

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651 Report Period Beginning: 10/1/2008 Ending: 9/30/2009

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	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3	170	Intermediate (ICF)	170	62,050	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	730	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,153	5,229	7,141	22,523	8
9	SNF/PED					9
10	ICF	11,696	15,727		27,423	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,849	20,956	7,141	49,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.76%

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 WHEELS

F. 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 7,141

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 10/1/2008 Fiscal Year: 09/30/2009

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

Facility Name & ID Number

BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/2008

Ending:

9/30/2009

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	576,457	39,404	(82,849)	533,012		533,012	(47,574)	485,438		1
2	Food Purchase		543,572		543,572		543,572		543,572		2
3	Housekeeping	281,672	69,178	969	351,819		351,819		351,819		3
4	Laundry	99,837	24,814		124,651		124,651		124,651		4
5	Heat and Other Utilities			336,919	336,919		336,919		336,919		5
6	Maintenance	113,924	54,271	220,877	389,072		389,072		389,072		6
7	Other (specify):*										7
8	TOTAL General Services	1,071,890	731,239	475,916	2,279,045		2,279,045	(47,574)	2,231,471		8
	B. Health Care and Programs										
9	Medical Director	45,600			45,600		45,600		45,600		9
10	Nursing and Medical Records	4,074,680	664,543	194,339	4,933,562		4,933,562	(257)	4,933,305		10
10a	Therapy	83,602	1,085	581,386	666,073		666,073		666,073		10a
11	Activities	94,402	1,031	17,862	113,295		113,295		113,295		11
12	Social Services	62,436	67	100	62,603		62,603		62,603		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,360,720	666,726	793,687	5,821,133		5,821,133	(257)	5,820,876		16
	C. General Administration										
17	Administrative	133,282		459,062	592,344		592,344	210,645	802,989		17
18	Directors Fees										18
19	Professional Services			126,539	126,539		126,539	(34,197)	92,342		19
20	Dues, Fees, Subscriptions & Promotions			8,530	8,530		8,530	(1,380)	7,150		20
21	Clerical & General Office Expenses	425,184	37,657	181,700	644,541		644,541	(185,261)	459,280		21
22	Employee Benefits & Payroll Taxes			986,883	986,883	12,772	999,655	3,017	1,002,672		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,013	10,013		10,013	(260)	9,753		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			228,419	228,419	(12,772)	215,647		215,647		26
27	Other (specify):* Volunteers			1,622	1,622		1,622		1,622		27
28	TOTAL General Administration	558,466	37,657	2,002,768	2,598,891		2,598,891	(7,436)	2,591,455		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,991,076	1,435,622	3,272,371	10,699,069		10,699,069	(55,267)	10,643,802		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			897,655	897,655		897,655		897,655			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,224	43,224		43,224		43,224			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,072	17,072		17,072		17,072			35
36	Other (specify):* Bond Issue			26,007	26,007		26,007		26,007			36
37	TOTAL Ownership			983,958	983,958		983,958		983,958			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			33	33		33	(33)				41
42	Provider Participation Fee							149,468	149,468			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			33	33		33	149,435	149,468			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,991,076	1,435,622	4,256,362	11,683,060		11,683,060	94,168	11,777,228			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	(25,887)	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	(661)	21		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	(34,197)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(182,864)	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	337,810	Pg 5A		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 94,201		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 94,201		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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 BETHANY TERRACE NURSING CENTRE

