

Facility Name & ID Number BETHANY TERRACE NURSING CENTER# 0015651 Report Period Beginning: 10/1/2007 Ending: 9/30/2008

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 _____

	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>37,698</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>170</u>	Intermediate (ICF)	<u>170</u>	<u>62,220</u>	3
4		Intermediate/DD			4
5	<u>2</u>	Sheltered Care (SC)	<u>2</u>	<u>732</u>	5
6		ICF/DD 16 or Less			6
7	<u>275</u>	TOTALS	<u>275</u>	<u>100,650</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>7,057</u>	<u>4,470</u>	<u>6,364</u>	<u>17,891</u>	8	
9	SNF/PED					9	
10	ICF	<u>21,339</u>	<u>15,748</u>	<u>19</u>	<u>37,106</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>28,396</u>	<u>20,218</u>	<u>6,383</u>	<u>54,997</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.64%

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? YES

G. 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 02/13/1965

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 6,014Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/1/2007 Fiscal Year: 09/30/2008

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

Facility Name & ID Number **BETHANY TERRACE NURSING CENTER** # **0015651** Report Period Beginning: **10/1/2007** Ending: **9/30/2008**

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	583,506	37,491	(92,136)	528,861		528,861	(47,019)	481,842		1
2	Food Purchase		541,921		541,921		541,921		541,921		2
3	Housekeeping	312,963	92,487	1,500	406,950		406,950		406,950		3
4	Laundry	91,885	931		92,816		92,816		92,816		4
5	Heat and Other Utilities			387,167	387,167		387,167		387,167		5
6	Maintenance	72,510	21,789	237,554	331,853		331,853		331,853		6
7	Other (specify):*										7
8	TOTAL General Services	1,060,864	694,619	534,085	2,289,568		2,289,568	(47,019)	2,242,549		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,345,724	621,374	144,698	5,111,796		5,111,796	(176)	5,111,620		10
10a	Therapy	94,410	360	578,582	673,352		673,352		673,352		10a
11	Activities	103,055	4,189	39,346	146,590		146,590		146,590		11
12	Social Services	78,487	175	3,846	82,508		82,508		82,508		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mission & Spiritual		282	2,095	2,377		2,377		2,377		15
16	TOTAL Health Care and Programs	4,621,676	626,380	768,567	6,016,623		6,016,623	(176)	6,016,447		16
	C. General Administration										
17	Administrative	103,985		424,583	528,568		528,568	173,438	702,006		17
18	Directors Fees										18
19	Professional Services			176,609	176,609		176,609	(43,161)	133,448		19
20	Dues, Fees, Subscriptions & Promotions			10,753	10,753		10,753	(455)	10,298		20
21	Clerical & General Office Expenses	407,930	31,617	215,991	655,538		655,538	(212,018)	443,520		21
22	Employee Benefits & Payroll Taxes			953,533	953,533	11,193	964,726	20,099	984,825		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,175	9,175		9,175	(582)	8,593		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			92,560	92,560	(11,193)	81,367		81,367		26
27	Other (specify):* Volunteers			2,843	2,843		2,843		2,843		27
28	TOTAL General Administration	511,915	31,617	1,886,047	2,429,579		2,429,579	(62,679)	2,366,900		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,194,455	1,352,616	3,188,699	10,735,770		10,735,770	(109,874)	10,625,896		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: 10/1/2007 Ending: 9/30/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			856,068	856,068		856,068	(5,458)	850,610			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			41,310	41,310		41,310		41,310			35
36	Other (specify):*											36
37	TOTAL Ownership			897,378	897,378		897,378	(5,458)	891,920			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops							(3,204)	(3,204)			40
41	Coffee and Gift Shops			2,296	2,296		2,296	(733)	1,563			41
42	Provider Participation Fee							149,468	149,468			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			2,296	2,296		2,296	145,531	147,827			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,194,455	1,352,616	4,088,373	11,635,444		11,635,444	30,199	11,665,643			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(47,019)	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	(43,161)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(209,212)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	329,591	Pg 5A		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 30,199		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 30,199		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BETHANY TERRACE NURSING CENTER

