply	2001 1,397	140	10	140		653		12
13	Elkay Handicapp Drinking Fountain Martin Supply	2001 1,580	158	10	158		737		13
14	Garbage Disposal Emerald Restaurant Serv	2001 2,483	497	5	497		2,111		14
15	Light Pole in Parking Lot Divane Bros. Elec Co.	2001 2,840	284	10	284		1,302		15
16	Boiler Retubing, Hayes Boiler & Mechanical	2001 3,541	354	10	354		1,357		16
17	Carpet Lobby, Duncan Carpet Inv 48145	2001 3,606	722	5	722		2,885		17
18	Voice Cabling for Bendix Unit Greatline Comm.	2001 6,143	614	10	614		2,814		18
19	Phone Cabling Anderson Lane Greatline Comm	2001 7,180	718	10	718		3,351		19
20	Nurse Call Sys Bendix & Anderson Advanced	2001 62,523	6,252	10	6,252		29,176		20
21	Windows (309) Thermopane	2001 201,057	5,026	40	5,026		21,779		21
22	Remodel Bendix & Anderson Lanes	2001 455,626	22,781	20	22,781		98,718		22
23	Remote Alarm Stations Friendship, Advanced Fire	2002 3,038	304	10	304		1,115		23
24	Magnetic Door Holders, Advanced Fire Inv 006885	2002 3,850	385	10	385		1,414		24
25	Boiler Tubes, Hayes Boiler Inv 152615-A	2002 11,926	596	20	596		2,235		25
26	Chiller, RMC Inc Inv 0066175	2002 39,169	2,611	15	2,611		9,356		26
27	Roof Replacement, Atlas Construction	2002 540,218	54,022	10	54,022		166,568		27
28	Panic Device Fire Rated, Anderson Lock Inv 334375	2003 647	65	10	65		146		28
29	Panic Device Fire Rated, Anderson Lock Inv 334375	2003 647	65	10	65		146		29
30	Panic Device Fire Rated, Anderson Lock Inv 334375	2003 647	65	10	65		146		30
31	Panic Device Fire Rated, Anderson Lock Inv 334375	2003 647	65	10	65		146		31
32	Panic Device Fire Rated, Anderson Lock Inv 334375	2003 647	65	10	65		146		32
33	Fire Rated Panic Device, Anderson Lock Co.	2003 663	66	10	66		143		33
34	TOTAL (lines 1 thru 33)	\$ 9,620,495	\$ 374,864		\$ 374,864		\$ 6,372,758		34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 9,620,495	\$ 374,864		\$ 374,864		\$ 6,372,758		1
2	Signage "Called to Care", Pryor Architectual Signage	2003 1,409	141	10	141		329		2
3	Phone and Data Lines Homeir Lane, Greatline	2003 1,508	151	10	151		340		3
4	Cast Iron Waste in Boiler Room, Lamantia Building	2003 1,560	156	10	156		364		4
5	Doors in Friendship & Asbury Wings, Lamantia	2003 2,782	185	15	185		432		5
6	Electrical Pipe on Roof, Bruschuk Elec. Inv A174	2003 4,330	216	20	216		505		6
7	Expansion Tanks, Hayes Boiler & Mech. Inv 173470	2003 4,405	440	10	440		991		7
8	Parker Bathtub, Lamantia Building &	2003 7,818	782	10	782		1,955		8
9	Electrical Pipe on Roof, Bruschuk Elec. Inv A170	2003 9,481	474	20	474		1,146		9
10	Laundry Room Remodeling, Lamantia Building	2003 49,450	2,472	20	2,472		5,769		10
11	Roof Phase 3 Terrace, Atlas Construction	2003 275,652	27,565	10	27,565		57,427		11
12	Display Case Single Locking Room	2004 569	38	15	38		60		12
13	Display Case Single Locking Room	2004 902	60	15	60		95		13
14	Exhaust for Soiled Linen, Bruschuk Electric Inv A853	2004 1,023	102	10	102		136		14
15	Exhaust Fan Relays, Bruschuk Electric Inv A852	2004 1,902	190	10	190		253		15
16	Ejector Pump in Gleamker Washroom	2004 2,500	167	15	167		167		16
17	Exhaust Fan Relay, Bruschuk Electric Inv A869	2004 3,092	309	10	309		412		17
18	Plant & Wallpaper -- Terrace	2004 3,310	662	5	662		662		18
19	Exhaust Fan Relay Wiring/Circuiting, Bruschuk Elec	2004 3,836	192	20	192		240		19
20	RSTU Cards for 18 Analog Prots, Greatline Comm	2004 5,127	513	10	513		641		20
21	Coil and Compressor for Cooler, Accu-Temp Refrig	2004 5,135	514	10	514		685		21
22	Sprinklers in Rotunda & Snach Shop	2004 41,420	1,519	25	1,519		1,519		22
23	Plumbing Etc for Remodeling Suites,	2004 132,292	6,615	20	6,615		8,820		23
24	Roof Project Phase 4	2004 216,431	19,840	10	19,840		19,870		24
25	Remodel Terrace Suites and Triangle, La Mantia	2004 1,473,358	73,668	20	73,668		98,224		25
26	Fan Friendship Ln Activity Room	2005 1,015	25	10	25		25		26
27	Dental Office Conversion to Nursing Office	2005 1,300	11	20	11		11		27
28	Secure Care Alarm at Dock Door	2005 1,600	160	5	160		160		28
29	Walk In Cooler	2005 5,135	114	15	114		114		29
30	Sprinklers	2005 6,640	155	25	155		155		30
31	Baseboard Heating Units	2005 7,000	39	15	39		39		31
32	Therapy Dining Room Remodeling	2005 11,480	48	20	48		48		32
33	Craft Room Renovation	2005 16,000	267	20	267		267		33
34	TOTAL (lines 1 thru 33)	\$ 11,919,957	\$ 512,654		\$ 512,654		\$ 6,574,619		34

