FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0015651

Facility Name: BETHANY TERRACE NURSING CENTRE

Address: 8425 WAUKEGAN ROAD (Number) MORTON GROVE (City) 60053 (Zip Code)

County: COOK

Telephone Number: (847) 965-8100 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 2/13/1969

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: James Gregory **Telephone Number:** (773)989-1469
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2009 to 9/30/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,293	5,300	7,749	21,342	8
9	SNF/PED					9
10	ICF	11,045	13,181		24,226	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,338	18,481	7,749	45,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.40%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 103 and days of care provided 7,032

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 10/1/2009 Fiscal Year: 9/30/2010

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	580,742	30,217	(99,465)	511,494		511,494	(42,550)	468,944			1
2	Food Purchase		503,467		503,467		503,467	(52)	503,415			2
3	Housekeeping	280,897	45,098	2,610	328,605		328,605		328,605			3
4	Laundry	94,691	47,124		141,815		141,815		141,815			4
5	Heat and Other Utilities			355,967	355,967		355,967		355,967			5
6	Maintenance	105,941	23,321	218,165	347,427		347,427		347,427			6
7	Other (specify):*											7
8	TOTAL General Services	1,062,271	649,227	477,277	2,188,775		2,188,775	(42,602)	2,146,173			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,068,015	689,028	237,070	4,994,113		4,994,113	(736)	4,993,377			10
10a	Therapy	83,632	1,433	732,299	817,364		817,364		817,364			10a
11	Activities	121,341	3,059	9,997	134,397		134,397	(125)	134,272			11
12	Social Services	65,618	125	113	65,856		65,856		65,856			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mission Spiritual		138	1,409	1,547		1,547		1,547			15
16	TOTAL Health Care and Programs	4,338,606	693,783	980,888	6,013,277		6,013,277	(861)	6,012,416			16
	C. General Administration											
17	Administrative	98,720		392,123	490,843		490,843	169,327	660,170			17
18	Directors Fees											18
19	Professional Services			44,855	44,855		44,855	(1,956)	42,899			19
20	Dues, Fees, Subscriptions & Promotions			14,479	14,479		14,479	(1,225)	13,254			20
21	Clerical & General Office Expenses	446,614	45,974	168,214	660,802		660,802	(362,220)	298,582			21
22	Employee Benefits & Payroll Taxes			1,035,492	1,035,492	14,342	1,049,834	3,711	1,053,545			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,675	13,675		13,675	(3,105)	10,570			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,087	96,087	(14,342)	81,745		81,745			26
27	Other (specify):* Voluneers		35	730	765		765		765			27
28	TOTAL General Administration	545,334	46,009	1,765,655	2,356,998		2,356,998	(195,468)	2,161,530			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,946,211	1,389,019	3,223,820	10,559,050		10,559,050	(238,931)	10,320,119			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE #0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			894,812	894,812		894,812		894,812			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			15,120	15,120		15,120		15,120			35
36	Other (specify):* **Bond Issue**			52,015	52,015		52,015		52,015			36
37	**TOTAL Ownership**			961,947	961,947		961,947		961,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,815	1,815		1,815	(1,346)	469			41
42	Provider Participation Fee							149,467	149,467			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,815	1,815		1,815	148,121	149,936			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,946,211	1,389,019	4,187,582	11,522,812		11,522,812	(90,810)	11,432,002			45

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(27,055)	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	(1,244)	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	(1,956)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(190,272)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	129,717	Pg 5A		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,810)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (90,810)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