ID# 0015651

Report Period Beginning: 10/1/2007

Ending: 9/30/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC REVENUE	\$ (2,806)	21	1
2	HEALTH INFO MGT MISC INC	(176)	10	2
3	GIFT SHOP REVENUE	(733)	41	3
4	BEAUTY SHOP REVENUE	(3,204)	40	4
5	COMM OUTREACH (PR) TRAVEL	(582)	24	5
6	COMM OUTREACH (PR) BENEFITS	(7,283)	22	6
7	COMM OUTREACH (PR) DUES	(455)	20	7
8	PROVIDER PARTICIPATION FEE	149,468	42	8
9	CORPORATE FINANCE SALARIES	154,439	17	9
10	CORPORATE FINANCE BENEFITS	27,382	22	10
11	CORPORATE FINANCE OTHER EXP	18,999	17	11
12	ASSET DEPRECIATION (UNDER \$2500)	(7,152)	30	12
13	ASSET DEPRECIATION (VARIANCE)	1,694	30	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	329,591		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BETHANY TERRACE NURSING CENTER# 0015651

Report Period Beginning:

10/1/2007

Ending:

9/30/2008

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(47,019)	0	0	0	0	0	0	0	0	0	0	(47,019)	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	(47,019)	0	(47,019)	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	(176)	0	0	0	0	0	0	0	0	0	0	(176)	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	(176)	0	(176)	16									
	C. General Administration													
17	Administrative	173,438	0	0	0	0	0	0	0	0	0	0	173,438	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(43,161)	0	0	0	0	0	0	0	0	0	0	(43,161)	19
20	Fees, Subscriptions & Promotions	(455)	0	0	0	0	0	0	0	0	0	0	(455)	20
21	Clerical & General Office Expenses	(212,018)	0	0	0	0	0	0	0	0	0	0	(212,018)	21
22	Employee Benefits & Payroll Taxes	20,099	0	0	0	0	0	0	0	0	0	0	20,099	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(582)	0	0	0	0	0	0	0	0	0	0	(582)	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	(62,679)	0	(62,679)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,874)	0	(109,874)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BETHANY TERRACE NURSING CENTER# 0015651

Report Period Beginning:

10/1/2007 Ending:

9/30/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,458)	0	0	0	0	0	0	0	0	0	0	(5,458)	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	(5,458)	0	0	0	0	0	0	0	0	0	0	(5,458)	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	(3,204)	0	0	0	0	0	0	0	0	0	0	(3,204)	40
41	Coffee and Gift Shops	(733)	0	0	0	0	0	0	0	0	0	0	(733)	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	145,531	0	0	0	0	0	0	0	0	0	0	145,531	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	30,199	0	0	0	0	0	0	0	0	0	0	30,199	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				METHODIST 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	CORPORATE SALARY	\$ 178,335	METHODIST HOSPITAL OF CHICAGO	100.00%	\$ 178,335		1
2	V	CORPORATE BENEFITS	170,599	METHODIST HOSPITAL OF CHICAGO	100.00%	170,599		2
3	V	CORPORATE PRO FEES	59,503	METHODIST HOSPITAL OF CHICAGO	100.00%	59,503		3
4	V	CORPORATE OTHER	55,655	METHODIST HOSPITAL OF CHICAGO	100.00%	55,655		4
5	V	HOSPITAL PURCHASING	82,151	METHODIST HOSPITAL OF CHICAGO	100.00%	82,151		5
6	V	HOSPITAL EDP	35,795	METHODIST HOSPITAL OF CHICAGO	100.00%	35,795		6
7	V	HOSPITAL HUMAN RESOURCES	39,336	METHODIST HOSPITAL OF CHICAGO	100.00%	39,336		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 621,374			\$ 621,374	\$ *	14

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTE # 0015651 Report Period Beginning: 10/1/2007 Ending: 9/30/2008

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:

