

Facility Name & ID Number BETHANY TERRACE NURSING CENTER# 0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

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	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,595</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>170</u>	Intermediate (ICF)	<u>170</u>	<u>62,050</u>	3
4		Intermediate/DD			4
5	<u>2</u>	Sheltered Care (SC)	<u>2</u>	<u>730</u>	5
6		ICF/DD 16 or Less			6
7	<u>275</u>	TOTALS	<u>275</u>	<u>100,375</u>	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	<u>448</u>	<u>187</u>	<u>6,387</u>	<u>7,022</u>	8
9	SNF/PED					9
10	ICF	<u>34,473</u>	<u>20,293</u>	<u>190</u>	<u>54,956</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,921</u>	<u>20,480</u>	<u>6,577</u>	<u>61,978</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.75%

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 2/13/1965

J. 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 5,790Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/1/2006 Fiscal Year: 9/30/2007

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

Facility Name & ID Number **BETHANY TERRACE NURSING CENTER** # **0015651** Report Period Beginning: **10/1/2006** Ending: **9/30/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	570,693	42,729	(71,969)	541,453		541,453	(24,396)	517,057		1
2	Food Purchase		557,768		557,768		557,768		557,768		2
3	Housekeeping	300,648	115,283	12,043	427,974		427,974		427,974		3
4	Laundry	91,300	5,358	2,764	99,422		99,422		99,422		4
5	Heat and Other Utilities			367,244	367,244		367,244		367,244		5
6	Maintenance	81,359	23,803	209,881	315,043		315,043		315,043		6
7	Other (specify):*										7
8	TOTAL General Services	1,044,000	744,941	519,963	2,308,904		2,308,904	(24,396)	2,284,508		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,275,714	631,465	227,190	5,134,369		5,134,369	(955)	5,133,414		10
10a	Therapy	86,872	119	477,100	564,091		564,091		564,091		10a
11	Activities	102,350	3,672	32,514	138,536		138,536		138,536		11
12	Social Services	72,012	1	816	72,829		72,829		72,829		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mission & Spiritual		36	645	681		681		681		15
16	TOTAL Health Care and Programs	4,536,948	635,293	738,265	5,910,506		5,910,506	(955)	5,909,551		16
	C. General Administration										
17	Administrative	148,029		473,270	621,299		621,299	(94,574)	526,725		17
18	Directors Fees										18
19	Professional Services			98,881	98,881		98,881	(28,431)	70,450		19
20	Dues, Fees, Subscriptions & Promotions			14,347	14,347		14,347		14,347		20
21	Clerical & General Office Expenses	341,302	24,601	218,593	584,496		584,496	(153,193)	431,303		21
22	Employee Benefits & Payroll Taxes			910,129	910,129	9,345	919,474	25,253	944,727		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,483	14,483		14,483	(436)	14,047		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,675	90,675	(9,345)	81,330		81,330		26
27	Other (specify):* Volunteers		838	2,653	3,491		3,491		3,491		27
28	TOTAL General Administration	489,331	25,439	1,823,031	2,337,801		2,337,801	(251,381)	2,086,420		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,070,279	1,405,673	3,081,259	10,557,211		10,557,211	(276,732)	10,280,479		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 CENTER #0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			669,449	669,449		669,449		669,449		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			21,394	21,394		21,394		21,394		35
36	Other (specify):*										36
37	TOTAL Ownership			690,843	690,843		690,843		690,843		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			1,002	1,002		1,002	(635)	367		41
42	Provider Participation Fee							149,468	149,468		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			1,002	1,002		1,002	148,833	149,835		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,070,279	1,405,673	3,773,104	11,249,056		11,249,056	(127,899)	11,121,157		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 CENTER**

0015651

Report Period Beginning: **10/1/2006**

Ending: **9/30/2007**

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,396)	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	(151,606)	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	286,551	Pg 5A		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 110,549		\$	30

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)	(238,448)	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (238,448)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (127,899)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 BETHANY TERRACE NURSING CENTER

ID# 0015651
 Report Period Beginning: 10/1/2006
 Ending: 9/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC REVENUE	\$ (1,587)	21	1
2	HEALTH INFO MGT MISC INC	(955)	10	2
3	GIFT SHOP REVENUE	(635)	41	3
4	COMM OUTREACH (PR) TRAVEL	(436)	24	4
5	COMM OUTREACH (PR) BENEFITS	(6,202)	22	5
6	PROVIDER PARTICIPATION FEE	149,468	42	6
7	CORPORATE FINANCE SALARIES	120,413	17	7
8	CORPORATE FINANCE BENEFITS	7,309	22	8
9	CORPORATE FINANCE OTHER EXP	23,461	17	9
10	FRINGE BENEFITS (F/S AUDIT AJE)	24,146	22	10
11	NON ALLOWABLE LEGAL FEES	(28,431)	19	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	286,551		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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	(24,396)	0	0	0	0	0	0	0	0	0	0	(24,396)	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	(24,396)	0	0	0	0	0	0	0	0	0	0	(24,396)	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	(955)	0	0	0	0	0	0	0	0	0	0	(955)	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	(955)	0	0	0	0	0	0	0	0	0	0	(955)	16
	C. General Administration													
17	Administrative	(94,574)	0	0	0	0	0	0	0	0	0	0	(94,574)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,431)	0	0	0	0	0	0	0	0	0	0	(28,431)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(153,193)	0	0	0	0	0	0	0	0	0	0	(153,193)	21
22	Employee Benefits & Payroll Taxes	25,253	0	0	0	0	0	0	0	0	0	0	25,253	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(436)	0	0	0	0	0	0	0	0	0	0	(436)	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	(251,381)	0	0	0	0	0	0	0	0	0	0	(251,381)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(276,732)	0	0	0	0	0	0	0	0	0	0	(276,732)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BETHANY TERRACE NURSING CENTER # 0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(635)	0	0	0	0	0	0	0	0	0	0	(635)	41
42	Provider Participation Fee	149,468	0	0	0	0	0	0	0	0	0	0	149,468	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	148,833	0	148,833	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(127,899)	0	(127,899)	45									

