

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE# 0015651 Report Period Beginning: 10/1/2005 Ending: 9/30/2006

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	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	180	Intermediate (ICF)	180	65,700	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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	2,096	2,400	5,315	9,811	8
9	SNF/PED					9
10	ICF	37,698	21,911	679	60,288	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,794	24,311	5,994	70,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.84%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 2/13/1965J. 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 _____ and days of care provided _____Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/1/2005 Fiscal Year: 9/30/2006

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** # **0015651** Report Period Beginning: **10/1/2005** Ending: **9/30/2006****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	566,641	33,384	(76,225)	523,800		523,800	(37,437)	486,363		1
2	Food Purchase		568,445		568,445		568,445		568,445		2
3	Housekeeping	293,757	97,514	15,253	406,524		406,524		406,524		3
4	Laundry	96,746	(20,823)	1,014	76,937		76,937		76,937		4
5	Heat and Other Utilities			339,445	339,445		339,445		339,445		5
6	Maintenance	92,908	13,656	177,112	283,676		283,676		283,676		6
7	Other (specify):*										7
8	TOTAL General Services	1,050,052	692,176	456,599	2,198,827		2,198,827	(37,437)	2,161,390		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,306,975	615,608	170,458	5,093,041		5,093,041	(685)	5,092,356		10
10a	Therapy	78,747	65	332,724	411,536		411,536		411,536		10a
11	Activities	98,609	3,074	30,323	132,006		132,006	(32)	131,974		11
12	Social Services	81,571	179	322	82,072		82,072		82,072		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mission & Spiritual	(1,319)		1,851	532		532		532		15
16	TOTAL Health Care and Programs	4,564,583	618,926	535,678	5,719,187		5,719,187	(717)	5,718,470		16
	C. General Administration										
17	Administrative	122,984		498,328	621,312		621,312	(258,195)	363,117		17
18	Directors Fees										18
19	Professional Services			64,372	64,372		64,372		64,372		19
20	Dues, Fees, Subscriptions & Promotions			9,319	9,319		9,319		9,319		20
21	Clerical & General Office Expenses	314,613	16,888	170,510	502,011		502,011	(50,660)	451,351		21
22	Employee Benefits & Payroll Taxes			947,838	947,838	9,788	957,626	10,118	967,744		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,332	8,332		8,332		8,332		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			82,760	82,760	(9,788)	72,972		72,972		26
27	Other (specify):* Volunteers		497	3,153	3,650		3,650		3,650		27
28	TOTAL General Administration	437,597	17,385	1,784,612	2,239,594		2,239,594	(298,737)	1,940,857		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,052,232	1,328,487	2,776,889	10,157,608		10,157,608	(336,891)	9,820,717		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: 10/1/2005 Ending: 9/30/2006

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			553,461	553,461		553,461		553,461			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			82,397	82,397		82,397		82,397			35
36	Other (specify):*											36
37	TOTAL Ownership			635,858	635,858		635,858		635,858			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			1,684	1,684		1,684	(1,110)	574			41
42	Provider Participation Fee							149,468	149,468			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,684	1,684		1,684	148,358	150,042			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,052,232	1,328,487	3,414,431	10,795,150		10,795,150	(188,533)	10,606,617			45

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

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE**

0015651

Report Period Beginning: **10/1/2005**

Ending: **9/30/2006**

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	(37,437)	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				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	(49,594)	21		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	156,693	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 69,662		\$	30

BHF 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)	(258,195)	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (258,195)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (188,533)		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: 10/1/2005

Ending: 9/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	SPECIAL REVENUE	\$ (1,066)	21	1
2	HEALTH INFO MGT MISC INC	(586)	10	2
3	GIFT SHOP REVENUE	(1,110)	41	3
4	ACTIVITIES MISC INC	(32)	11	4
5	MARKETING/ADVERTISING SUPPLIES	(99)	10	5
6	PROVIDER PARTICIPATION FEE	149,468	42	6
7	F/S AUDIT AJE -- FRINGE BENEFITS	10,118	22	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	156,693		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE# 0015651