10/1/2007

Ending: **1/30/2008**

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	\$ 891,677	\$ 891,677	20	\$ 178,335	1
2	CORPORATE BENEFITS	% to TOTAL COST	100	VARIOUS	852,995		20	170,599	2
3	CORPORATE PRO FEES	% to TOTAL COST	100	VARIOUS	297,516		20	59,503	3
4	CORPORATE OTHER	% to TOTAL COST	100	VARIOUS	278,273		20	55,655	4
5	HOSPITAL PURCHASING	% to TOTAL COST	100	VARIOUS	256,723		32	82,151	5
6	HOSPITAL EDP	% to TOTAL COST	100	VARIOUS	397,722		9	35,795	6
7	HOSPITAL HR	% to TOTAL COST	100	VARIOUS	171,026		23	39,336	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	TOTALS				\$ 3,145,932	\$ 891,677		\$ 621,374	25

Facility Name & ID Number

BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2007

Ending:

9/30/2008

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	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	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.)

Facility Name & ID Number BETHANY TERRACE NURSING CENTER

0015651

Report Period Beginning:

10/1/2007

Ending:

9/30/2008

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		1965	1965	\$ 1,249,972	\$ -	40	\$ -	\$	\$ 1,249,972
5		1965	1965	82,162	-	40	-		82,162
6		1997	1997	1,372,256	34,307	40	34,307		394,521
7		2000	2000	284,128	7,103	40	7,103		60,376
8		2001	2001	201,057	5,026	40	5,026		36,858
Improvement Type**									
9	ASSET DEPRECIATION -- 1965	1965		655,879	-	Various	-		655,879
10	ASSET DEPRECIATION -- 1966	1966		59,405	-	Various	-		59,405
11	ASSET DEPRECIATION -- 1967	1967		145,657	-	Various	-		145,657
12	ASSET DEPRECIATION -- 1968	1968		9,208	-	Various	-		9,208
13	ASSET DEPRECIATION -- 1969	1969		16,700	-	Various	-		16,700
14	ASSET DEPRECIATION -- 1970	1970		9,003	-	Various	-		9,003
15	ASSET DEPRECIATION -- 1973	1973		98,059	-	Various	-		98,059
16	ASSET DEPRECIATION -- 1975	1975		63,079	-	Various	-		63,079
17	ASSET DEPRECIATION -- 1976	1976		135,350	-	Various	-		135,350
18	ASSET DEPRECIATION -- 1977	1977		102,368	-	Various	-		102,368
19	ASSET DEPRECIATION -- 1978	1978		3,156	-	Various	-		3,156
20	ASSET DEPRECIATION -- 1979	1979		24,316	-	Various	-		24,316
21	ASSET DEPRECIATION -- 1980	1980		19,092	-	Various	-		19,092
22	ASSET DEPRECIATION -- 1981	1981		14,029	-	Various	-		14,029
23	ASSET DEPRECIATION -- 1982	1982		73,203	-	Various	-		73,203
24	ASSET DEPRECIATION -- 1983	1983		258,058	-	Various	-		258,058
25	ASSET DEPRECIATION -- 1984	1984		118,729	-	Various	-		118,729
26	ASSET DEPRECIATION -- 1985	1985		606,905	-	Various	-		606,905
27	ASSET DEPRECIATION -- 1986	1986		653,329	-	Various	-		653,329
28	ASSET DEPRECIATION -- 1987	1987		174,234	-	Various	-		174,234
29	ASSET DEPRECIATION -- 1988	1988		317,438	3,719	Various	3,719		300,700
30	ASSET DEPRECIATION -- 1989	1989		327,350	-	Various	-		327,350
31	ASSET DEPRECIATION -- 1990	1990		6,538	-	Various	-		6,538
32	ASSET DEPRECIATION -- 1991	1991		41,840	-	Various	-		41,840
33	ASSET DEPRECIATION -- 1992	1992		1,342,752	-	Various	-		1,342,752
34	ASSET DEPRECIATION -- 1993	1993		379,324	-	Various	-		379,324
35	ASSET DEPRECIATION -- 1994	1994		290,572	1,052	Various	1,052		285,672
36	ASSET DEPRECIATION -- 1995	1995		85,023	2,273	Various	2,273		71,121

*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:

10/1/2007

Ending:

9/30/2008

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	
37	ASSET DEPRECIATION -- 1996	1996	\$ 1,400,184	\$ 91,545	Various	\$ 91,545		\$ 1,171,323	37
38	ASSET DEPRECIATION -- 1997	1997	23,920	-	Various	-		23,920	38
39	ASSET DEPRECIATION -- 1998	1998	194,014	9,212	Various	9,212		108,681	39
40	ASSET DEPRECIATION -- 1999	1999	413,588	21,822	Various	21,822		215,081	40
41	ASSET DEPRECIATION -- 2000	2000	45,113	3,467	Various	3,467		34,268	41
42	ASSET DEPRECIATION -- 2001	2001	541,459	31,005	Various	31,005		233,337	42
43	ASSET DEPRECIATION -- 2002	2002	598,201	57,917	Various	57,917		354,439	43
44	ASSET DEPRECIATION -- 2003	2003	353,918	32,138	Various	32,138		164,635	44
45	ASSET DEPRECIATION -- 2004	2004	1,886,501	105,939	Various	105,939		449,028	45
46	POND INSTALLATION	2005	7,800	780	10	780		2,665	46
47	LANDSCAPING SECTIONS 2,3,4,5	2005	18,500	1,850	10	1,850		6,013	47
48	SPRINKLERS	2005	6,640	266	25	266		953	48
49	CARRIER 15 TON ROOF UNIT	2005	16,087	1,609	10	1,609		5,631	49
50	WALK IN COOLER	2005	5,135	342	15	342		1,140	50
51	CRAFT ROOM RENOVATION	2005	16,000	800	20	800		2,667	51
52	IRRIGATION SYSTEM	2005	22,755	2,275	10	2,275		7,395	52
53	DIALYSIS CENTER CAPITAL PROJECT	2005	47,691	2,385	20	2,385		7,552	53
54	BASEBOARD HEATING UNITS	2005	7,000	467	15	467		1,440	54
55	THERAPY DINING ROOM REMODELING	2005	11,480	574	20	574		1,770	55
56	CRAFT ROOM RENOVATION	2005	24,370	1,218	20	1,218		3,757	56
57	EMPLOYEE DINING ROOM REMODELING	2005	60,750	3,038	20	3,038		9,366	57
58	WASHER EXTRACTOR 40LB	2005	6,220	778	8	778		2,333	58
59	EXPANSION TANKS	2005	4,110	411	10	411		1,165	59
60	TREES AND LANDSCAPING	2006	3,545	355	10	355		857	60
61	NEW STORM DRAINS IN PARKING LOT	2006	4,900	490	10	490		1,021	61
62	NEW STORM DRAINS IN PARKING LOT	2006	5,000	500	10	500		1,083	62
63	ALUMINUM ORNAMENTAL FENCE (WHITE)	2006	5,520	368	15	368		889	63
64	RESURFACING PARKING LOT	2006	6,186	773	8	773		1,482	64
65	COMPRESSORS IN CARRIER ROOF TOP UNIT	2006	5,157	516	10	516		1,247	65
66	NURSE CALL SYSTEM VISION LINK 2500	2006	21,160	2,116	10	2,116		4,585	66
67	ROOFTOP UNIT BLOWER MOTOR	2006	5,613	561	10	561		1,169	67
68	TELEPHONE SYSTEM UPGRADE	2007	8,954	895	10	895		1,119	68
69	BUILDING REPAIRS	2007	3,954	395	10	395		494	69
70	TOTAL (lines 4 thru 69)		\$ 15,001,596	\$ 430,287		\$ 430,287		\$ 10,641,450	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:

10/1/2007

Ending:

9/30/2008

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 12A, Carried Forward		\$ 15,001,596	\$ 430,287		\$ 430,287	\$	\$ 10,641,450	1
2	TERRACE NURSING CENTER REMODELING	2007	6,648	266	25	266		332	2
3	HVAC CONNECTOR UNIT FOR NRSG CARE PLAN OFFICE	2007	2,700	270	10	270		293	3
4	NEW FLOOR CONCRETE IN LOCKER ROOM	2007	3,348	153	20	153		153	4
5	INSTALL TEE FROM REMOVING & RDING 2 TOILETS	2007	2,950	164	15	164		164	5
6	REMODELING ROTUNDA	2007	188,100	7,838	20	7,838		7,838	6
7	AIR CONDITION FOR COMPUTER /TELEPHONE ROOM	2007	2,511	209	10	209		209	7
8	PAVEMENT SIDEWALK WORK	2007	2,840	189	15	189		189	8
9	INSTALL NEW DRAIN SYSTEM	2007	9,000	450	20	450		563	9
10	ELECTRICAL SERVICE FOR NEW PHONE SYSTEM	2007	20,019	2,002	10	2,002		3,503	10
11	PHONE SYSTEM UPGRADE	2007	14,219	1,422	10	1,422		2,370	11
12	INSTALL AUTOMATIC DOOR OPENER	2007	4,900	327	15	327		490	12
13	REWORK NURSE BATHROOM	2007	5,807	581	10	581		871	13
14	DOORS AND EXIT SIGNS	2007	6,450	645	10	645		968	14
15	PERMIT FEE	2007	8,701	870	10	870		1,305	15
16	HVAC	2007	28,935	1,929	15	1,929		2,894	16
17	COOLING RETROFIT FOR KITCHEN	2007	32,000	2,133	15	2,133		3,200	17
18	HVAC AND SPRINKLER SYSTEM	2007	235,500	15,700	15	15,700		23,550	18
19	PHASE TWO-LINDGREN	2007	877,000	87,700	10	87,700		131,550	19
20	PHASE ONE-FRIENDSHIP AND DINING ROOM	2007	893,500	89,350	10	89,350		134,025	20
21	ROOF CAULKING	2007	4,797	480	10	480		640	21
22	REMODELING ANDERSON	2008	1,291,074	48,415	20	48,415		48,415	22
23	CABLE TV AIR CONDITIONING	2008	2,511	188	10	188		188	23
24	ACTIVATE 6 ANAOLGO LINES IN SYSTM	2008	3,186	212	10	212		212	24
25	ACTIVATE 6 ANALOG LINES TELEPHONE	2008	3,186	212	10	212		212	25
26	CABLE TV AIR CONDITIONING	2008	2,511	167	10	167		167	26
27	REMODELING BENDIX	2008	41,309	1,033	20	1,033		1,033	27
28	INSTALL VINYL TILE	2008	26,675	1,111	10	1,111		1,111	28
29	ROOF UPGRADES	2008	15,860	661	10	661		661	29
30	PHYSICAL THERAPY WORK STATION INSTALLATION	2008	15,980	200	20	200		200	30
31	FRONT ENTRANCE WORK AND FENCE WORK	2008	15,550	173	15	173		173	31
32	REMODELING BENDIX WING	2008	20,124	168	20	168		168	32
33	REMODELING PHYSICAL THERAPY	2008	29,400	245	20	245		245	33
34	TOTAL (lines 1 thru 33)		\$ 18,818,887	\$ 695,750		\$ 695,750	\$	\$ 11,009,342	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:

10/1/2007

Ending:

9/30/2008

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3	Year Constructed	4	Cost	5	Current Book Depreciation	6	Life in Years	7	Straight Line Depreciation	8	Adjustments	9	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward			\$	18,818,887	\$	695,750			\$	695,750	\$		\$	11,009,342	1
2	SINK IN BENDIX	2008			3,550		30		20		30				30	2
3	UPGRADE OXYGEN SYSTEM	2008			43,300		361		10		361				361	3
4	LANDSCAPING FRONT ENTRANCE TERRACE	2008			5,035		84		10		84				84	4
5	LANDSCAPING NORTH LOT	2008			12,120		202		10		202				202	5
6	NEW OXYGEN PADS AND FRONT LOT ASPHALT WORK	2008			75,150		3,914		8		3,914				3,914	6
7																7
8																8
9																9
10																10
11																11
12																12
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28																28
29																29
30																30
31																31
32																32
33																33
34	TOTAL (lines 1 thru 33)			\$	18,958,042	\$	700,341			\$	700,341	\$		\$	11,013,933	34