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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 HOSP	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	\$ 236,487	METHODIST HOSPITAL OF CHICAGO	100.00%	\$ 130,068	\$ (106,419)	1
2	V	CORPORATE BENEFITS	140,999	METHODIST HOSPITAL OF CHICAGO	100.00%	59,219	(81,780)	2
3	V	CORPORATE PRO FEES	51,891	METHODIST HOSPITAL OF CHICAGO	100.00%	28,540	(23,351)	3
4	V	CORPORATE OTHER	59,774	METHODIST HOSPITAL OF CHICAGO	100.00%	32,876	(26,898)	4
5	V	HOSPITAL PURCHASING	51,345	METHODIST HOSPITAL OF CHICAGO	100.00%	51,345		5
6	V	HOSPITAL EDP	35,795	METHODIST HOSPITAL OF CHICAGO	100.00%	35,795		6
7	V	HOSPITAL HUMAN RESOURCES	41,046	METHODIST HOSPITAL OF CHICAGO	100.00%	41,046		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 617,337			\$ 378,889	\$ * (238,448)	14

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER # 0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

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 CENTER

0015651

Report Period Beginning:

10/1/2006

Ending: 1/30/2007

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	<u>CORPORATE SALARY</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>\$ 1,028,205</u>	<u>\$ 1,028,205</u>	<u>23</u>	<u>\$ 236,487</u>	<u>1</u>
2	<u>CORPORATE BENEFITS</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>613,037</u>		<u>23</u>	<u>140,999</u>	<u>2</u>
3	<u>CORPORATE PRO FEES</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>225,614</u>		<u>23</u>	<u>51,891</u>	<u>3</u>
4	<u>CORPORATE OTHER</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>259,886</u>		<u>23</u>	<u>59,774</u>	<u>4</u>
5	<u>HOSPITAL PURCHASING</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>256,723</u>		<u>20</u>	<u>51,345</u>	<u>5</u>
6	<u>HOSPITAL EDP</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>397,722</u>		<u>9</u>	<u>35,795</u>	<u>6</u>
7	<u>HOSPITAL HR</u>	<u>% to TOTAL COST</u>	<u>100</u>	<u>VARIOUS</u>	<u>171,026</u>		<u>24</u>	<u>41,046</u>	<u>7</u>
8									<u>8</u>
9									<u>9</u>
10									<u>10</u>
11									<u>11</u>
12									<u>12</u>
13									<u>13</u>
14									<u>14</u>
15									<u>15</u>
16									<u>16</u>
17									<u>17</u>
18									<u>18</u>
19									<u>19</u>
20									<u>20</u>
21									<u>21</u>
22									<u>22</u>
23									<u>23</u>
24									<u>24</u>
25	TOTALS				\$ 2,952,213	\$ 1,028,205		\$ 617,337	25

Facility Name & ID Number BETHANY TERRACE NURSING CENTER # 0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BETHANY TERRACE NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0015651

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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 Allocations

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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		4/1/1965	4/1/1965	\$ 1,332,134	\$	40	\$	\$	1,332,134	4
5			4/1/1997	4/1/1997	1,372,256	34,306	40	34,306		360,214	5
6			9/1/2000	9/1/2000	284,128	7,103	40	7,103		53,273	6
7			6/1/2001	6/1/2001	201,057	5,027	40	5,027		31,832	7
8											8
			Improvement Type**								
9		SYSTEM TV ANTENNA	4/1/1965		9,455	-	10	-		9,455	9
10		SYSTEM NURSES CALL	4/1/1965		2,775	-	15	-		2,775	10
11		SYSTEM NURSES CALL	4/1/1965		3,011	-	15	-		3,011	11
12		SYSTEM INTERCOM	4/1/1965		3,593	-	15	-		3,593	12
13		SYSTEM NURSES CALL	4/1/1965		4,349	-	15	-		4,349	13
14		SYSTEM NURSES CALL	4/1/1965		4,349	-	15	-		4,349	14
15		SYSTEM INTERCOM	4/1/1965		7,091	-	15	-		7,091	15
16		CHILLER ACME G12-31	4/1/1965		10,758	-	15	-		10,758	16
17		CHILLER ACME G12-24	4/1/1965		10,758	-	15	-		10,758	17
18		COUNTER CABINET	4/1/1965		2,569	-	20	-		2,569	18
19		TOWER COOLING HAVENS	4/1/1965		3,219	-	20	-		3,219	19
20		TOWER COOLING HAVENS	4/1/1965		3,219	-	20	-		3,219	20
21		HEAT VENT AIR COND	4/1/1965		4,633	-	20	-		4,633	21
22		INCINERATOR MOD 300-IR	4/1/1965		5,378	-	20	-		5,378	22
23		COUNTER ALUM WORK	4/1/1965		6,175	-	20	-		6,175	23
24		FIXTURES & PIPING	4/1/1965		8,320	-	20	-		8,320	24
25		OXYG VACUUM SYSTEM	4/1/1965		8,775	-	20	-		8,775	25
26		PIPE FITTING	4/1/1965		9,612	-	20	-		9,612	26
27		FIXTURES & WIRING	4/1/1965		10,740	-	20	-		10,740	27
28		BOILER PACIFIC 20585	4/1/1965		11,157	-	20	-		11,157	28
29		BOILER PACIFIC 20585	4/1/1965		11,157	-	20	-		11,157	29
30		WIRING IN CINDUIT	4/1/1965		15,284	-	20	-		15,284	30
31		PIPE FITTING	4/1/1965		42,031	-	20	-		42,031	31
32		FIXTURES & PIPING	4/1/1965		138,870	-	20	-		138,870	32
33		FIXTURES & WIRING	4/1/1965		154,127	-	20	-		154,127	33
34		HEAT VENT AIR COND	4/1/1965		157,038	-	20	-		157,038	34
35		SYS FIRE ALARM	4/1/1966		11,278	-	20	-		11,278	35
36		PIPING & CONN BG	4/1/1966		37,465	-	20	-		37,465	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 CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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	PIPING & CONN	4/1/1967	\$ 10,667	\$ -	18	\$ -	\$ -	\$ 10,667	37
38	FIXTURES & WIRING	4/1/1967	19,523	-	18	-	-	19,523	38
39	PIPE FITTING	4/1/1967	28,300	-	18	-	-	28,300	39
40	FIXTURES & PIPING	4/1/1967	87,167	-	17	-	-	87,167	40
41	EMERGENCY LIGHTS 26	4/1/1968	5,438	-	17	-	-	5,438	41
42	CONSTRUCTION BATHROOM	4/1/1970	9,003	-	17	-	-	9,003	42
43	ITEM REMODELING	4/1/1973	23,592	-	17	-	-	23,592	43
44	ITEM REMODELING	4/1/1973	44,792	-	17	-	-	44,792	44
45	IMPROVEMENTS FIRE ALARM SYSTEM	4/1/1975	18,001	-	17	-	-	18,001	45
46	IMPROVEMENTS LANE CONVERSION ASBURY LANE	4/1/1975	42,023	-	17	-	-	42,023	46
47	NEW ROOF	4/1/1976	116,001	-	25	-	-	116,001	47
48	WASHER WCTRACTOR COOK #76DDX3368	4/1/1977	2,695	-	16	-	-	2,695	48
49	NEW LAUNDRY ROOM	4/1/1977	5,120	-	16	-	-	5,120	49
50	COPPER ROOF DECK	4/1/1977	38,960	-	16	-	-	38,960	50
51	IMPROVEMENTS LINDGREN LANE	4/1/1977	55,593	-	16	-	-	55,593	51
52	FAN COIL UNIT CARRIER 1/2BH 3	4/1/1978	3,156	-	16	-	-	3,156	52
53	COOLER BOHN DXMA 1210T	4/1/1979	7,208	-	13	-	-	7,208	53
54	COOLER BOHN DXMA 1210T	4/1/1979	7,208	-	13	-	-	7,208	54
55	AIR COND COMPRESSOR SN 06LH128500	4/1/1979	9,900	-	13	-	-	9,900	55
56	INSTALLATION NEW TELEPHONE SYSTEM	4/1/1980	4,265	-	12	-	-	4,265	56
57	NEW HOT/CHILLED WATER MAINS	4/1/1980	14,827	-	12	-	-	14,827	57
58	IMPROVEMENT ASBURY LANE	4/1/1982	17,564	-	12	-	-	17,564	58
59	IMPROVEMENT	4/1/1982	55,639	-	12	-	-	55,639	59
60	TERRACE PATIO	4/1/1983	10,477	-	12	-	-	10,477	60
61	ROOF IMPROVEMENT(MAIN DINING ROOM)	4/1/1983	17,300	-	12	-	-	17,300	61
62	ROOF IMPROVEMENT(WALLENIOUS & ASHBURY LANES)	4/1/1983	31,025	-	15	-	-	31,025	62
63	ROOF IMPROVEMENTS(WALLENIOUS & BENDIX LANES)	4/1/1983	132,607	-	20	-	-	132,607	63
64	DIETARY IMPROVEMENTS	4/1/1983	66,649	-	10	-	-	66,649	64
65	ROOFING REPAIRS	4/1/1984	4,284	-	10	-	-	4,284	65
66	REPAIR HEATING MAINS-ASBURY/ ANDERSON PATIOS	4/1/1984	13,585	-	10	-	-	13,585	66
67	CARRIER COMPRESSOR S/N 4683PA0262	4/1/1984	19,000	-	10	-	-	19,000	67
68	DIETARY ELECTRICAL WORK	4/1/1984	10,348	-	10	-	-	10,348	68
69	REMODELING OF TERRACE ANDERSON LANE	4/1/1984	13,370	-	10	-	-	13,370	69
70	TOTAL (lines 4 thru 69)		\$ 4,832,048	\$ 46,436		\$ 46,436	\$ -	\$ 3,419,926	70