Report Period Beginning: 10/1/2008
 Ending: 9/30/2009

ID# 0015651

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	ADMIN MISC INCOME	\$ (1,736)	21	1
2	HEALTH INFO MGT MISC INC	(25)	10	2
3	MEALS ON WHEELS	(20,876)	1	3
4	DIETARY MISC INC	(811)	1	4
5	GIFT SHOP MISC INC	(33)	41	5
6	COMM OUTREACH (PR) CHARGE SUPP	(232)	10	6
7	COMM OUTREACH (PR) TRAVEL	(260)	24	7
8	COMM OUTREACH (PR) BENEFITS	(6,795)	22	8
9	COMM OUTREACH (PR) DUES	(1,380)	20	9
10	PROVIDER PARTICIPATION FEE	149,468	42	10
11	CORPORATE FINANCE SALARIES	185,498	17	11
12	CORPORATE FINANCE BENEFITS	9,812	22	12
13	CORPORATE FINANCE OTHER EXP	25,147	17	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		337,777	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE# 0015651

Report Period Beginning:

10/1/2008

Ending:

9/30/2009

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	(47,574)	0	0	0	0	0	0	0	0	0	0	(47,574)	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	(47,574)	0	0	0	0	0	0	0	0	0	0	(47,574)	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	(257)	0	0	0	0	0	0	0	0	0	0	(257)	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	(257)	0	0	0	0	0	0	0	0	0	0	(257)	16
	C. General Administration													
17	Administrative	210,645	0	0	0	0	0	0	0	0	0	0	210,645	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(34,197)	0	0	0	0	0	0	0	0	0	0	(34,197)	19
20	Fees, Subscriptions & Promotions	(1,380)	0	0	0	0	0	0	0	0	0	0	(1,380)	20
21	Clerical & General Office Expenses	(185,261)	0	0	0	0	0	0	0	0	0	0	(185,261)	21
22	Employee Benefits & Payroll Taxes	3,017	0	0	0	0	0	0	0	0	0	0	3,017	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(7,436)	0	0	0	0	0	0	0	0	0	0	(7,436)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,267)	0	0	0	0	0	0	0	0	0	0	(55,267)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE# 0015651

Report Period Beginning:

10/1/2008 Ending:

9/30/2009

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	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	(33)	0	0	0	0	0	0	0	0	0	0	(33)	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	149,435	0	0	0	0	0	0	0	0	0	0	149,435	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	94,168	0	0	0	0	0	0	0	0	0	0	94,168	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:	
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	\$ 173,535	METHODIST HOSPITAL OF CHICAGO	100.00%	\$ 173,535	\$	1
2	V	CORPORATE BENEFITS	146,564	METHODIST HOSPITAL OF CHICAGO	100.00%	146,564		2
3	V	CORPORATE PRO FEES	57,127	METHODIST HOSPITAL OF CHICAGO	100.00%	57,127		3
4	V	CORPORATE OTHER	52,524	METHODIST HOSPITAL OF CHICAGO	100.00%	52,524		4
5	V	HOSPITAL PURCHASING	78,785	METHODIST HOSPITAL OF CHICAGO	100.00%	78,785		5
6	V	HOSPITAL EDP	16,096	METHODIST HOSPITAL OF CHICAGO	100.00%	16,096		6
7	V	HOSPITAL HUMAN RESOURCES	79,573	METHODIST HOSPITAL OF CHICAGO	100.00%	79,573		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 604,204			\$ 604,204	\$ *	14

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTR # 0015651 Report Period Beginning: 10/1/2008 Ending: 9/30/2009

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2008 Ending: 1/30/2009

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	\$ 913,344	\$ 913,344	19	\$ 173,535	1
2	CORPORATE BENEFITS	% to TOTAL COST	100	VARIOUS	771,389		19	146,564	2
3	CORPORATE PRO FEES	% to TOTAL COST	100	VARIOUS	300,667		19	57,127	3
4	CORPORATE OTHER	% to TOTAL COST	100	VARIOUS	276,443		19	52,524	4
5	HOSPITAL PURCHASING	% to TOTAL COST	100	VARIOUS	393,925		20	78,785	5
6	HOSPITAL EDP	% to TOTAL COST	100	VARIOUS	178,844		9	16,096	6
7	HOSPITAL HR	% to TOTAL COST	100	VARIOUS	331,554		24	79,573	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				\$ 3,166,166	\$ 913,344		\$ 604,204	25

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		3	4	5	6		8	9	10						
		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	MB Financial Bank		X	Construction	\$57,375.00	4/22/09	\$ 15,000,000	\$ 15,000,000	4/22/16	0.0459	\$ 43,224	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$57,375.00		\$ 15,000,000	\$ 15,000,000			\$ 43,224	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 15,000,000	\$ 15,000,000			\$ 43,224	15					

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)								
3. Under or (over) accrual (line 2 minus line 1).								
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.								