Report Period Beginning:

10/1/2005

Ending:

9/30/2006**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	(37,437)	0	0	0	0	0	0	0	0	0	0	(37,437)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(37,437)	0	0	0	0	0	0	0	0	0	0	(37,437)	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	(685)	0	0	0	0	0	0	0	0	0	0	(685)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(32)	0	0	0	0	0	0	0	0	0	0	(32)	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	(717)	0	0	0	0	0	0	0	0	0	0	(717)	16
	C. General Administration													
17	Administrative	(258,195)	0	0	0	0	0	0	0	0	0	0	(258,195)	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	(50,660)	0	0	0	0	0	0	0	0	0	0	(50,660)	21
22	Employee Benefits & Payroll Taxes	10,118	0	0	0	0	0	0	0	0	0	0	10,118	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	(298,737)	0	0	0	0	0	0	0	0	0	0	(298,737)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(336,891)	0	0	0	0	0	0	0	0	0	0	(336,891)	29

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE**

0015651

Report Period Beginning: **10/1/2005**

Ending: **9/30/2006**

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	\$ 152,996	Methodist Hospital of Chicago	100.00%	\$ 84,148	\$ (68,848) 1
2	V	Corporate Benefits	189,911	Methodist Hospital of Chicago	100.00%	79,763	(110,148) 2
3	V	Corporate Pro Fees	51,271	Methodist Hospital of Chicago	100.00%	28,199	(23,072) 3
4	V	Corporate Other	60,725	Methodist Hospital of Chicago	100.00%	33,399	(27,326) 4
5	V	Hospital Administrative	28,800	Methodist Hospital of Chicago	100.00%	(1)	(28,801) 5
6	V	Hospital Accounting	92,220	Methodist Hospital of Chicago	100.00%	92,220	6
7	V	Hospital Purchasing	40,454	Methodist Hospital of Chicago	100.00%	40,454	7
8	V	Hospital EDP	32,104	Methodist Hospital of Chicago	100.00%	32,104	8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 648,481			\$ 390,286	\$ * (258,195) 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: 10/1/2005 Ending: 9/30/2006

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: **10/1/2005** Ending: **3/30/2006**

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	\$ 611,984	\$	25	\$ 152,996	1
2	Corporate Benefits	% to Total Cost	100	Various	759,643		25	189,911	2
3	Corporate Pro Fees	% to Total Cost	100	Various	205,084		25	51,271	3
4	Corporate Other	% to Total Cost	100	Various	242,899		25	60,725	4
5	Hospital Administrative	% to Total Cost	100	Various	28,800		100	28,800	5
6	Hospital Accounting	% to Total Cost	100	Various	368,878		25	92,220	6
7	Hospital Purchasing	% to Total Cost	100	Various	210,697		19	40,454	7
8	Hospital EDP	% to Total Cost	100	Various	356,713		9	32,104	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				\$ 2,784,698	\$		\$ 648,481	25

Facility Name & ID Number **BETHANY TERRACE NURSING CENTRE** # **0015651** Report Period Beginning: **10/1/2005** Ending: **9/30/2006**

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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 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 2006 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"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 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 2005 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 2005.

(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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

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	1995	\$ 189,809	1
2	TERR LAND TRIANGLE		1996	92,064	2
3	TOTALS	183,600		\$ 281,873	3

STATE OF ILLINOIS

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/2005

Ending:

9/30/2006

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 BHF 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		40			\$ 1,332,134	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Item Remodeling		1973	23,592		32			23,592	9
10	Item Remodeling		1973	44,792		32			44,792	10
11	Improvements Fire Alarm System		1975	18,001		30			18,001	11
12	Improvements Lane Conversion		1975	42,023		30			42,023	12
13	Re-Wiring of Electrical Conduit		1985	59,165		20			59,165	13
14	Kitchen and Employee Dining Room		1985	392,466		20			392,466	14
15	Dental Suite and Chaplains Office		1986	4,260		19			4,260	15
16	Wheelchair Access -- Wallenius I		1986	4,907		19			4,907	16
17	Wheelchair Access -- Asbury I		1986	4,908		19			4,908	17
18	Wheelchair Access -- Lindgren I		1986	4,908		19			4,908	18
19	Electrical Work-Administrative Area		1986	5,065		19			5,065	19
20	Electrical Work-Administrative		1986	6,418		19			6,418	20
21	Electrical Work-Bendix		1986	15,975		19			15,975	21
22	Anderson Lane Resident Rooms		1986	16,532		19			16,532	22
23	Electrical Work-Glemaker		1986	17,030		19			17,030	23
24	Electrical Work-Wallenius I		1986	17,030		19			17,030	24
25	Electrical Work-Wallenius II		1986	17,030		19			17,030	25
26	Electrical Work-Asbury I		1986	17,030		19			17,030	26
27	Electrical Work-Asbury II		1986	17,030		19			17,030	27
28	Electrical Work-Anderson		1986	17,030		19			17,030	28
29	Electrical Work-Lingren II		1986	19,160		19			19,160	29
30	Electrical Work-Lingren I		1986	21,290		19			21,290	30
31	Heating/Cooling Lines		1986	44,252		19			44,252	31
32	Remodeling of the Nurses Station		1986	107,800		19			107,800	32
33	Dietary Remodeling		1986	166,018		19			166,018	33
34	Lock Changes, All Lanes		1987	3,354		18			3,354	34
35	Gazebo Glenmaker Patio		1987	3,803		18			3,803	35
36	Add to Dietary Improvements		1987	4,547		18			4,547	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/2005

Ending:

9/30/2006

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	Heating/Cooling Lines, Lindgren Lane	1987	\$ 7,888	\$	18	\$	\$ 7,888		37
38	Wheelchair Acc Bathrooms	1987	14,810		18		14,810		38
39	Heating/Cooling Lines, Anderson-Glemaker	1987	15,986		18		15,986		39
40	Improvement Snack Bar	1988	3,336		17		3,336		40
41	Remodeling Beauty Shop	1988	4,784		17		4,784		41
42	Improvement Alzheimer Unit	1988	7,338		17		7,338		42
43	Improvement Bendix Linen Rm	1988	7,512		17		7,512		43
44	Wallenius Utility Room	1988	8,916		17		8,916		44
45	Soffits Rebuilt in House	1988	9,558		17		9,558		45
46	Rotunda Remodeling	1988	157,446		17		157,446		46
47	Water Main System	1988	92,988	3,720	25	3,720	68,812		47
48	Rotunda Renovation	1989	22,188		16		22,188		48
49	Interior Design Main Dining Room	1989	30,672		16		30,672		49
50	Remodeling Alzheimer Triangle	1989	30,809		16		30,809		50
51	Remodeling Bendix Lane	1989	101,675		16		101,675		51
52	Additional Terrace Remodeling	1989	114,204		16		114,204		52
53	Remodeling Terrace Lobby	1992	2,991		13		2,991		53
54	Remodeling Lindgren II	1992	137,324		13		137,324		54
55	Alzheimer Project	1992	1,132,621		13		1,132,621		55
56	Lobb/Offices	1993	4,300		12		4,300		56
57	Remodeling Dietary	1993	32,370		12		32,370		57
58	Remodeling Asbury II	1993	37,106		12		37,106		58
59	Remodeling Asbury I	1993	37,464		12		37,464		59
60	Remodeling Lindgren I	1993	49,201		12		49,201		60
61	Physical Therapy/Sensory Room	1993	61,250		12		61,250		61
62	6" Concrete Pad for Compactor	1994	2,650	176	15	176	2,208		62
63	New Heating & A/C Unit	1994	17,500	875	20	875	10,938		63
64	Overbed Table	1995	2,623	175	15	175	2,012		64
65	Workforce Personnel Lift Cap	1995	2,955		10		2,955		65
66	Phone Interface Unit	1995	3,024		10		3,024		66
67	Labor for Exterior Lighting	1995	4,100		10		4,100		67
68	Phone Interface Unit	1995	6,000		10		6,000		68
69	Digital Telephone System	1995	7,000		10		7,000		69
70	TOTAL (lines 4 thru 69)		\$ 4,618,139	\$ 4,946		\$ 4,946	\$ 4,586,348		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:

10/1/2005

Ending: 9/30/2006

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	\$ 4,618,139	\$ 4,946		\$ 4,946		\$ 4,586,348		1
2	Light & Power on Emergency Service	1995	8,030		10		8,030		2
3	Landscaping	1995	2,800		10		2,800		3
4	PL Improv -- H&L Constr	1995	6,525		10		6,525		4
5	Retube Boiler #1 & New Burner	1995	9,966	498	20	498	5,728		5
6	Heat Recovery & Evaporative Cooling	1995	32,000	1,600	20	1,600	18,400		6
7	A M H U Outpatient Clinic	1996	5,387	359	15	359	3,770		7
8	Bethany Terrace Roof	1996	4,950	495	10	495	5,198		8
9	Roofing	1996	5,300	530	10	530	5,565		9
10	Communication System	1996	5,833	583	10	583	6,124		10
11	Whirl Pool & Lift Bath Trolley	1996	14,287	952	15	952	10,000		11
12	Terrace Remodel	1996	1,353,487	90,232	15	90,232	947,440		12
13	Architectural Building	1997	2,608	260	10	260	2,477		13
14	Refrigeration Unit Deep Freezer	1997	2,720	272	10	272	2,584		14
15	Exit Door System	1997	4,600	460	10	460	4,370		15
16	PT-Daycare-Parking	1997	1,372,256	34,306	40	34,306	325,907		16
17	Soil Pipe	1998	2,540	170	15	170	1,439		17
18	Plate Glass Replacement	1998	2,825	283	10	283	2,402		18
19	Terrace Remodeling	1998	178,041	8,902	20	8,902	75,667		19
20	Carpentry	1999	5,041	252	20	252	1,890		20
21	Gasline for Bi-Fuel Conversion	1999	6,500	325	20	325	2,438		21
22	Land Improv -- Landscaping	1999	10,191	510	20	510	3,823		22
23	Paving Stones & Interlocking Pavement	1999	5,300	530	10	530	3,445		23
24	Bi-Fuel Conversion System	1999	12,400	620	20	620	4,650		24
25	Inst New Doors	1999	9,679	645	15	645	4,838		25
26	Door Replacement/Carpentry	1999	16,901	845	20	845	6,338		26
27	Chapel Dining Hall Sound System	1999	8,550	855	10	855	6,413		27
28	Upper Parking Lot Pavement	1999	13,450	897	15	897	6,727		28
29	Electro Magnetic Locking Devices	1999	10,658	1,066	10	1,066	6,929		29
30	Mechanical Insulation	1999	22,595	1,130	20	1,130	8,475		30
31	Fuel Storage Tank Upgrade	1999	9,360	1,170	8	1,170	8,775		31
32	Chapel Renovation	1999	98,934	4,947	20	4,947	37,102		32
33	Emergency Generator	1999	184,029	9,202	20	9,202	69,011		33
34	TOTAL (lines 1 thru 33)	\$ 8,045,882	\$ 167,842		\$ 167,842		\$ 6,191,628		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:

10/1/2005

Ending: 9/30/2006

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	\$ 8,045,882	\$ 167,842		\$ 167,842		\$ 6,191,628		1
2	Terrace Remodeling FY 2000	2000 284,128	7,103	40	7,103		46,170		2
3	Software for Call Acct. System S.D.T. Invoice 10727	2000 3,214		5			3,214		3
4	Aluminum Floor in Walk In Coolers	2000 4,165	417	10	417		2,708		4
5	Convection Oven Edward Don Inv. 1351909	2000 4,792	479	10	479		3,114		5
6	Boiler Upgrade for Dual Fuel Source	2000 5,217	261	20	261		1,696		6
7	ID Card Reading System Advanced Fire Inv 005811	2000 5,831	583	10	583		3,790		7
8	Paving for Bus & Van	2000 3,390	423	8	423		2,754		8
9	Stairs & Concrete	2000 4,475	112	40	112		728		9
10	Stoning Grading	2000 14,029	1,403	10	1,403		9,119		10
11	Carpet Lobby, Duncan Carpet Inv 48145	2001 3,606	722	5	722		3,607		11
12	Windows (309) Thermopane	2001 201,057	5,026	40	5,026		26,805		12
13	Remodel Bendix & Anderson Lanes	2001 455,626	22,781	20	22,781		121,499		13
14	Light Pole in Parking Lot Divane Bros. Elec Co.	2001 2,840	284	10	284		1,586		14
15	Boiler Retubing, Hayes Boiler & Mechanical	2001 3,541	354	10	354		1,711		15
16	Voice Cabling for Bendix Unit Greatline Comm.	2001 6,143	614	10	614		3,428		16
17	Nurse Call Sys Bendix & Anderson Advanced	2001 62,523	6,252	10	6,252		35,428		17
18	Chiller, RMC Inc Inv 0066175	2002 39,169	2,611	15	2,611		11,967		18
19	Roof Replacement, Atlas Construction	2002 540,218	54,022	10	54,022		220,590		19
20	Remote Alarm Stations Friendship, Advanced Fire	2002 3,038	304	10	304		1,419		20
21	Magnetic Door Holders, Advanced Fire Inv 006885	2002 3,850	385	10	385		1,799		21
22	Boiler Tubes, Hayes Boiler Inv 152615-A	2002 11,926	596	20	596		2,831		22
23	Laundry Room Remodeling, Lamantia Building	2003 49,450	2,472	20	2,472		8,241		23
24	Roof Phase 3 Terrace, Atlas Construction	2003 275,652	27,565	10	27,565		84,992		24
25	Doors in Friendship & Asbury Wings, Lamantia	2003 2,782	185	15	185		617		25
26	Electrical Pipe on Roof, Bruschuk Elec. Inv A174	2003 4,330	216	20	216		721		26
27	Expansion Tanks, Hayes Boiler & Mech. Inv 173470	2003 4,405	440	10	440		1,431		27
28	Parker Bath tub, Lamantia Building &	2003 7,818	782	10	782		2,737		28
29	Electrical Pipe on Roof, Bruschuk Elec. Inv A170	2003 9,481	474	20	474		1,620		29
30	Plant & Wallpaper -- Terrace	2004 3,310	662	5	662		1,324		30
31	Roof Project Phase 4	2004 216,431	19,840	10	19,840		39,710		31
32	Remodel Terrace Suites and Triangle, La Mantia	2004 1,473,358	73,668	20	73,668		171,892		32
33	Ejector Pump in Gleamker Washroom	2004 2,500	167	15	167		334		33
34	TOTAL (lines 1 thru 33)	\$ 11,758,177	\$ 399,045		\$ 399,045		\$ 7,011,210		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:

10/1/2005

Ending: 9/30/2006

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	\$ 11,758,177	\$ 399,045		\$ 399,045		\$ 7,011,210		1
2	Exhaust Fan Relay, Bruschuk Electric Inv A869	2004 3,092	309	10	309		721		2
3	Exhaust Fan Relay Wiring/Circuiting, Bruschuk Elec	2004 3,836	192	20	192		432		3
4	RSTU Cards for 18 Analog Prots, Greatline Comm	2004 5,127	513	10	513		1,154		4
5	Coil and Compressor for Cooler, Accu-Temp Refrig	2004 5,135	514	10	514		1,199		5
6	Sprinklers in Rotunda & Snach Shop	2004 41,420	1,519	25	1,519		3,038		6
7	Plumbing Etc for Remodeling Suites,	2004 132,292	6,615	20	6,615		15,435		7
8	Therapy Dining Room Remodeling	2005 11,480	48	20	48		96		8
9	Craft Room Renovation	2005 16,000	267	20	267		534		9
10	Carrier 15 Ton Roof Unit	2005 16,087	804	10	804		1,608		10
11	Craft Room Renovation	2005 24,370	102	20	102		204		11
12	Dialysis Center Capital Project	2005 47,691	397	20	397		794		12
13	Employee Dining Room Remodeling	2005 60,750	253	20	253		506		13
14	Expansion Tanks	2005 4,110	343	10	343		343		14
15	Washer Extractor 40LB	2005 6,220	778	8	778		778		15
16	Walk In Cooler	2005 5,135	114	15	114		228		16
17	Sprinklers	2005 6,640	155	25	155		310		17
18	Baseboard Heating Units	2005 7,000	39	15	39		78		18
19	Irrigation System	2005 22,755	569	10	569		1,138		19
20	Pond Install	2005 7,800	325	10	325		650		20
21	Landscape Sections 2,3,4,5	2005 18,500	463	10	463		926		21
22	Compressors in Carrier Roof Top Unit	2006 5,157	215	10	215		215		22
23	Nurse call system Vision Link 2500	2006 21,160	353	10	353		353		23
24	Rooftop Unit Blower Motor	2006 5,613	47	10	47		47		24
25	Aluminum Ornamental Fence	2006 5,520	153	15	153		153		25
26	Trees & Landscaping	2006 3,545	148	10	148		148		26
27	New Storm Drains-Parking Lot	2006 5,000	83	10	83		83		27
28	New Storm Drains-Parking Lot	2006 4,900	41	10	41		41		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 12,254,512	\$ 414,404		\$ 414,404		\$ 7,042,422		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: **10/1/2005** Ending: **9/30/2006**

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	\$ 1,660,324	\$ 112,030	\$ 112,030	\$	Various	\$ 1,022,004	71
72	Current Year Purchases	66,565	4,304	4,304		Various	4,304	72
73	Fully Depreciated Assets	See Depreciation Report						73
74								74
75	TOTALS	\$ 1,726,889	\$ 116,334	\$ 116,334	\$		\$ 1,026,308	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	\$ 3,825	76
77										77
78										78
79										79
80	TOTALS			\$ 19,125	\$ 3,825	\$ 3,825	\$		\$ 3,825	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)	\$ 14,282,399	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 534,563	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 534,563	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)	\$ 8,072,555	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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: \$ 82,397 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	\$	1,906	\$	116,771	\$	1,906	\$	116,771	1		
2	Licensed Speech and Language Development Therapist	10a	hrs		263		19,792		263		19,792	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a	hrs		2,932		195,380		2,932		195,380	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			\$	5,100	\$	331,942	\$	5,100	\$	331,942	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

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Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/2005

Ending:

9/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 850	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 569,583)		2,226,109	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		111,794	7
8	Accounts Receivable (owners or related parties)		2,323,046	8
9	Other(specify): DUE TO 3RD PARTIES		(321,110)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 4,340,689	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		281,873	13
14	Buildings, at Historical Cost		12,437,086	14
15	Leasehold Improvements, at Historical Cost		1,040,721	15
16	Equipment, at Historical Cost		4,225,970	16
17	Accumulated Depreciation (book methods)		(11,145,496)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OTHER		60,778	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 6,900,932	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 11,241,621	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 314,652	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	TRUST FUNDS		23,497	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 338,149	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 338,149	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,903,472	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,903,472	\$ 338,149	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,887,202	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,887,202	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(151,668)	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)	(1,832,062)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,983,730)	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)	\$ 10,903,472	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/2005

Ending:

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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	\$ 15,062,523	1
2	Discounts and Allowances for all Levels	(4,491,722)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,570,801	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	1,110	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	37,437	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	1,652	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,199	23
D. Non-Operating Revenue			
24	Contributions	7,918	24
25	Interest and Other Investment Income***	24,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,918	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Activity Misc Rev</u>	32	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,642,950	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,198,827	31
32	Health Care	5,719,187	32
33	General Administration	2,239,594	33
B. Capital Expense			
34	Ownership	635,858	34
C. Ancillary Expense			
35	Special Cost Centers	1,684	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Mission & Spiritual</u>	(532)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,794,618	40
41	Income before Income Taxes (line 30 minus line 40)**	(151,668)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (151,668)	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: 10/1/2005