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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		\$ 4,832,048	\$ 46,436		\$ 46,436	\$	\$ 3,419,926	1
2	REMODELING OF TERRACE DIETARY	4/1/1984	58,142	-	20	-		58,142	2
3	ROOF IMPROVEMENT-ASBURY I	4/1/1985	21,500	-	10	-		21,500	3
4	ROOF IMPROVEMENT-ANDERSON	4/1/1985	26,900	-	10	-		26,900	4
5	ROOF IMPROVEMENT-GLEMAKER	4/1/1985	34,600	-	10	-		34,600	5
6	ROOF IMPROVEMENT-LINDGREN	4/1/1985	51,500	-	10	-		51,500	6
7	REMODELING OF ALZHEIMER	4/1/1985	3,774	-	11	-		3,774	7
8	COMPRESSOR	4/1/1985	17,000	-	15	-		17,000	8
9	RE-WIRING OF ELECTRICAL CONDUIT ON ALL NURSING LANE	4/1/1985	59,165	-	20	-		59,165	9
10	KITCHEN AND EMPLOYEE DINING ROOM RECONSTRUCTION	4/1/1985	392,466	-	20	-		392,466	10
11	LITE CELING FIXTURES	4/1/1986	2,859	-	10	-		2,859	11
12	INSTALLATION OF EMERGENCY PULL CORD	4/1/1986	3,451	-	10	-		3,451	12
13	CARRIER COMPRESSOR	4/1/1986	4,660	-	10	-		4,660	13
14	EMERGENCY PULL CORD	4/1/1986	7,840	-	10	-		7,840	14
15	DIETARY ROOF	4/1/1986	14,100	-	10	-		14,100	15
16	GLEMAKER DOORS	4/1/1986	26,035	-	10	-		26,035	16
17	SINKS, TWIST DRAINS AND FAUCET	4/1/1986	15,178	-	15	-		15,178	17
18	EMERGENCY GENERATOR	4/1/1986	55,533	-	15	-		55,533	18
19	DENTAL SUITE AND CHAPLAINS OFFICE	4/1/1986	4,260	-	19	-		4,260	19
20	WHEELCHAIR ACCESS BATHRM-WALLENUS I	4/1/1986	4,907	-	19	-		4,907	20
21	WHEELCHAIR ACCESS BATHROOMS-ASBURY I	4/1/1986	4,908	-	19	-		4,908	21
22	WHEELCHAIR ACCES BATHRMS-LINDGREN I	4/1/1986	4,908	-	19	-		4,908	22
23	ELECTRICAL WORK-ADMINISTRATIVE AREA	4/1/1986	5,065	-	19	-		5,065	23
24	ELECTRICAL WORK-ADMINISTRATIVE	4/1/1986	6,418	-	19	-		6,418	24
25	ELECTRICAL WORK-BENDIX	4/1/1986	15,975	-	19	-		15,975	25
26	ANDERSON LANE RESIDENT ROOMS NURSES STATION	4/1/1986	16,532	-	19	-		16,532	26
27	ELECTRICAL WORK-GLEMAKER	4/1/1986	17,030	-	19	-		17,030	27
28	ELECTRICAL WORK-WALLENUS I	4/1/1986	17,030	-	19	-		17,030	28
29	ELECTRICAL WORK-WALLENUS II	4/1/1986	17,030	-	19	-		17,030	29
30	ELECTRICAL WORK-ASBURY I	4/1/1986	17,030	-	19	-		17,030	30
31	ELECTRICAL WORK-ASBURY II	4/1/1986	17,030	-	19	-		17,030	31
32	ELECTRICAL WORK-ANDERSON	4/1/1986	17,030	-	19	-		17,030	32
33	ELECTRICAL WORK-LINDGREN II	4/1/1986	19,160	-	19	-		19,160	33
34	TOTAL (lines 1 thru 33)		\$ 5,811,064	\$ 46,436		\$ 46,436	\$	\$ 4,398,942	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,811,064	\$ 46,436		\$ 46,436	\$	\$ 4,398,942	1
2	ELECTRICAL WORK-LINDGREN I	4/1/1986	21,290	-	19	-		21,290	2
3	HEATING/COOLING LINES	4/1/1986	44,252	-	19	-		44,252	3
4	REMODELING OF THE NURSES STATION	4/1/1986	107,800	-	19	-		107,800	4
5	DIETARY REMODELING	4/1/1986	166,018	-	19	-		166,018	5
6	PM6R GALBREATH TRASH COMPACTOR	4/1/1987	4,750	-	10	-		4,750	6
7	ADD'L EMERGENCY GENERATOR	4/1/1987	93,399	-	10	-		93,399	7
8	LOCK CHANGES, ALL LANES	4/1/1987	3,354	-	18	-		3,354	8
9	GAZEBO GLENMAKER PATIO	4/1/1987	3,803	-	18	-		3,803	9
10	ADDL TO DIETARY IMPROVEMENTS	4/1/1987	4,547	-	18	-		4,547	10
11	HEATING/COOLING LINES, LINDGREN LANE	4/1/1987	7,888	-	18	-		7,888	11
12	WHEELCHAIR ACC BATHROOMS	4/1/1987	14,810	-	18	-		14,810	12
13	HEATING/COOLING LINES, ANDERSON-GLEMAKER	4/1/1987	15,986	-	18	-		15,986	13
14	LOBBY CARPETING	4/1/1988	4,164	-	5	-		4,164	14
15	BOILER REPAIRS	4/1/1988	16,214	-	10	-		16,214	15
16	IMPROVEMENT SNACK BAR	4/1/1988	3,336	-	17	-		3,336	16
17	REMODELING BEAUTY SHOP	4/1/1988	4,784	-	17	-		4,784	17
18	IMPROVEMENT ALZHEIMER UNIT	4/1/1988	7,338	-	17	-		7,338	18
19	IMPROVEMENT BENDIX LINEN RM	4/1/1988	7,512	-	17	-		7,512	19
20	WALLENIOUS UTILITY ROOM	4/1/1988	8,916	-	17	-		8,916	20
21	SOFFITS REBUILT IN HOUSE	4/1/1988	9,558	-	17	-		9,558	21
22	ROTUNDA REMODELING	4/1/1988	157,446	-	17	-		157,446	22
23	DRAW DRAPERIES/ CUBICLE CURTAINS	4/1/1989	7,265	-	5	-		7,265	23
24	MEDI-CARE DATA COMPUTER SYSTEM	4/1/1989	12,875	-	5	-		12,875	24
25	HUGHES EQPT WASHER	4/1/1989	3,075	-	10	-		3,075	25
26	ROOM/DOOR SIGNS IN BUILDING	4/1/1989	4,587	-	12	-		4,587	26
27	ROTUNDA RENOVATION	4/1/1989	22,188	-	16	-		22,188	27
28	INTERIOR DESIGN MAIN DINING ROOM	4/1/1989	30,672	-	16	-		30,672	28