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004		8
	2005		9
	2006		10
	2007		11
	2008		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BETHANY TERRACE NURSING CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0015651

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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 CENTRE

0015651 Report Period Beginning:

10/1/2008 Ending:

9/30/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>183,600</u>	<u>1995</u>	<u>\$ 189,809</u>	<u>1</u>
2	<u>TERR LAND TRIANGLE</u>		<u>1996</u>	<u>92,064</u>	<u>2</u>
3	TOTALS	183,600		\$ 281,873	3

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		428,827
7		2000	2000	284,128	7,103	40	7,103		67,479
8		2001	2001	201,057	5,026	40	5,026		41,885
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	3,720	Various	3,720		304,420
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	963	Various	963		286,635
36	ASSET DEPRECIATION -- 1995		1995	85,023	2,273	Various	2,273		73,394

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/2008

Ending:

9/30/2009

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	\$ 91,544	Various	\$ 91,544		\$ 1,262,867	37
38	ASSET DEPRECIATION -- 1997	1997	23,920	-	Various	-		23,920	38
39	ASSET DEPRECIATION -- 1998	1998	194,014	9,072	Various	9,072		117,753	39
40	ASSET DEPRECIATION -- 1999	1999	413,588	21,394	Various	21,394		236,475	40
41	ASSET DEPRECIATION -- 2000	2000	45,113	3,255	Various	3,255		37,523	41
42	ASSET DEPRECIATION -- 2001	2001	541,459	31,003	Various	31,003		264,340	42
43	ASSET DEPRECIATION -- 2002	2002	598,201	57,917	Various	57,917		412,356	43
44	ASSET DEPRECIATION -- 2003	2003	353,918	32,134	Various	32,134		196,769	44
45	ASSET DEPRECIATION -- 2004	2004	1,886,501	105,939	Various	105,939		554,967	45
46	ASSET DEPRECIATION -- 2005	2005	254,538	16,792	Various	16,792		70,639	46
47	COMPRESSORS IN CARRIER ROOF TOP UNIT	2006	5,157	516	10	516		1,763	47
48	TREES AND LANDSCAPING	2006	3,545	354	10	354		1,211	48
49	ALUMINUM ORNAMENTAL FENCE (WHITE)	2006	5,520	368	15	368		1,257	49
50	NURSE CALL SYSTEM VISION LINK 2500	2006	21,160	2,116	10	2,116		6,701	50
51	NEW STORM DRAINS IN PARKING LOT	2006	5,000	500	10	500		1,583	51
52	NEW STORM DRAINS IN PARKING LOT	2006	4,900	490	10	490		1,511	52
53	ROOFTOP UNIT BLOWER MOTOR	2006	5,613	561	10	561		1,730	53
54	RESURFACING PARKING LOT	2006	6,186	773	8	773		2,255	54
55	ELECTRICAL SERVICE FOR NEW PHONE SYSTEM & SYSTEM	2007	20,019	2,002	10	2,002		5,505	55
56	PHONE SYSTEM UPGRADE	2007	14,219	1,422	10	1,422		3,792	56
57	INSTALL AUTOMATIC DOOR OPENER	2007	4,900	327	15	327		817	57
58	REWORK NURSE BATHROOM	2007	5,807	581	10	581		1,452	58
59	DOORS AND EXIT SIGNS	2007	6,450	645	10	645		1,613	59
60	PERMIT FEE	2007	8,701	870	10	870		2,175	60
61	HVAC	2007	28,935	1,929	15	1,929		4,823	61
62	COOLING RETROFIT FOR KITCHEN	2007	32,000	2,133	15	2,133		5,333	62
63	PHASE TWO-LINDGREN	2007	877,000	87,700	10	87,700		219,250	63
64	PHASE ONE-FRIENDSHIP AND DINING ROOM	2007	893,500	89,350	10	89,350		223,375	64
65	HVAC AND SPRINKLER SYSTEM	2007	235,500	15,700	15	15,700		39,250	65
66	ROOF CAULKING	2007	4,797	480	10	480		1,120	66
67	TELEPHONE SYSTEM UPGRADE	2007	8,954	895	10	895		2,014	67
68	INSTALL NEW DRAIN SYSTEM	2007	9,000	450	20	450		1,013	68
69	BUILDING REPAIRS	2007	3,954	395	10	395		889	69
70	TOTAL (lines 4 thru 69)		\$ 17,142,425	\$ 632,999		\$ 632,999		\$ 11,580,378	70