BETHANY TERRACE NURSING CENTRE

ID# 0015651

Report Period Beginning: 10/1/2009

Ending: 9/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ADMIN MISC INCOME	$ (170,704)	21	1
2	HEALTH INFO MGT MISC INC	(736)	10	2
3	MEALS ON WHEELS	(15,495)	1	3
4	ACTIVITIES MISC IN	(125)	11	4
5	GIFT SHOP MISC INC	(1,346)	41	5
6	COMM OUTREACH (PR) TRAVEL	(3,105)	24	6
7	COMM OUTREACH (PR) BENEFITS	(5,392)	22	7
8	COMM OUTREACH (PR) DUES	(465)	20	8
9	COMM OUTREACH (PR) FOOD	(52)	2	9
10	PROVIDER PARTICIPATION FEE	149,467	42	10
11	CORPORATE FINANCE SALARIES	153,750	17	11
12	CORPORATE FINANCE BENEFITS	9,103	22	12
13	CORPORATE FINANCE OTHER EXP	15,577	17	13
14	NON ALLOWABLE DUES	(760)	20	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**	129,717		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 **Report Period Beginning:** 10/1/2009 **Ending:** 9/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(42,550)	0	0	0	0	0	0	0	0	0	0	(42,550)	1
2	Food Purchase	(52)	0	0	0	0	0	0	0	0	0	0	(52)	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**	(42,602)	0	0	0	0	0	0	0	0	0	0	(42,602)	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	(736)	0	0	0	0	0	0	0	0	0	0	(736)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(125)	0	0	0	0	0	0	0	0	0	0	(125)	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**	(861)	0	0	0	0	0	0	0	0	0	0	(861)	16
	C. General Administration													
17	Administrative	169,327	0	0	0	0	0	0	0	0	0	0	169,327	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,956)	0	0	0	0	0	0	0	0	0	0	(1,956)	19
20	Fees, Subscriptions & Promotions	(1,225)	0	0	0	0	0	0	0	0	0	0	(1,225)	20
21	Clerical & General Office Expenses	(362,220)	0	0	0	0	0	0	0	0	0	0	(362,220)	21
22	Employee Benefits & Payroll Taxes	3,711	0	0	0	0	0	0	0	0	0	0	3,711	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,105)	0	0	0	0	0	0	0	0	0	0	(3,105)	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**	(195,468)	0	0	0	0	0	0	0	0	0	0	(195,468)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(238,931)	0	0	0	0	0	0	0	0	0	0	(238,931)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 **Report Period Beginning:** 10/1/2009 **Ending:** 9/30/2010

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

	Capital Expense D. Ownership	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)	
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	(1,346)	0	0	0	0	0	0	0	0	0	0	(1,346)	41
42	Provider Participation Fee	149,467	0	0	0	0	0	0	0	0	0	0	149,467	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	148,121	0	0	0	0	0	0	0	0	0	0	148,121	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(90,810)	0	0	0	0	0	0	0	0	0	0	(90,810)	45

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		CORPORATE SALARY	$ 176,953	METHODIST HOSPITAL OF CHICAGO	100.00%	$ 176,953	$	1
2	V		CORPORATE BENEFITS	156,613	METHODIST HOSPITAL OF CHICAGO	100.00%	156,613		2
3	V		CORPORATE PRO FEES	43,139	METHODIST HOSPITAL OF CHICAGO	100.00%	43,139		3
4	V		CORPORATE OTHER	48,439	METHODIST HOSPITAL OF CHICAGO	100.00%	48,439		4
5	V		HOSPITAL PURCHASING	52,189	METHODIST HOSPITAL OF CHICAGO	100.00%	52,189		5
6	V		HOSPITAL EDP	18,703	METHODIST HOSPITAL OF CHICAGO	100.00%	18,703		6
7	V		HOSPITAL HUMAN RESOURCES	46,875	METHODIST HOSPITAL OF CHICAGO	100.00%	46,875		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 542,911			$ 542,911	$ *	14

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTRI # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 10/1/2009 Ending: 9/30/2010

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 [X] NO [ ]

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

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: ( )

	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	$ 983,072	$ 983,072	18	$ 176,953	1
2		CORPORATE BENEFITS	% to TOTAL COST	100	VARIOUS	870,072		18	156,613	2
3		CORPORATE PRO FEES	% to TOTAL COST	100	VARIOUS	239,661		18	43,139	3
4		CORPORATE OTHER	% to TOTAL COST	100	VARIOUS	269,106		18	48,439	4
5		HOSPITAL PURCHASING	% to TOTAL COST	100	VARIOUS	260,945		20	52,189	5
6		HOSPITAL EDP	% to TOTAL COST	100	VARIOUS	374,060		5	18,703	6
7		HOSPITAL HR	% to TOTAL COST	100	VARIOUS	234,375		20	46,875	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					$ 3,231,291	$ 983,072		$ 542,911	25