29	REMODELING ALZHEIMER TRIANGLE	4/1/1989	30,809	-	16	-		30,809	29
30	REMODELING BENDIX LANE	4/1/1989	101,675	-	16	-		101,675	30
31	ADDITIONAL TERRACE REMODELING	4/1/1989	114,204	-	16	-		114,204	31
32	R GILL HEATED LOWERATOR	4/1/1990	2,782	-	10	-		2,782	32
33	ALLADIN INSULATED DOME/DRYING RACK	4/1/1990	3,756	-	10	-		3,756	33
34	TOTAL (lines 1 thru 33)		\$ 6,852,117	\$ 46,436		\$ 46,436	\$	\$ 5,439,995	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,852,117	\$ 46,436		\$ 46,436	\$	\$ 5,439,995	1
2	PAIRS DRAPERIES	4/1/1991	10,000	-	5	-		10,000	2
3	R. GILL BASE HEATER FOR UNITIZED BASES 208V	4/1/1992	3,527	-	5	-		3,527	3
4	CARPETING	4/1/1992	3,688	-	5	-		3,688	4
5	DRAPES, LINERS, CUBICLE CURTAINS	4/1/1992	8,434	-	5	-		8,434	5
6	DRAPES, CUBICLES, RODS/LINERS	4/1/1992	10,116	-	5	-		10,116	6
7	DRAPERIES/CUBICLE CURTAINS	4/1/1992	17,548	-	5	-		17,548	7
8	FLUSH METAL DOOR PANIC DEVICE	4/1/1992	4,026	-	10	-		4,026	8
9	ROOF IMPROVEMENTS	4/1/1992	4,725	-	10	-		4,725	9
10	TILE & GROUT FOOD PREP AREA	4/1/1992	6,445	-	10	-		6,445	10
11	SMOKE DETECTORS SITTING RM	4/1/1992	8,132	-	10	-		8,132	11
12	REMODELING TERRACE LOBBY	4/1/1992	2,991	-	13	-		2,991	12
13	REMODELING LINDGREN II	4/1/1992	137,324	-	13	-		137,324	13
14	ALZHEIMER PROJECT	4/1/1992	1,132,621	-	13	-		1,132,621	14
15	LONG LIFE BULBS/SHUNTS	4/1/1993	3,060	-	5	-		3,060	15
16	DRAPERIES/RODS/INSTALLATION	4/1/1993	4,542	-	5	-		4,542	16
17	DRAPERIES/RODS/INSTALLATION	4/1/1993	4,542	-	5	-		4,542	17
18	CUBICLE CURTAINS & RODS	4/1/1993	6,525	-	5	-		6,525	18
19	CUBICLE TRACKS/SPRING/CURTAINS	4/1/1993	7,505	-	5	-		7,505	19
20	DRAPERIES/RODS/INSTALLATION	4/1/1993	7,671	-	5	-		7,671	20
21	AUTOMATIC CLOSE TIMERS ON GARAGE DOORS	4/1/1993	2,944	-	9	-		2,944	21
22	RELOCATION OF ROTUNDA ROOF TOP UNIT	4/1/1993	4,000	-	9	-		4,000	22
23	REGENCY ROOFING SYSTEM	4/1/1993	40,280	-	9	-		40,280	23
24	ROOF IMPROVEMENT	4/1/1993	66,470	-	9	-		66,470	24
25	WALL COVERING PROTECTION IN FRONT OF BEDS	4/1/1993	2,711	-	10	-		2,711	25
26	TELEPHONE EQUIPMENT	4/1/1993	2,898	-	10	-		2,898	26
27	48" METAL DOORS & HARDWARE	4/1/1993	4,485	-	10	-		4,485	27
28	LOBB/OFFICES	4/1/1993	4,300	-	12	-		4,300	28
29	REMODELING DIETARY	4/1/1993	32,370	-	12	-		32,370	29
30	REMODELING ASBURY II	4/1/1993	37,106	-	12	-		37,106	30
31	REMODELING ASBURY I	4/1/1993	37,464	-	12	-		37,464	31
32	REMODELING LINDGREN I	4/1/1993	49,201	-	12	-		49,201	32
33	PHYSICAL THERAPY/SENSORY ROOM	4/1/1993	61,250	-	12	-		61,250	33
34	TOTAL (lines 1 thru 33)		\$ 8,581,018	\$ 46,436		\$ 46,436	\$	\$ 7,168,896	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,581,018	\$ 46,436		\$ 46,436	\$	\$ 7,168,896	1
2	CARPETING, ROTUNDA	4/1/1994	2,789	-	5	-		2,789	2
3	CUBICLES & TRACKS	4/1/1994	3,909	-	5	-		3,909	3
4	CARPETING	4/1/1994	14,372	-	5	-		14,372	4
5	CUBICLE RODS, CURTAINS, DRAPERIES	4/1/1994	15,796	-	5	-		15,796	5
6	LOCKS, CLOSET DOORS	4/1/1994	3,643	-	10	-		3,643	6
7	REMODELING	4/1/1994	3,698	-	10	-		3,698	7
8	ELECTRIC PARALLEL BARS	4/1/1994	4,808	-	10	-		4,808	8
9	MAGIC AIRE UNIT MN#60BVW	4/1/1994	6,428	-	10	-		6,428	9
10	FLOORING REPAIRS	4/1/1994	6,538	-	10	-		6,538	10
11	REMODELING CLOSETS RMS ANDERSON LN	4/1/1994	6,614	-	10	-		6,614	11
12	REMODELING ROOMS ASBURY I	4/1/1994	7,606	-	10	-		7,606	12
13	CUBICLE TRACKS	4/1/1994	8,412	-	10	-		8,412	13
14	CLOSETS ASBURY 1&2	4/1/1994	9,096	-	10	-		9,096	14
15	ROOF IMPROVEMENT, GLENMAKER WING	4/1/1994	19,878	-	10	-		19,878	15
16	DK280 DIGITAL TELEPHONE SYSTEM	4/1/1994	62,976	-	10	-		62,976	16
17	TERRACE LANES REMODELING	4/1/1994	93,859	-	10	-		93,859	17
18	6" CONCRETE PAD FOR COMPACTOR	4/1/1994	2,650	176	15	176		2,385	18
19	NEW HEATING & A/C UNIT	4/1/1994	17,500	875	20	875		11,813	19
20	WORKFORCE PERSONEL LIFT CAP	4/1/1995	2,955	-	10	-		2,955	20
21	PHONE INTERFACE UNIT	4/1/1995	3,024	-	10	-		3,024	21
22	LABOR FOR EXTERIOR LIGHTING	4/1/1995	4,100	-	10	-		4,100	22
23	PHONE INTERFACE UNIT	4/1/1995	6,000	-	10	-		6,000	23
24	DIGITAL TELEPHONE SYSTEM	4/1/1995	7,000	-	10	-		7,000	24
25	LIGHT & POWER ON EMERGENCY SERVICE	4/1/1995	8,030	-	10	-		8,030	25