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

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	\$ 1,907,907	\$ 128,603	\$ 128,603	\$	VARIOUS	\$ 1,273,393	71
72	Current Year Purchases	263,444	17,841	17,841		VARIOUS	17,841	72
73	Fully Depreciated Assets	SEE ATTACHED SCHEDULE						73
74								74
75	TOTALS	\$ 2,171,351	\$ 146,444	\$ 146,444	\$		\$ 1,291,234	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	1999 FORD EL DORADO BUS	10/1/2003	\$ 19,125	\$ 3,825	\$ 3,825	\$	5	\$ 19,125	76
77										77
78										78
79										79
80	TOTALS			\$ 19,125	\$ 3,825	\$ 3,825	\$		\$ 19,125	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)	\$ 21,430,391	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 850,610	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 850,610	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)	\$ 12,324,292	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

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: \$ **41,310** Description: **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

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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

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?</p> <p><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		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	\$	2,382	\$ 146,484	\$	2,382	\$ 146,484	1
2	Licensed Speech and Language Development Therapist	10A	hrs		649	57,387		649	57,387	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs		4,233	268,166		4,233	268,166	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	7,264	\$ 472,037	\$	7,264	\$ 472,037	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/2008**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 850	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (186,327))	1,113,144		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	125,404		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/(from) Other Funds	(1,069,704)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 169,694	\$	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	15,988,413		14
15	Leasehold Improvements, at Historical Cost	490,739		15
16	Equipment, at Historical Cost	5,068,058		16
17	Accumulated Depreciation (book methods)	(12,594,781)		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): BT & Assisted Living	425,745		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,660,047	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,829,741	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 70,248	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,000		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)	\$ 94,745	\$	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)	\$ 94,745	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,734,996	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,829,741	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,713,812	1
2	Restatements (describe):		2
3	Due to/from Subsidiary	(26,601)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,687,211	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(952,215)	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)	\$ (952,215)	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)	\$ 9,734,996	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BETHANY TERRACE NURSING CENTER**# **0015651**Report Period Beginning: **10/1/2007**Ending: **9/30/2008**

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	\$ 14,594,437	1
2	Discounts and Allowances for all Levels	(3,913,524)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,680,913	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	733	12
13	Barber and Beauty Care	3,204	13
14	Non-Patient Meals	46,909	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 50,846	23
D. Non-Operating Revenue			
24	Contributions	23,142	24
25	Interest and Other Investment Income***	(77,221)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (54,079)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue (see TB & Pg 5 AJEs)	3,092	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,092	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,680,772	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,289,568	31
32	Health Care	6,016,623	32
33	General Administration	2,429,579	33
B. Capital Expense			
34	Ownership	897,378	34
C. Ancillary Expense			
35	Special Cost Centers	2,296	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Pastoral Care	(2,172)	37
38	Variance	(285)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,632,987	40
41	Income before Income Taxes (line 30 minus line 40)**	(952,215)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (952,215)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: **10/1/2007**

Ending:

9/30/2008

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	3,744	4,168	\$ 142,980	\$ 34.30	1
2	Assistant Director of Nursing	3,712	4,160	165,601	39.81	2
3	Registered Nurses	33,378	37,452	1,038,992	27.74	3
4	Licensed Practical Nurses	27,054	30,142	706,837	23.45	4
5	CNAs & Orderlies	135,726	150,682	1,870,142	12.41	5
6	CNA Trainees					6
7	Licensed Therapist	20	20	471	23.55	7
8	Rehab/Therapy Aides	4,853	5,555	76,185	13.71	8
9	Activity Director	1,768	2,080	43,707	21.01	9
10	Activity Assistants	14,252	15,965	140,796	8.82	10
11	Social Service Workers	3,335	3,776	79,762	21.12	11
12	Dietician					12
13	Food Service Supervisor	4,028	4,123	52,101	12.64	13
14	Head Cook	7,648	8,331	139,283	16.72	14
15	Cook Helpers/Assistants	39,404	42,118	370,679	8.80	15
16	Dishwashers					16
17	Maintenance Workers	2,656	2,901	68,362	23.56	17
18	Housekeepers	30,306	34,250	328,270	9.58	18
19	Laundry	7,159	8,329	83,355	10.01	19
20	Administrator	1,664	1,664	103,985	62.49	20
21	Assistant Administrator	2,480	2,645	113,404	42.87	21
22	Other Administrative	15,582	17,453	369,657	21.18	22
23	Office Manager					23
24	Clerical	12,355	13,693	191,268	13.97	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	2,012	2,268	44,572	19.65	31
32	Other Health C: PHYSICIANS	87	87	46,996	540.18	32
33	Other(specify) VARIANCE			17,050		33
34	TOTAL (lines 1 - 33)	353,223	391,862	\$ 6,194,455 *	\$ 15.81	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,034	\$ 26,650	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,034	\$ 26,650		53