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	$	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			$	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			$	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 CENTRE # 0015651 **Report Period Beginning:** 10/1/2009 **Ending:** 9/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 10/1/2009 Ending: 9/30/2010

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? [X] (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? [X] (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).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	183,600	1995	$ 189,809	1
2	TERR LAND TRIANGLE		1996	92,064	2
3	TOTALS	183,600		$ 281,873	3

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1965	1965	$ 1,249,972	$ -	40	$ -	$	$ 1,249,972	4
5			1965	1965	82,162	-	40	-		82,162	5
6			1997	1997	1,372,256	34,307	40	34,307		463,134	6
7			2000	2000	284,128	7,103	40	7,103		46,911	7
8			2001	2001	201,057	5,026	40	5,026		74,582	8
	Improvement Type**										
9	ASSET DEPRECIATION -- 1965			1965	655,879	-	Various	-		655,879	9
10	ASSET DEPRECIATION -- 1966			1966	59,405	-	Various	-		59,405	10
11	ASSET DEPRECIATION -- 1967			1967	145,657	-	Various	-		145,657	11
12	ASSET DEPRECIATION -- 1968			1968	9,208	-	Various	-		9,208	12
13	ASSET DEPRECIATION -- 1969			1969	16,700	-	Various	-		16,700	13
14	ASSET DEPRECIATION -- 1970			1970	9,003	-	Various	-		9,003	14
15	ASSET DEPRECIATION -- 1973			1973	98,059	-	Various	-		98,059	15
16	ASSET DEPRECIATION -- 1975			1975	63,079	-	Various	-		63,079	16
17	ASSET DEPRECIATION -- 1976			1976	135,350	-	Various	-		135,350	17
18	ASSET DEPRECIATION -- 1977			1977	102,368	-	Various	-		102,368	18
19	ASSET DEPRECIATION -- 1978			1978	3,156	-	Various	-		3,156	19
20	ASSET DEPRECIATION -- 1979			1979	24,316	-	Various	-		24,316	20
21	ASSET DEPRECIATION -- 1980			1980	19,092	-	Various	-		19,092	21
22	ASSET DEPRECIATION -- 1981			1981	14,029	-	Various	-		14,029	22
23	ASSET DEPRECIATION -- 1982			1982	73,203	-	Various	-		73,203	23
24	ASSET DEPRECIATION -- 1983			1983	258,058	-	Various	-		258,058	24
25	ASSET DEPRECIATION -- 1984			1984	118,729	-	Various	-		118,729	25
26	ASSET DEPRECIATION -- 1985			1985	606,905	-	Various	-		606,905	26
27	ASSET DEPRECIATION -- 1986			1986	653,329	-	Various	-		653,329	27
28	ASSET DEPRECIATION -- 1987			1987	174,234	-	Various	-		174,234	28
29	ASSET DEPRECIATION -- 1988			1988	317,438	3,719	Various	3,719		308,139	29
30	ASSET DEPRECIATION -- 1989			1989	327,350	-	Various	-		327,350	30
31	ASSET DEPRECIATION -- 1990			1990	6,538	-	Various	-		6,538	31
32	ASSET DEPRECIATION -- 1991			1991	41,840	-	Various	-		41,840	32
33	ASSET DEPRECIATION -- 1992			1992	1,342,752	-	Various	-		1,342,752	33
34	ASSET DEPRECIATION -- 1993			1993	379,324	-	Various	-		379,324	34
35	ASSET DEPRECIATION -- 1994			1994	290,572	875	Various	875		287,510	35
36	ASSET DEPRECIATION -- 1995			1995	85,023	2,186	Various	2,186		75,580	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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	
37	ASSET DEPRECIATION -- 1996	1996	$ 1,400,184	$ 91,545	Various	$ 91,545	$	$ 1,354,412	37
38	ASSET DEPRECIATION -- 1997	1997	23,920	-	Various	-		23,920	38
39	ASSET DEPRECIATION -- 1998	1998	194,014	9,072	Various	9,072		126,824	39
40	ASSET DEPRECIATION -- 1999	1999	413,588	20,167	Various	20,167		256,643	40
41	ASSET DEPRECIATION -- 2000	2000	45,113	1,814	Various	1,814		39,337	41
42	ASSET DEPRECIATION -- 2001	2001	541,459	31,005	Various	31,005		295,345	42
43	ASSET DEPRECIATION -- 2002	2002	598,201	57,918	Various	57,918		470,274	43
44	ASSET DEPRECIATION -- 2003	2003	353,918	32,138	Various	32,138		228,907	44
45	ASSET DEPRECIATION -- 2004	2004	1,886,501	105,276	Various	105,276		660,243	45
46	ASSET DEPRECIATION -- 2005	2005	254,538	16,793	Various	16,793		87,432	46
47	ASSET DEPRECIATION -- 2006	2006	57,081	5,679	Various	5,679		23,690	47
48	ELECTRICAL SERVICE FOR NEW PHONE SYSTEM & SYSTEM	2007	20,019	2,002	10	2,002		7,507	48
49	PHONE SYSTEM UPGRADE	2007	14,219	1,422	10	1,422		5,214	49
50	INSTALL AUTOMATIC DOOR OPENER	2007	4,900	327	15	327		1,144	50
51	REWORK NURSE BATHROOM	2007	5,807	581	10	581		2,033	51
52	DOORS AND EXIT SIGNS	2007	6,450	645	10	645		2,258	52
53	PERMIT FEE	2007	8,701	870	10	870		3,045	53
54	HVAC	2007	28,935	1,929	15	1,929		6,752	54
55	COOLING RETROFIT FOR KITCHEN	2007	32,000	2,133	15	2,133		7,466	55
56	PHASE TWO-LINDGREN	2007	877,000	87,700	10	87,700		306,950	56
57	PHASE ONE-FRIENDSHIP AND DINING ROOM	2007	893,500	89,350	10	89,350		312,725	57
58	HVAC AND SPRINKLER SYSTEM	2007	235,500	15,700	15	15,700		54,950	58
59	ROOF CAULKING	2007	4,797	480	10	480		1,600	59
60	TELEPHONE SYSTEM UPGRADE	2007	8,954	896	10	896		2,910	60
61	INSTALL NEW DRAIN SYSTEM	2007	9,000	450	20	450		1,463	61
62	BUILDING REPAIRS	2007	3,954	395	10	395		1,284	62
63	TERRACE NURSING CENTER REMODELING	2007	6,648	266	25	266		864	63
64	HVAC CONNECTOR UNIT FOR NURSING CARE PLAN OFFICE	2007	2,700	270	10	270		833	64
65	PAVEMENT SIDEWALK WORK	2007	2,840	189	15	189		567	65
66	NEW FLOOR CONCRETE IN LOCKER ROOM	2007	3,348	167	20	167		487	66
67	INSTALL TEE FROM REMOVING & RDING 2 TOILETS	2007	2,950	197	15	197		558	67
68	REMODELING ROTUNDA	2007	188,100	9,405	20	9,405		26,648	68
69	AIR CONDITION FOR COMPUTER /TELEPHONE ROOM	2007	2,511	251	10	251		711	69
70	**TOTAL (lines 4 thru 69)**		**$ 17,351,522**	**$ 640,248**		**$ 640,248**	**$**	**$ 12,240,549**	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: 10/1/2009 Ending: 9/30/2010