26	OVERBED TABLE	4/1/1995	2,623	175	15	175		2,187	26
27	RETUBE BOILER #1 & NEW BURNER	4/1/1995	9,966	498	20	498		6,227	27
28	HEAT RECOVERY & EVAPORATIVE COOLING	4/1/1995	32,000	1,600	20	1,600		20,000	28
29	CABLE COMMUNICATION LINES	4/1/1996	10,940	-	8	-		10,940	29
30	BETHANY TERRACE ROOF	4/1/1996	4,950	-	10	-		4,950	30
31	ROOFING	4/1/1996	5,300	-	10	-		5,300	31
32	COMMUNICATION SYSTEM	4/1/1996	5,833	-	10	-		5,833	32
33	A M H U OUTPATIENT CLINIC	4/1/1996	5,387	359	15	359		4,129	33
34	TOTAL (lines 1 thru 33)		\$ 8,979,698	\$ 50,119		\$ 50,119	\$	\$ 7,544,191	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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		\$ 8,979,698	\$ 50,119		\$ 50,119	\$	\$ 7,544,191	1
2	WHIRL POOL & LIFT BATH TROLLEY	4/1/1996	14,287	952	15	952		10,953	2
3	TERRACE REMODEL	4/1/1996	1,353,487	90,232	15	90,232		1,037,673	3
4	PAINTING	4/1/1997	2,813	-	5	-		2,813	4
5	VIDEO WASTE SECURITY SYSTEM	4/1/1997	11,179	-	5	-		11,179	5
6	ARCHITECTURAL BUILDING	4/1/1997	2,608	130	10	130		2,608	6
7	REFRIGERATION UNIT DEEP FREEZER	4/1/1997	2,720	136	10	136		2,720	7
8	EXIT DOOR SYSTEM	4/1/1997	4,600	230	10	230		4,600	8
9	BALLAST LAMP	4/1/1998	2,885	-	5	-		2,885	9
10	LOCKNETICS DELAYED EGRESS SYSTEM	4/1/1998	2,957	-	5	-		2,957	10
11	CARPETING	4/1/1998	4,766	-	5	-		4,766	11
12	PLATE GLASS REPLACEMENT	4/1/1998	2,825	283	10	283		2,684	12
13	SOIL PIPE	4/1/1998	2,540	170	15	170		1,608	13
14	TERRACE REMODELING	4/1/1998	178,041	8,902	20	8,902		84,569	14
15	FUEL STORAGE TANK UPGRADE	4/1/1999	9,360	585	8	585		9,360	15
16	CHAPEL DINING HALL SOUND SYSTEM	4/1/1999	8,550	855	10	855		7,268	16
17	INST NEW DOORS	4/1/1999	9,679	645	15	645		5,483	17
18	CARPENTRY	4/1/1999	5,041	252	20	252		2,142	18
19	GASLINE FOR BI-FUEL CONVERSION	4/1/1999	6,500	325	20	325		2,763	19
20	BI-FUEL CONVERSION SYSTEM	4/1/1999	12,400	620	20	620		5,270	20
21	DOOR REPLACEMENT/CARPENTRY	4/1/1999	16,901	845	20	845		7,183	21
22	MECHANICAL INSULATION	4/1/1999	22,595	1,130	20	1,130		9,605	22
23	CHAPEL RENOVATION	4/1/1999	98,934	4,947	20	4,947		42,049	23
24	EMERGENCY GENERATOR	4/1/1999	184,029	9,202	20	9,202		78,212	24
25	ELECTRO MAGNETIC LOCKING DEVICES ANDERSON LOCK C	12/1/1999	10,658	1,065	10	1,065		7,994	25
26	SOFTWARE FOR CALL ACCT. SYSTEM S.D.T INVOICE 10727	2/1/2000	3,214	-	5	-		3,214	26
27	BOILER UPGRADE FOR DUEL FUEL SOURCE HAYES BOILER &	2/1/2000	5,217	261	20	261		1,957	27
28	ALUMINUM FLOOR IN WALK IN COOLERS RESTAURANT STAIR	3/1/2000	4,165	417	10	417		3,124	28
29	CONVECTION OVEN EDWARD DON INV. 1351909	9/1/2000	4,792	479	10	479		3,593	29
30	ID CARD READING SYSTEM ADVANCED FIRE INV 005811	9/1/2000	5,831	583	10	583		4,373	30
31	PHONE CABLING ANDERSON LANE GREATLINE COMMUNICATIO	2/1/2001	7,180	718	10	718		4,787	31
32	NURSE CALL SYS BENDIX & ANDERSON ADVANCED FIRE & SEC	2/1/2001	62,523	6,252	10	6,252		41,681	32
33	LIGHT POLE IN PARKING LOT DIVANE BROS. ELECTRIC CO INV C	3/1/2001	2,840	284	10	284		1,870	33
34	TOTAL (lines 1 thru 33)		\$ 11,045,815	\$ 180,619		\$ 180,619	\$	\$ 8,958,134	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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 12F, Carried Forward		\$ 11,045,815	\$ 180,619		\$ 180,619	\$	\$ 8,958,134	1
2	VOICE CABLING FOR BENDIX UNIT GREATLINE COMM. INV 5060	3/1/2001	6,143	614	10	614		4,043	2
3	REMODEL BENDIX & ANDERSON LANES LAMANTIA CONSTRUCT	6/1/2001	455,626	22,781	20	22,781		144,280	3
4	CARPET LOBBY, DUNCAN CARPET INV 48145	10/1/2001	3,606	-	5	-		3,606	4
5	BOILER RETUBING, HAYES BOILER & MECHANICAL	12/1/2001	3,541	354	10	354		2,065	5
6	BOILER TUBES, HAYES BOILER INV 152615-A	1/1/2002	11,926	596	20	596		3,427	6
7	REMOTE ALARM STATIONS FRIENDSHIP, ADVANCED FIRE INV 0	2/1/2002	3,038	304	10	304		1,723	7
8	MAGNETIC DOOR HOLDERS, ADVANCED FIRE INV 006885	2/1/2002	3,850	385	10	385		2,182	8
9	CHILLER, RMC INC INV 066175	3/1/2002	39,169	2,611	15	2,611		14,578	9
10	ROOF REPLACEMENT, ATLAS CONSTRUCTION	9/1/2002	540,218	54,022	10	54,022		274,612	10
11	PARKER BATHTUB, LAMANTIA BUILDING & SUPP INV 2043	4/1/2003	7,818	782	10	782		3,519	11