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE

0015651

Report Period Beginning:

10/1/2008

Ending:

9/30/2009

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		\$ 17,142,425	\$ 632,999		\$ 632,999		\$ 11,580,378	1
2	TERRACE NURSING CENTER REMODELING	2007	6,648	266	25	266		598	2
3	HVAC CONNECTOR UNIT FOR NURSING CARE PLAN OFFICE	2007	2,700	270	10	270		563	3
4	PAVEMENT SIDEWALK WORK	2007	2,840	189	15	189		378	4
5	NEW FLOOR CONCRETE IN LOCKER ROOM	2007	3,348	167	20	167		320	5
6	INSTALL TEE FROM REMOVING & RDING 2 TOILETS	2007	2,950	197	15	197		361	6
7	REMODELING ROTUNDA	2007	188,100	9,405	20	9,405		17,243	7
8	AIR CONDITION FOR COMPUTER /TELEPHONE ROOM	2007	2,511	251	10	251		460	8
9	REMODELING ANDERSON	2008	1,291,074	64,554	20	64,554		112,969	9
10	CABLE TV AIR CONDITIONING	2008	2,511	251	10	251		439	10
11	ACTIVATE 6 ANAOLGO LINES IN SYSTM	2008	3,186	319	10	319		531	11
12	ACTIVATE 6 ANALOG LINES TELEPHONE	2008	3,186	319	10	319		531	12
13	CABLE TV AIR CONDITIONING	2008	2,511	251	10	251		418	13
14	REMODELING BENDIX	2008	41,309	2,065	20	2,065		3,098	14
15	NEW OXYGEN PADS AND FRONT LOT ASHPHALT WORK	2008	75,150	9,394	8	9,394		13,308	15
16	ROOF UPGRADES	2008	15,860	1,586	10	1,586		2,247	16
17	PHYSICAL THERAPY WORK STATION INSTALLATION	2008	15,980	799	20	799		999	17
18	FRONT ENTRANCE WORK AND FENCE WORK	2008	15,550	1,037	15	1,037		1,210	18
19	REMODELING BENDIX WING	2008	20,124	1,006	20	1,006		1,174	19
20	REMODELING PHYSICAL THERAPY	2008	29,400	1,470	20	1,470		1,715	20
21	LANDSCAPING FRONT ENTRANCE TERRACE	2008	5,035	503	10	503		587	21
22	LANDSCAPING NORTH LOT	2008	12,120	1,212	10	1,212		1,414	22
23	SINK IN BENDIX	2008	3,550	177	20	177		207	23
24	UPGRADE OXYGEN SYSTEM	2008	43,300	4,330	10	4,330		4,691	24
25	NURSES STATION NORTH TERRACE SUITES	2008	7,122	475	15	475		475	25
26	PLUMBING PIPING	2009	6,837	114	20	114		114	26
27	ASHBURY HALLWAY REMODELING	2009	4,350	24	15	24		24	27
28	2 DOORS HALLWAY & INSTALLATION	2009	10,528	58	15	58		58	28
29	BEAUTY SALON	2009	69,800	388	15	388		388	29
30	ASSET DEPRECIATION -- (LESS THAN \$2500)		303,537	7,314	VARIOUS	7,314		260,310	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,333,541	\$ 741,390		\$ 741,390		\$ 12,007,208	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	\$ 2,195,696	\$ 155,759	\$ 155,759	\$	VARIOUS	\$ 1,446,104	71
72	Current Year Purchases	17,251	506	506		VARIOUS	506	72
73	Fully Depreciated Assets	See Attached Schedule						73
74								74
75	TOTALS	\$ 2,212,947	\$ 156,265	\$ 156,265	\$		\$ 1,446,610	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	2003	\$ 19,125	\$	\$	\$	5	\$ 19,125	76
77										77
78										78
79										79
80	TOTALS			\$ 19,125	\$	\$	\$		\$ 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)	\$ 21,847,486	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 897,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 897,655	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)	\$ 13,472,943	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 17,072 Description: VAC FREEDOM, SPECIAL BEDS, & OXYGEN TANK