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 12A, Carried Forward**		$ 17,351,522	$ 640,248		$ 640,248	$	$ 12,240,549	1
2	REMODELING ANDERSON	2008	1,291,074	64,554	20	64,554		177,523	2
3	CABLE TV AIR CONDITIONING	2008	2,511	251	10	251		690	3
4	ACTIVATE 6 ANAOLGO LINES IN SYSTME	2008	3,186	319	10	319		850	4
5	ACTIVATE 6 ANALOG LINES TELEPHONE	2008	3,186	319	10	319		850	5
6	CABLE TV AIR CONDITIONING	2008	2,511	251	10	251		669	6
7	REMODELING BENDIX	2008	41,309	2,065	20	2,065		5,163	7
8	NEW OXYGEN PADS AND FRONT LOT ASHPHALT WORK	2008	75,150	9,394	8	9,394		22,702	8
9	ROOF UPGRADES	2008	15,860	1,586	10	1,586		3,833	9
10	PHYSICAL THERAPY WORK STATION INSTALLATION	2008	15,980	799	20	799		1,798	10
11	FRONT ENTRANCE WORK AND FENCE WORK	2008	15,550	1,037	15	1,037		2,247	11
12	REMODELING BENDIX WING	2008	20,124	1,006	20	1,006		2,180	12
13	REMODELING PHYSICAL THERAPY	2008	29,400	1,470	20	1,470		3,185	13
14	LANDSCAPING FRONT ENTRANCE TERRACE	2008	5,035	504	10	504		1,091	14
15	LANDSCAPING NORTH LOT	2008	12,120	1,212	10	1,212		2,626	15
16	SINK IN BENDIX	2008	3,550	178	20	178		385	16
17	UPGRADE OXYGEN SYSTEM	2008	43,300	4,330	10	4,330		9,021	17
18	NURSES STATION NORTH TERRACE SUITES	2008	7,122	475	15	475		950	18
19	PLUMBING PIPING	2009	6,837	342	20	342		456	19
20	ASHBURY HALLWAY REMODELING	2009	4,350	290	15	290		314	20
21	2 DOORS HALLWAY & INSTALLATION	2009	10,528	702	15	702		760	21
22	BEAUTY SALON	2009	69,800	4,653	15	4,653		5,041	22
23	CARPET & BASEBOARD REPLACEMENT FOR SYLVESTER SUITES	2009	20,868	3,478	5	3,478		3,478	23
24	BATHROOM HEATER FOR SYLVESTER SUITES SOUTH	2010	2,800	140	15	140		140	24
25	LAMINATED FLOORING FURNISH & INSTALL	2010	4,280	178	10	178		178	25
26	REPAIR TO PT HVAC UNIT ROOF-TOP	2010	12,980	162	20	162		162	26
27	ASSET DEPRECIATION -- (LESS THAN $2500)		303,573	7,387	Various	7,387		267,697	27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		**$ 19,374,505**	**$ 747,330**		**$ 747,330**	**$**	**$ 12,754,538**	34

