FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 #** 847-965-8104

HFS ID Number:

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

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code 501(C)(3)
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

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 10/1/2010 to 9/30/2011 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) Scott E. Martin, CPA, Director
(Firm Name & Address) Crowe Horwath LLP, 330 E. Jefferson Blvd., P.O.Box 7, South Bend, IN 46624-000
(Telephone) (574) 232-3992 Fax # (574) 236-8692

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: ####### Ending: 9/30/2011

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 N/A

	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	7,162	3,868	9,714	20,744	8
9	SNF/PED					9
10	ICF	7,727	15,463		23,190	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,889	19,331	9,714	43,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.77%

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 [ ] NO [X]

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 8,658

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: FYE 9/30/11 Fiscal Year: FYE 9/30/11

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

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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	600,632	29,614		630,246		630,246		630,246			1
2	Food Purchase		450,048		450,048		450,048	(37,563)	412,485			2
3	Housekeeping	297,574	45,772	1,708	345,054		345,054		345,054			3
4	Laundry	87,367	7,106		94,473		94,473		94,473			4
5	Heat and Other Utilities			361,939	361,939		361,939		361,939			5
6	Maintenance	90,348	11,322	154,837	256,507		256,507		256,507			6
7	Other (specify):*											7
8	TOTAL General Services	1,075,921	543,862	518,484	2,138,267		2,138,267	(37,563)	2,100,704			8
	B. Health Care and Programs											
9	Medical Director	37,000		21,600	58,600		58,600		58,600			9
10	Nursing and Medical Records	3,907,525	268,859	84,961	4,261,345		4,261,345	(1,139)	4,260,206			10
10a	Therapy	81,142	1,223	718,886	801,251		801,251		801,251			10a
11	Activities	95,943	1,964	5,510	103,417		103,417		103,417			11
12	Social Services	71,145		171	71,316		71,316		71,316			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,192,755	272,046	831,128	5,295,929		5,295,929	(1,139)	5,294,790			16
	C. General Administration											
17	Administrative			423,466	423,466	122,086	545,552	(50,744)	494,808			17
18	Directors Fees											18
19	Professional Services			3,090	3,090		3,090		3,090			19
20	Dues, Fees, Subscriptions & Promotions			10,890	10,890		10,890		10,890			20
21	Clerical & General Office Expenses	434,883	30,407	61,874	527,164	(122,086)	405,078	(364)	404,714			21
22	Employee Benefits & Payroll Taxes			1,032,279	1,032,279		1,032,279	11,665	1,043,944			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,467	4,467		4,467		4,467			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,003	61,003		61,003		61,003			26
27	Other (specify):*											27
28	TOTAL General Administration	434,883	30,407	1,597,069	2,062,359		2,062,359	(39,443)	2,022,916			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,703,559	846,315	2,946,681	9,496,555		9,496,555	(78,145)	9,418,410			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: 10/1/2010 Ending: 9/30/2011

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			828,332	828,332		828,332		828,332			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			25,880	25,880		25,880		25,880			35
36	Other (specify):*			88,095	88,095		88,095	(88,095)				36
37	**TOTAL Ownership**			942,307	942,307		942,307	(88,095)	854,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		508,021	18,673	526,694		526,694		526,694			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			383	383		383	(383)				41
42	Provider Participation Fee							149,059	149,059			42
43	Other (specify):* **Marketing**	80,455	54	62,583	143,092		143,092	(143,092)				43
44	**TOTAL Special Cost Centers**	80,455	508,075	81,639	670,169		670,169	5,584	675,753			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,784,014	1,354,390	3,970,627	11,109,031		11,109,031	(160,656)	10,948,375			45

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

SCHEDULE V - Reclassifications

		To Line	From Line
Administrator wages	$ 122,086	17	21

SCHEDULE V - Line 36, Column 3, Other Ownership

Unrealized change in swap	$ 88,095

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: ######

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	(37,007)	2		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	(556)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(143,092)	43		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 See Supplemental Schedule	59,078			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (121,577)		$	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)	(39,079)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (39,079)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (160,656)		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.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Bethany Terrace Nursing Centre