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/04

Ending:

9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward		\$ 11,919,957	\$ 512,654		\$ 512,654		\$ 6,574,619	1
2	2005	16,087	804	10	804		804		2
3	2005	22,755	569	10	569		569		3
4	2005	24,370	102	20	102		102		4
5	2005	47,691	397	20	397		397		5
6	2005	60,750	253	20	253		253		6
7	1988	92,988	3,720	25	3,720		65,092		7
8	1994	1,460	121	12	121		1,399		8
9	1995	6,525	326	10	326		6,525		9
10	1995	2,800	140	10	140		2,800		10
11	1999	10,191	510	20	510		3,313		11
12	1999	13,450	897	15	897		5,830		12
13	1999	5,300	530	10	530		2,915		13
14	2000	14,029	1,403	10	1,403		7,716		14
15	2000	4,475	112	40	112		616		15
16	2000	2,271	284	8	284		1,562		16
17	2000	3,390	423	8	423		2,331		17
18	2005	7,800	325	10	325		325		18
19	2005	18,500	463	10	463		463		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,274,789	\$ 524,033		\$ 524,033		\$ 6,677,631	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** # **0015651** Report Period Beginning: **10/1/04** Ending: **9/30/05**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,146,452	\$ 97,215	\$ 97,215	\$	Various	\$ 591,501	71
72	Current Year Purchases	92,575	8,783	8,783		Various	8,783	72
73	Fully Depreciated Assets	See Dep Report						73
74								74
75	TOTALS	\$ 1,239,027	\$ 105,998	\$ 105,998	\$		\$ 600,284	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT ACTIVITIES	FORD, EL DORADO BUS, 99	2003	\$ 19,125	\$ 3,825	\$ 3,825	\$	5	\$ 7,650	76
77										77
78										78
79										79
80	TOTALS			\$ 19,125	\$ 3,825	\$ 3,825	\$		\$ 7,650	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,814,814	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 633,856	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 633,856	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,285,565	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 60,444 Description: THERAPY EQUIPT, VAC FREEDOM, SPECIAL BEDS
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a	hrs	\$	2,789	\$	173,934				2,789	\$	173,934	1
2	Licensed Speech and Language Development Therapist	10a	hrs		829		64,043				829		64,043	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a	hrs		4,305		282,859				4,305		282,859	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$	7,923	\$	520,836	\$			7,923	\$	520,836	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/04

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/05

(last day of reporting year)

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,066,528	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		3
4	Supply Inventory (priced at)	400,683	4
5	Short-Term Investments	10,006,916	5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	335,659	7
8	Accounts Receivable (owners or related parties)	13,521,270	8
9	Other(specify): <u>Due to 3rd Parties</u>	(3,418,451)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 21,912,605	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	82,340	12
13	Land	6,056,344	13
14	Buildings, at Historical Cost	83,253,142	14
15	Leasehold Improvements, at Historical Cost	2,371,157	15
16	Equipment, at Historical Cost	13,963,076	16
17	Accumulated Depreciation (book methods)	(52,988,253)	17
18	Deferred Charges	542,778	18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds	10,235,046	21
22	Other Long-Term Assets (specify):		22
23	Other(specify): <u>Land Not Used in Ops</u>	33,684	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 63,549,314	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 85,461,919	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 1,348,726	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	1,037,094	29
30	Accrued Salaries Payable	3,210,253	30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable	123,859	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	<u>Due to 3rd Parties</u>	1,505,562	36
37	<u>Other</u>	1,227,121	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,452,615	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,032,462	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43	<u>Accrued Pension</u>	847,095	43
44	<u>Malpractice</u>	1,493,480	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,373,037	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 54,825,652	46
47	TOTAL EQUITY (page 18, line 24)	\$ 30,671,643	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 30,671,643 \$ 54,825,652	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 33,990,260	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 33,990,260	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	542,202	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Gain/Loss Period	(3,468,087)	15
16	Other (describe) TERR Net Income	(392,732)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,318,617)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 30,671,643	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/04