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	
<u>DAVID RANDLE</u>	<u>ADMINISTRATOR</u>		\$ <u>103,985</u>	Workers' Compensation Insurance	\$ <u>68,694</u>	IDPH License Fee	\$ _____	
				Unemployment Compensation Insurance	<u>27,422</u>	Advertising: Employee Recruitment	<u>60</u>	
				FICA Taxes	<u>456,878</u>	Health Care Worker Background Check	_____	
				Employee Health Insurance	<u>246,661</u>	(Indicate # of checks performed _____)		
				Employee Meals	_____	<u>Naier & HC Pro</u>	<u>1,151</u>	
				Illinois Municipal Retirement Fund (IMRF)*	_____	<u>Wound Care Education Institute</u>	<u>2,427</u>	
				<u>Group Life Insurance</u>	<u>5,382</u>	<u>Magazines & Newspapers (Various)</u>	<u>3,922</u>	
				<u>Tuition Reimbursement</u>	<u>1,674</u>	<u>MHCH Service Corp</u>	<u>1,775</u>	
				<u>Transfers of Fringe Benefits</u>	<u>158,015</u>	<u>Chamber of Commerce</u>	<u>455</u>	
				<u>Corporate Benefits</u>	<u>27,382</u>	<u>Other</u>	<u>963</u>	
				<u>Comm Outreach PR Benefits</u>	<u>(7,283)</u>	Less: Public Relations Expense	<u>(455)</u>	
						Non-allowable advertising	(_____)	
						Yellow page advertising	(_____)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>103,985</u>	TOTAL (agree to Schedule V,	\$ <u>984,825</u>	TOTAL (agree to Sch. V,	\$ <u>10,298</u>	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>CORPORATE ALLOCATION</u>			\$ <u>424,583</u>			\$ _____	Out-of-State Travel	\$ _____
							In-State Travel	_____
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>424,583</u>	TOTAL		\$ _____	Seminar Expense	<u>9,175</u>
(Attach a copy of any management service agreement)							<u>COMM OUTREACH (PR)</u>	<u>(582)</u>
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	(_____)
<u>Cox Limited</u>	<u>Architectural Consulting</u>		\$ <u>28,963</u>				(agree to Sch. V,	
<u>Sawgrass Partners, LLC</u>	<u>Marketing Assessment</u>		<u>13,196</u>				line 24, col. 8)	
<u>Schain, Burney, Ross & Citron</u>	<u>Legal</u>		<u>11,375</u>				TOTAL	\$ <u>8,593</u>
<u>Foley and Lardner</u>	<u>Consultant</u>		<u>10,845</u>					
<u>Kenneth Kolich</u>	<u>IDPA Survey Consultant</u>		<u>7,679</u>					
<u>Carlin and Associates</u>	<u>Med Rec Consultant</u>		<u>4,296</u>					
<u>Cernivivo and Fasciana</u>	<u>Legal Consultant</u>		<u>3,495</u>					
<u>Carol Gordon</u>	<u>Social Srvc Consultant</u>		<u>2,250</u>					
<u>Quality Care Consulting</u>	<u>Dementia Consultant</u>		<u>4,400</u>					
<u>Januzs Golec, MD</u>	<u>Deposition Testimony</u>		<u>2,093</u>					
<u>Drinker, Biddle, & Reath</u>	<u>Legal</u>		<u>1,244</u>					
<u>Other</u>	<u>Various</u>		<u>86,773</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>176,609</u>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **BETHANY TERRACE NURSING CENTER**# **0015651**Report Period Beginning: **10/1/2007**Ending: **9/30/2008****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. \$ _____ 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. \$ 47,019
- (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 AND FINAL
- (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.