(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 CENTRE # 0015651 Report Period Beginning: 10/1/2008 Ending: 9/30/2009
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	hrs	\$	2,861	\$ 184,095	\$	2,861	\$ 184,095	1
2	Licensed Speech and Language Development Therapist	10A	hrs		961	67,392		961	67,392	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs		5,005	328,614		5,005	328,614	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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,827	\$ 580,101	\$	8,827	\$ 580,101	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 CENTRE**# **0015651**Report Period Beginning: **10/1/2008**

Ending:

9/30/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **9/30/2009**

(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 (<u>164,791</u>)	923,954		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	78,096		7
8	Accounts Receivable (owners or related parties)	60,080		8
9	Other(specify): <u>Due From Subsidiary</u>	1,368,780		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,431,760	\$	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	16,089,549		14
15	Leasehold Improvements, at Historical Cost	490,739		15
16	Equipment, at Historical Cost	5,118,556		16
17	Accumulated Depreciation (book methods)	(13,492,436)		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):	444,784		22
23	Other(specify): <u>Bond Related</u>	12,813,356		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,746,421	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,178,181	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,787	\$	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	50,116		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Trust & Memorial Fund</u>	25,598		36
37	<u>BT Resident</u>	10,074		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 121,575	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	165,504		39
40	Mortgage Payable			40
41	Bonds Payable	15,000,000		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)	\$ 15,165,504	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,287,079	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,891,103	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 24,178,182	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,734,996	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,734,996	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(824,778)	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)	(19,115)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (843,893)	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)	\$ 8,891,103	24 *

* This must agree with page 17, line 47.

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	\$ 14,386,931	1
2	Discounts and Allowances for all Levels	(3,565,376)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,821,555	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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)	\$	23
D. Non-Operating Revenue			
24	Contributions	20,233	24
25	Interest and Other Investment Income***	(40,031)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (19,798)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income (See Support for Pg 5 & 5A)	56,525	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 56,525	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,858,282	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,279,045	31
32	Health Care	5,821,133	32
33	General Administration	2,598,891	33
B. Capital Expense			
34	Ownership	983,958	34
C. Ancillary Expense			
35	Special Cost Centers	33	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,683,060	40
41	Income before Income Taxes (line 30 minus line 40)**	(824,778)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (824,778)	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 CENTRE**

0015651

Report Period Beginning: **10/1/2008**

Ending:

9/30/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,824	3,032	\$ 115,113	\$ 37.97	1
2	Assistant Director of Nursing	3,160	4,160	162,489	39.06	2
3	Registered Nurses	29,305	33,874	961,193	28.38	3
4	Licensed Practical Nurses	25,046	28,004	685,331	24.47	4
5	CNAs & Orderlies	121,683	134,788	1,738,198	12.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,541	3,964	59,376	14.98	8
9	Activity Director	1,504	1,687	43,064	25.53	9
10	Activity Assistants	11,434	12,344	120,952	9.80	10
11	Social Service Workers	2,992	3,240	58,720	18.12	11
12	Dietician					12
13	Food Service Supervisor	3,778	4,072	52,615	12.92	13
14	Head Cook	7,591	8,269	141,944	17.17	14
15	Cook Helpers/Assistants	37,545	40,636	369,794	9.10	15
16	Dishwashers					16
17	Maintenance Workers	3,742	4,166	110,119	26.43	17
18	Housekeepers	24,900	28,224	282,678	10.02	18
19	Laundry	8,792	9,802	97,598	9.96	19
20	Administrator	2,080	2,080	133,282	64.08	20
21	Assistant Administrator	3,368	3,600	141,608	39.34	21
22	Other Administrative	15,375	17,515	393,343	22.46	22
23	Office Manager	1,032	1,200	23,088	19.24	23
24	Clerical	9,650	10,447	142,648	13.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director			45,600		27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,917	2,205	44,761	20.30	31
32	Other Health C: <u>Physicians</u>			43,332		32
33	Other(specify) <u>Variance</u>			24,230		33
34	TOTAL (lines 1 - 33)	321,259	357,309	\$ 5,991,076 *	\$ 16.77	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	4,328	19	37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	14	740	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	157	7,065	19	45
46	Other(specify) <u>Dementia</u>	88	4,436	19	46
47	<u>Environmental Consultant</u>		4,000	19	47
48				48	
49	TOTAL (lines 35 - 48)	259	\$ 20,569		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,375	\$ 66,108	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8	144	10	52
53	TOTAL (lines 50 - 52)	2,383	\$ 66,252		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	
DAVID RANDLE	ADMINISTRATOR		\$ 133,282	Workers' Compensation Insurance	\$ 109,345	IDPH License Fee	\$	
				Unemployment Compensation Insurance	32,169	Advertising: Employee Recruitment		
				FICA Taxes	436,641	Health Care Worker Background Check		
				Employee Health Insurance	269,416	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Chicago Tribune	4,686	
				Group Life Insurance	5,883	NAEIR	1,180	
				Tuition Reimbursement	3,112	Morton Grove Chamber of Comm	925	
				Transfers of Fringe Benefits	143,087	HCPRO	546	
				Corporate Benefits	9,812	Other	1,193	
				Comm Outreach PR Benefits (FICA)	(6,795)	Less: Public Relations Expense	(1,380)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 133,282	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,002,670	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,150	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CORPORATE ALLOCATION			\$ 459,062			\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 459,062				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Carol Gordon	Social Service Consulting		\$ 7,065					
Quality Care Consulting	Dementia Consulting		4,436					
Carlin & Associates	Med Rec Consulting		4,328					
Cernivo & Fasciana	Legal Fees		42,389					
Schain, Burney, Ross & Citron	Legal Fees		16,731					
Pappas & Bell	Legal Fees		6,310					
PricewaterhouseCoopers	Auditing Fees		26,000					
Lorenz & Associates	Appraisal Fees		5,000					
Stanley Polit MD FACP	Expert Witness		5,250					
Axis Response Group	Environmental Consulting		4,000					
Other	Other		5,030					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 126,539	TOTAL		\$	Seminar Expense	10,013
(If total legal fees exceed \$5,000, attach copy of invoices.)							Comm Outreach (PR)	(260)
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 9,753

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
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9												
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13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 38,620 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. \$ 47,573
- (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? _____
Firm Name: PRICEWATERHOUSECOOPERS LLP
- (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.