Ending:

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9/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,943,527	1
2	Discounts and Allowances for all Levels	(4,704,440)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,239,087	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,084	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	29,913	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,300	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,297	23
D. Non-Operating Revenue			
24	Contributions	347,390	24
25	Interest and Other Investment Income***	23,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 370,390	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain/Loss on Disposal of Asset	(8,155)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (8,155)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,635,619	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,231,178	31
32	Health Care	6,237,244	32
33	General Administration	2,134,959	33
B. Capital Expense			
34	Ownership	711,127	34
C. Ancillary Expense			
35	Special Cost Centers	2,662	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Provider Participation Fee	(149,470)	37
38	Variance	(223)	38
39	Mission & Spiritual	(74,060)	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,093,417	40
41	Income before Income Taxes (line 30 minus line 40)**	542,202	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 542,202	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/04

Ending: 9/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,328	2,328	\$ 90,090	\$ 38.70	1
2	Assistant Director of Nursing	4,160	4,160	145,013	34.86	2
3	Registered Nurses	40,765	40,765	1,047,910	25.71	3
4	Licensed Practical Nurses	29,376	29,376	646,646	22.01	4
5	CNAs & Orderlies	196,386	196,386	2,264,051	11.53	5
6	CNA Trainees					6
7	Licensed Therapist	2,520	2,520	69,076	27.41	7
8	Rehab/Therapy Aides	5,326	5,326	68,528	12.87	8
9	Activity Director	2,080	2,080	39,558	19.02	9
10	Activity Assistants	21,473	21,473	204,468	9.52	10
11	Social Service Workers	3,095	3,095	48,545	15.68	11
12	Dietician	1,531	1,531	20,077	13.11	12
13	Food Service Supervisor	4,535	4,535	52,999	11.69	13
14	Head Cook	9,132	9,132	145,779	15.96	14
15	Cook Helpers/Assistants	40,176	40,176	326,946	8.14	15
16	Dishwashers					16
17	Maintenance Workers	4,190	4,190	87,248	20.82	17
18	Housekeepers	36,586	36,586	314,469	8.60	18
19	Laundry	14,568	14,568	120,093	8.24	19
20	Administrator					20
21	Assistant Administrator	160	160	4,616	28.85	21
22	Other Administrative	29,488	29,488	598,133	20.28	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,284	2,284	41,007	17.95	31
32	Other Health Care (PHYSICIAN)			28,245		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	450,159	450,159	\$ 6,363,497 *	\$ 14.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
35	Dietary Consultant	\$	35
36	Medical Director		36
37	Medical Records Consultant		37
38	Nurse Consultant		38
39	Pharmacist Consultant		39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant		45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$	49

C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$	50
51	Licensed Practical Nurses		51
52	Certified Nurse Assistants/Aides		52
53	TOTAL (lines 50 - 52)	\$	53

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/04

Ending: 9/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kenneth Kolich	Administrator		\$ 117,131	Workers' Compensation Insurance	\$ 30,115	IDPH License Fee	\$ 14,079	
				Unemployment Compensation Insurance	27,996	Advertising: Employee Recruitment	14,079	
				FICA Taxes	470,844	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	225,701	Life Services Network	12,204	
				Employee Meals		NAIER	1,090	
				Illinois Municipal Retirement Fund (IMRF)*		Chicago Tribune	1,454	
				Employee Life Insurance	7,019	HCPRO	906	
				Transfers of Fringe Benefits	162,736	Other	874	
				F/S AUDIT AJE	11,597			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,131	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 936,008		\$ 30,607		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Corporate Allocation			\$ 210,744				Out-of-State Travel	\$
							In-State Travel	5,878
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 210,744				Seminar Expense	3,696
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 9,574
C. Professional Services								
Vendor/Payee	Type	Amount						
Quality Care Consulting	Activity Consulting	\$ 4,975						
Comp Therapeutic	Rehab Consulting	4,425						
Carol Gordon	SS Consulting	2,025						
Carlin & Assoc	MR Consulting	5,412						
Frost Ruttenberg & Rothblatt	Reimb Consulting	3,402						
Adminastar Federal	Patient Accts	396						
Cassidy, Schade, & Gloor	Legal Fees	3,030						
Gardner, Carter, & Douglas	Legal Fees	855						
Village of Morton Grove	Licenses	990						
MCHC -- Service Corp	Background Reviews	576						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 26,086	TOTAL			\$	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICES NETWORK -- \$12,204
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 85,978 Line 10.02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 149,470
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 29,914
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: PRICEWATERHOUSECOOPERS LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT YET AVAILABLE
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.