12	ELECTRICAL PIPE ON ROOF, BRUSCHUK ELEC. INV A170	5/1/2003	9,481	474	20	474		2,094	12
13	DOORS IN FRIENDSHIP & ASBURY WINGS, LAMANTIA BUILDING	6/1/2003	2,782	185	15	185		803	13
14	ELECTRICAL PIPE ON ROOF, BRUSCHUK ELECTRIC INV A174	6/1/2003	4,330	216	20	216		938	14
15	LAUNDRY ROOM REMODELING, LAMANTIA BUILDING INV 2054	6/1/2003	49,450	2,472	20	2,472		10,714	15
16	EXPANSION TANKS, HAYES BOILER & MECH. INV 173470	7/1/2003	4,405	440	10	440		1,872	16
17	ROOF PHASE 3 TERRACE, ATLAS CONSTRUCTION	9/1/2003	275,652	27,565	10	27,565		112,557	17
18	EXHAUST FAN RELAY, BRUSCHUK ELECTRIC INV A869	6/1/2004	3,092	309	10	309		1,030	18
19	COIL AND COMPRESSOR FOR COOLER, ACCU-TEMP REFRIGERA	6/1/2004	5,135	514	10	514		1,712	19
20	PLUMBING ETC FOR REMODELING SUITES, NORTHWESTERN IN	6/1/2004	132,292	6,615	20	6,615		22,050	20
21	REMODEL TERRACE SUITES AND TRIANGLE, LA MANTIA BUILD	6/1/2004	1,473,358	73,668	20	73,668		245,560	21
22	RSTU CARDS FOR 18 ANALOG PROTOS, GREATLINE COMMUNICA	7/1/2004	5,127	513	10	513		1,667	22
23	EXHUAST FAN RELAY WIRING/CIRCUITING, BRUSCHUK ELECTRI	7/1/2004	3,836	192	20	192		624	23
24	PIANT & WALLPAPER ASSOCIATED WITH TERRACE SUITE REMO	10/1/2004	3,310	662	5	662		1,986	24
25	EJECTOR PUMP IN GLEAMKER WASHROOM	10/1/2004	2,500	167	15	167		501	25
26	ROOF PROJECT PHASE 4	11/1/2004	216,431	21,643	10	21,643		63,126	26
27	SPRINKLERS IN ROTUNDA & SNACK SHOP	11/1/2004	41,420	1,657	25	1,657		4,833	27
28	SPRINKLERS	3/1/2005	6,640	266	25	266		687	28
29	CARRIER 15 TON ROOF UNIT	4/1/2005	16,087	1,609	10	1,609		4,022	29
30	WALK IN COOLER	6/1/2005	5,135	342	15	342		798	30
31	CRAFT ROOM RENOVATION	6/1/2005	16,000	800	20	800		1,867	31
32	IRRIGATION SYSTEM	7/1/2005	22,755	2,276	10	2,276		5,120	32
33	DIALYSIS CENTER CAPITAL PROJECT	8/1/2005	47,691	2,385	20	2,385		5,167	33
34	TOTAL (lines 1 thru 33)		\$ 14,467,659	\$ 408,038		\$ 408,038	\$	\$ 9,901,897	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 14,467,659	\$ 408,038		\$ 408,038	\$	\$ 9,901,897	1
2	BASEBOARD HEATING UNITS	9/1/2005	7,000	467	15	467		973	2
3	THERAPY DINING ROOM REMODELING	9/1/2005	11,480	574	20	574		1,196	3
4	CRAFT ROOM RENOVATION	9/1/2005	24,370	1,219	20	1,219		2,539	4
5	EMPLOYEE DINING ROOM REMODELING	9/1/2005	60,750	3,037	20	3,037		6,328	5
6	WASHER EXTRACTOR 40LB	10/21/2005	6,220	777	8	777		1,555	6
7	EXPANSION TANKS	12/12/2005	4,110	411	10	411		754	7
8	COMPRESSORS IN CARRIER ROOF TOP UNIT	5/5/2006	5,157	516	10	516		731	8
9	NURSE CALL SYSTEM VISION LINK 2500	8/7/2006	21,160	2,116	10	2,116		2,469	9
10	ROOFTOP UNIT BLOWER MOTOR	9/26/2006	5,613	561	10	561		608	10
11	ELECTRICAL SERVICE FOR NEW PHONE SYSTEM & SYSTEM	1/2/2007	20,019	1,501	10	1,501		1,501	11
12	PHONE SYSTEM UPGRADE	2/1/2007	14,219	948	10	948		948	12
13	REWORK NURSE BATHROOM	4/16/2007	5,807	290	10	290		290	13
14	DOORS AND EXIT SIGNS	4/16/2007	6,450	323	10	323		323	14
15	PERMIT FEE	4/16/2007	8,701	435	10	435		435	15
16	PHASE TWO-LINDGREN	4/16/2007	877,000	43,850	10	43,850		43,850	16
17	PHASE ONE-FRIENDSHIP AND DINING ROOM	4/16/2007	893,500	44,675	10	44,675		44,675	17
18	INSTALL AUTOMATIC DOOR OPENER	4/16/2007	4,900	163	15	163		163	18
19	HVAC	4/16/2007	28,935	965	15	965		965	19
20	COOLING RETROFIT FOR KITCHEN	4/16/2007	32,000	1,067	15	1,067		1,067	20
21	HVAC AND SPRINKLER SYSTEM	4/16/2007	235,500	7,850	15	7,850		7,850	21
22	ROOF CAULKING	6/19/2007	4,797	160	10	160		160	22
23	TELEPHONE SYSTEM UPGRADE	7/15/2007	8,954	224	10	224		224	23
24	BUILDING REPAIRS	7/19/2007	3,954	99	10	99		99	24
25	TERRACE NURSING CENTER REMODELING	7/19/2007	6,648	66	25	66		66	25
26	HVAC CONNECTOR UNIT FOR NURSING CARE PLAN OFFICE	9/1/2007	2,700	23	10	23		23	26
27									27
28	ASSETS UNDER \$2500 (FE)		209,344	4,732		4,732		181,036	28
29	ASSETS UNDER \$2500 (BLDG)		69,180	1,328		1,328		54,913	29
30									30
31	LAND IMPROVEMENTS		394,206	13,042		13,042		301,798	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,440,333	\$ 539,457		\$ 539,457	\$	\$ 10,559,436	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTER # 0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