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

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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	$ 2,218,627	$ 145,771	$ 145,771	$	VARIOUS	$ 1,592,381	71
72	Current Year Purchases	20,724	1,711	1,711		VARIOUS	1,711	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,239,351	$ 147,482	$ 147,482	$		$ 1,594,092	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)	$ 21,914,854	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 894,812	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 894,812	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)	$ 14,367,755	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.

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 15,120 Description: VAC FREEDOM, C-PAP, & POSTAGE
(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: 10/1/2009 Ending: 9/30/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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

	1	2	3	4	5	6	7	8	
	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		hrs	$	3,318	$ 217,422	$	3,318	$ 217,422	1
2	Licensed Speech and Language Development Therapist		hrs		1,081	91,878		1,081	91,878	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		6,352	421,376		6,352	421,376	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			$	10,751	$ 730,675	$	10,751	$ 730,675	14

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

STATE OF ILLINOIS

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 850	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 117,025)	1,208,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	111,794		7
8	Accounts Receivable (owners or related parties)	345,671		8
9	Other(specify): Due from Subsidiary	1,232,104		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,898,822	$	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	16,094,049		14
15	Leasehold Improvements, at Historical Cost	490,739		15
16	Equipment, at Historical Cost	5,185,888		16
17	Accumulated Depreciation (book methods)	(14,387,248)		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):	7,704,518		22
23	Other(specify): Bond Issuance	5,331,905		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 20,701,724	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 23,600,546	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 24,265	$	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	BT Resident	2,101		36
37	BT Memorial Fund	9,598		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 36,964	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	852,231		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)**	$ 15,852,231	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,889,195	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,711,351	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 23,600,546	$	48