Ending: 9/30/2006

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	3,711	4,170	\$ 128,972	\$ 30.93	1
2	Assistant Director of Nursing	3,680	4,160	151,778	36.49	2
3	Registered Nurses	30,529	55,303	915,527	16.55	3
4	Licensed Practical Nurses	25,496	36,571	634,417	17.35	4
5	CNAs & Orderlies	154,824	205,925	2,088,856	10.14	5
6	CNA Trainees					6
7	Licensed Therapist	37	37	994	26.86	7
8	Rehab/Therapy Aides	5,431	6,040	77,093	12.76	8
9	Activity Director	1,768	2,080	41,292	19.85	9
10	Activity Assistants	15,197	16,339	150,407	9.21	10
11	Social Service Workers	3,593	3,957	59,085	14.93	11
12	Dietician	1,424	1,632	21,602	13.24	12
13	Food Service Supervisor	3,861	4,425	53,890	12.18	13
14	Head Cook	7,917	9,663	146,624	15.17	14
15	Cook Helpers/Assistants	38,115	43,753	336,398	7.69	15
16	Dishwashers					16
17	Maintenance Workers	3,686	6,509	90,672	13.93	17
18	Housekeepers	31,855	35,778	313,652	8.77	18
19	Laundry	7,980	8,749	80,829	9.24	19
20	Administrator					20
21	Assistant Administrator	1,767	1,934	57,669	29.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	32,753	30,038	532,607	17.73	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	2,024	2,220	40,834	18.39	31
32	Other Health Care PHYSICIANS			46,996		32
33	Other(specify) Variance			82,038		33
34	TOTAL (lines 1 - 33)	375,648	479,283	\$ 6,052,232 *	\$ 12.63	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	8	\$ 446	19	35
36	Medical Director				36
37	Medical Records Consultant	104	4,576	19	37
38	Nurse Consultant	234	14,040	19	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	49	2,425	19	44
45	Social Service Consultant	48	2,160	19	45
46	Other(specify) DEMENTIA	54	2,738	19	46
47					47
48					48
49	TOTAL (lines 35 - 48)	497	\$ 26,385		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,088	\$ 655,561	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,088	\$ 655,561		53

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning: 10/1/2005

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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		\$ 122,984	Workers' Compensation Insurance	\$ 44,309	IDPH License Fee	\$	
				Unemployment Compensation Insurance	15,978	Advertising: Employee Recruitment	1,439	
				FICA Taxes	442,815	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	264,879	Patient Background Checks	840	
				Employee Meals		Life Services Network	2,963	
				Illinois Municipal Retirement Fund (IMRF)*		Chicago Tribune & Other	1,661	
				Transfers of Fring Benefits	191,975	Adminastar Federal	792	
				Employee Life Insurance	7,788	HCPPro	613	
						Other	1,011	
						Less: Public Relations Expense (
						Non-allowable advertising (
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 122,984			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,319	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Corporate Allocation			\$ 498,328	Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
							In-State Travel	5,828
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 498,328				Seminar Expense	2,504
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense (
Quality Care Consulting	Dementia/Activity Consultin		\$ 5,163				(agree to Sch. V, line 24, col. 8)	\$ 8,332
Comprehensive Therapeutic	Rehab Nurse Consulting		14,040					
Carol Gordon	Social Service Consulting		2,160					
Carlin & Assoc	Med Rec Consulting		4,576					
Cynthia Chow & Assoc	Dietary Consulting		446					
Adminastar Federal	Misc		396					
Various	Billing Consulting		12,440					
Various	Legal		22,771					
MCHC Service Corp	Background Checks		2,160					
Village of Morton Grove	Licenses		220					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 64,372	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 -- \$2,963
- (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? VARIOUS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 89,562 Line 10
- (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. \$ 149,468
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. \$ 37,437
- (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? YES
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 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 \$5,000, 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.