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	\$ 1,717,524	\$ 117,826	\$ 117,826	\$	VARIOUS	\$ 1,136,449	71
72	Current Year Purchases	189,572	8,341	8,341		VARIOUS	8,341	72
73	Fully Depreciated Assets	See Depreciation Report						73
74								74
75	TOTALS	\$ 1,907,096	\$ 126,167	\$ 126,167	\$		\$ 1,144,790	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	10/1/2003	\$ 19,125	\$ 3,825	\$ 3,825	\$	5	\$ 15,300	76
77										77
78										78
79										79
80	TOTALS			\$ 19,125	\$ 3,825	\$ 3,825	\$		\$ 15,300	80

E. Summary of Care-Related Assets

	1	Reference	2	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)	\$	19,648,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	669,449	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	669,449	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)	\$	11,719,526	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 21,394

Description: POSTAGE MACHINE, 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.

Facility Name & ID Number BETHANY TERRACE NURSING CENTER # 0015651 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
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)	\$			

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	

- (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.

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$	2,329	\$ 147,984	\$	2,329	\$ 147,984	1
2	Licensed Speech and Language Development Therapist	10a	hrs		413	42,382		413	42,382	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		4,010	272,652		4,010	272,652	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			\$	6,752	\$ 463,018	\$	6,752	\$ 463,018	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.