***(See instructions.)**

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,891,103	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,891,103	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(492,365)	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) **Loss on Swap**	(687,387)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,179,752)	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)**	$ 7,711,351	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,154,317	1
2	Discounts and Allowances for all Levels	(4,484,703)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,669,614	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	16,493	24
25	Interest and Other Investment Income***	122,241	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 138,734	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	221,442	28
28a	Reconciling Item	657	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 222,099	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,030,447	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,188,775	31
32	Health Care	6,013,277	32
33	General Administration	2,356,998	33
	B. Capital Expense		
34	Ownership	961,947	34
	C. Ancillary Expense		
35	Special Cost Centers	1,815	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Other Reconciling items		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,522,812	40
41	**Income before Income Taxes (line 30 minus line 40)****	(492,365)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (492,365)	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: 10/1/2009 Ending: 9/30/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,080	$ 81,451	$ 39.16	1
2	Assistant Director of Nursing	3,120	3,871	140,956	36.41	2
3	Registered Nurses	30,760	34,269	1,015,362	29.63	3
4	Licensed Practical Nurses	22,388	24,582	613,719	24.97	4
5	CNAs & Orderlies	116,323	129,090	1,740,390	13.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,590	3,987	61,611	15.45	8
9	Activity Director	1,920	2,080	60,573	29.12	9
10	Activity Assistants	11,714	12,818	133,532	10.42	10
11	Social Service Workers	3,005	3,456	66,153	19.14	11
12	Dietician					12
13	Food Service Supervisor	3,551	4,135	54,819	13.26	13
14	Head Cook	7,718	8,233	148,655	18.06	14
15	Cook Helpers/Assistants	36,840	40,492	371,854	9.18	15
16	Dishwashers					16
17	Maintenance Workers	3,561	4,151	108,163	26.06	17
18	Housekeepers	24,289	26,811	278,475	10.39	18
19	Laundry	8,102	9,260	95,980	10.37	19
20	Administrator	3,512	3,600	162,560	45.16	20
21	Assistant Administrator	864	980	51,642	52.70	21
22	Other Administrative	16,123	18,683	451,371	24.16	22
23	Office Manager	1,472	2,072	40,608	19.60	23
24	Clerical	8,876	9,583	138,091	14.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,955	2,243	45,109	20.11	31
32	Other Health C: Physicians			37,000		32
33	Other(specify) Variance			48,137		33
34	TOTAL (lines 1 - 33)	311,555	346,476	$ 5,946,211 *	$ 17.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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	10	500	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	54	2,430	19	45
46	Other(specify) Medical Records		2,560	19	46
47	Marketing	21	425		47
48	Administration	35	4,365		48
49	TOTAL (lines 35 - 48)	120	$ 10,280		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,373	$ 65,908	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	17	233	10	52
53	TOTAL (lines 50 - 52)	2,390	$ 66,141		53

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marya Jordan	Administrator		$ 98,720
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,720

B. Administrative - Other

Description	Amount
CORPORATE ALLOCATION	$ 392,123
TOTAL (agree to Schedule V, line 17, col. 3)	$ 392,123
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Carol Gordon	Social Service Consulting	$ 2,430
Quality Care Consulting	Dementia Consulting	408
Carlin & Associates	Med Rec Consulting	2,560
Schain, Burney, Ross & Citron	Legal Fees	881
Pappas & Bell	Legal Fees	1,686
Advocate Medical Group	Rehab Med Dir	21,600
Ira B. Kornblatt	Ortho Med Dir	10,000
Touhy Parmacy	Pharmaceutical Consulting	500
Rimkus Consulting Group	Environmental Consulting	1,865
Other	Other	2,925
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 44,855

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,957
Unemployment Compensation Insurance	(44,223)
FICA Taxes	428,335
Employee Health Insurance	353,725
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	5,686
Tuition Reimbursement	8,525
Transfers of Fringe Benefits	150,788
Corporate Benefits	9,103
Comm Outreach PR Benefits (FICA)	(5,392)
Variance	1
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,052,504

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Publications	7,455
Life Service Network	3,754
HCPRO	108
Other	2,402
Less: Public Relations Expense	(465)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,675
Comm Outreach (PR)	(3,105)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,570

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 Report Period Beginning: 10/1/2009 Ending: 9/30/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BETHANY TERRACE NURSING CENTRE # 0015651 **Report Period Beginning:** 10/1/2009 **Ending:** 9/30/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network 3,754

(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. $ 27,558 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. $ 42,549

(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.