Facility Name & ID Number **BETHANY TERRACE NURSING CENTER**# **0015651**Report Period Beginning: **10/1/2006**

Ending:

9/30/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **9/30/2007**

(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 (244,583))	1,638,503		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)			8
9	Other(specify): Due to/from Other Funds	423,681		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,174,828	\$	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	15,274,638		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,769,236		16
17	Accumulated Depreciation (book methods)	(11,738,713)		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): BETH TERR	63,345		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,650,379	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,825,207	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,898	\$	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 FUND	23,497		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 111,395	\$	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)	\$ 111,395	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,713,812	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,825,207	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,903,472	1
2	Restatements (describe):		2
3	CHANGE IN EQUITY	8,970	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,912,442	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(198,630)	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (198,630)	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)	\$ 10,713,812	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BETHANY TERRACE NURSING CENTER# 0015651Report Period Beginning: 10/1/2006Ending: 9/30/2007**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	\$ 15,451,559	1
2	Discounts and Allowances for all Levels	(4,876,827)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,574,732	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	635	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	24,396	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	2,542	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,573	23
D. Non-Operating Revenue			
24	Contributions	217,452	24
25	Interest and Other Investment Income***	229,756	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 447,208	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,049,513	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,308,904	31
32	Health Care	5,910,506	32
33	General Administration	2,337,801	33
B. Capital Expense			
34	Ownership	690,843	34
C. Ancillary Expense			
35	Special Cost Centers	1,002	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	PASTORAL CARE	(913)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,248,143	40
41	Income before Income Taxes (line 30 minus line 40)**	(198,630)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (198,630)	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 CENTER**

0015651

Report Period Beginning: **10/1/2006**

Ending:

9/30/2007

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	3,680	4,160	\$ 137,503	\$ 33.05	1
2	Assistant Director of Nursing	3,720	4,160	159,512	38.34	2
3	Registered Nurses	30,017	34,356	945,403	27.52	3
4	Licensed Practical Nurses	24,885	27,143	636,206	23.44	4
5	CNAs & Orderlies	144,912	159,156	1,956,121	12.29	5
6	CNA Trainees					6
7	Licensed Therapist	40	40	921	23.03	7
8	Rehab/Therapy Aides	5,059	5,767	75,710	13.13	8
9	Activity Director	1,896	2,072	42,269	20.40	9
10	Activity Assistants	15,379	16,667	150,223	9.01	10
11	Social Service Workers	2,768	3,277	51,969	15.86	11
12	Dietician					12
13	Food Service Supervisor	3,827	4,222	52,272	12.38	13
14	Head Cook	7,830	8,896	149,476	16.80	14
15	Cook Helpers/Assistants	38,808	42,048	362,931	8.63	15
16	Dishwashers					16
17	Maintenance Workers	3,230	3,821	84,570	22.13	17
18	Housekeepers	30,726	34,766	314,449	9.04	18
19	Laundry	7,124	7,875	75,710	9.61	19
20	Administrator	2,080	2,080	148,029	71.17	20
21	Assistant Administrator	1,879	2,520	98,904	39.25	21
22	Other Administrative	16,019	18,048	372,739	20.65	22
23	Office Manager					23
24	Clerical	10,602	11,398	152,727	13.40	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	1,999	2,207	41,667	18.88	31
32	Other Health Care(specify)			46,996		32
33	Other(specify) <u>VARIANCE</u>			13,972		33
34	TOTAL (lines 1 - 33)	356,480	394,679	\$ 6,070,279 *	\$ 15.38	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	96	4,224	19	37
38	Nurse Consultant	12	1,225	19	38
39	Pharmacist Consultant		160	19	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	128	5,738	19	45
46	Other(specify) <u>DEMENTIA</u>	100	4,800	19	46
47	<u>BILLING CONSULTANT</u>	33	2,141	19	47
48	<u>OTHER</u>	108	12,163	19	48
49	TOTAL (lines 35 - 48)	477	\$ 30,451		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9	\$ 536	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	\$ 536		53

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

0015651

Report Period Beginning: **10/1/2006**

Ending: **9/30/2007**

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	
David Randle	Administrator		\$ 148,029	Workers' Compensation Insurance	\$ 109,879	IDPH License Fee	\$ 3,302	
				Unemployment Compensation Insurance	3,745	Advertising: Employee Recruitment		
				FICA Taxes	441,186	Health Care Worker Background Check		
				Employee Health Insurance	215,179	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	2,603	
				Illinois Municipal Retirement Fund (IMRF)*		HC Pro	1,538	
				Tuition Reimbursement	3,584	Chicago Tribune	2,126	
				Group Life Insurance	3,775	State Police	500	
				Transfers of Fringe Benefits	135,924	Healthcare Info Network	795	
				Corporate Benefits	7,309	Other	3,483	
				Fringe Benefits (F/S Audit Adjustment)	24,146	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 148,029	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,347
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description		Description		Amount
Amount				Line #		Amount		
Corporate Allocation						Out-of-State Travel		\$ 305
\$ 473,270						In-State Travel		13,231
						Seminar Expense		947
						Comm Outreach (PR) Travel		(436)
						Entertainment Expense		()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL		TOTAL (agree to Sch. V, line 24, col. 8)		\$ 14,047
\$ 473,270				\$				
C. Professional Services								
Vendor/Payee	Type		Amount					
Quality Care Consulting	Dementia Consulting		\$ 4,800.00					
Carol Gordon	Social Service Consulting		5,737.50					
Carlin & Associates	Medical Records Consulting		4,224.00					
Pathway Health Services	Billing Consulting		2,141.23					
Cox Limited	Consulting		12,162.50					
Cernivivo & Fasciana	Legal Fees		17,780.88					
Schain Burney Ross & Citron LTD	Legal Fees		14,332.07					
Cassiday Schade & Gloor	Legal Fees		6,083.55					
James C. Zinman Attorney	Legal Fees		5,500.00					
Gremley & Biedermann INC	Topography		13,550.00					
Medical Director	Pro Fee		16,000.00					
Other	Various		(3,431)					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 98,881								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning: 10/1/2006

Ending: 9/30/2007

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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action 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. \$ 96,784 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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 24,396
- (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 COMPLETE
- (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.