ID# 0015651

Report Period Beginning: 10/1/2010

Ending: 9/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Revenue Offset - Medical Records Income	$ (1,139)	10	1
2	Revenue Offset - Miscellaneous Income	(349)	21	2
3	Revenue Offset - Patient Accounts Miscellaneous Income	(15)	21	3
4	Non Operating Unrealized Change in Swap	(88,095)	36	4
5	Revenue Offset - Gift shop to the extent of expenses	(383)	41	5
6	Add: Provider Participation fees (reclass from rev allowa	149,059	42	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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27				27
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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**	59,078		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Bethany Terrace Nursing Centre **#** 0015651 **Report Period Beginning:** 10/1/2010 **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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(37,563)	0	0	0	0	0	0	0	0	0	0	(37,563)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(37,563)	0	0	0	0	0	0	0	0	0	0	(37,563)	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	(1,139)	0	0	0	0	0	0	0	0	0	0	(1,139)	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**	(1,139)	0	0	0	0	0	0	0	0	0	0	(1,139)	16
	C. General Administration													
17	Administrative	0	295,890	(346,634)	0	0	0	0	0	0	0	0	(50,744)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(364)	0	0	0	0	0	0	0	0	0	0	(364)	21
22	Employee Benefits & Payroll Taxes	0	191,059	(179,394)	0	0	0	0	0	0	0	0	11,665	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(364)	486,949	(526,028)	0	0	0	0	0	0	0	0	(39,443)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,066)	486,949	(526,028)	0	0	0	0	0	0	0	0	(78,145)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/2010 **Ending:** 9/30/2011

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):*	(88,095)	0	0	0	0	0	0	0	0	0	0	(88,095)	36
37	**TOTAL Ownership**	(88,095)	0	0	0	0	0	0	0	0	0	0	(88,095)	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	(383)	0	0	0	0	0	0	0	0	0	0	(383)	41
42	Provider Participation Fee	149,059	0	0	0	0	0	0	0	0	0	0	149,059	42
43	Other (specify):*	(143,092)	0	0	0	0	0	0	0	0	0	0	(143,092)	43
44	**TOTAL Special Cost Centers**	5,584	0	0	0	0	0	0	0	0	0	0	5,584	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(121,577)	486,949	(526,028)	0	0	0	0	0	0	0	0	(160,656)	45

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethany Methodist Corporation	100%			Bethany Hospital of Chicago	Chicago	Hospital
				Chestnut Square	Glenview	Senior Living
				Bethany Retirement Community	Chicago	Independent Living
				Terrace Gardens	Morton Grove	Assisted Living

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	17	Corporate salary	$	Bethany Methodist Corporation	100%	$ 96,757	$ 96,757	1
2	V	17	Corporate finance salaries		Bethany Methodist Corporation	100%	129,956	129,956	2
3	V	17	Corporate other		Bethany Methodist Corporation	100%	32,496	32,496	3
4	V	17	Corporate professional fees		Bethany Methodist Corporation	100%	23,948	23,948	4
5	V	17	Corporate finance other fees		Bethany Methodist Corporation	100%	5,420	5,420	5
6	V	17	Corporate finance supplies		Bethany Methodist Corporation	100%	3,033	3,033	6
7	V	17	Corporate finance purchased services		Bethany Methodist Corporation	100%	3,823	3,823	7
8	V	17	Corporate finance other expenses		Bethany Methodist Corporation	100%	457	457	8
9	V	22	Corporate employee benefits		Bethany Methodist Corporation	100%	3,560	3,560	9
10	V	22	Corporate finance employee benefits		Bethany Methodist Corporation	100%	8,298	8,298	10
11	V	22	Unemployment		Bethany Methodist Corporation	100%	912	912	11
12	V	22	Health insurance		Bethany Methodist Corporation	100%	12,313	12,313	12
13	V	22	Pension		Bethany Methodist Corporation	100%	165,976	165,976	13
14	Total			$			$ 486,949	$ * 486,949	14

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

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

VII. RELATED PARTIES (continued)

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)	
15	V			$	CARRY FORWARD TOTALS FROM PREVIOUS PAGE		$ 486,949	$ 486,949	15
16	V	22	Workman's compensation		Bethany Methodist Corporation	100.00%	4,682	4,682	16
17	V	17	Corporate transfers	346,634	Bethany Methodist Corporation	100.00%		(346,634)	17
18	V	22	Corporate employee benefits transfers	184,076	Bethany Methodist Corporation	100.00%		(184,076)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 530,710			$ 491,631	$ * (39,079)	39

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

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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	N/A								$		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: 10/1/2010 Ending: ######

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: Bethany Methodist Corporation
Street Address: 5025 North Paulina Street
City / State / Zip Code: Chicago, IL 60640
Phone Number: ((773) 989-1469
Fax Number: ((773) 989-1377

	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	17	Corporate salaries	Percent of Cost	100	Various	$ 977,346	$ 977,346	10	$ 96,757	1
2	17	Professional fees	Percent of Cost	100	Various	241,902		10	23,948	2
3	17	Other expenses	Percent of Cost	100	Various	328,238		10	32,496	3
4	22	Employee benefits	Percent of Cost	100	Various	47,094		8	3,560	4
5	17	Corporate finance salaries	Percent of Revenue	100	Various	721,979	721,979	18	129,956	5
6	17	Corporate finance supplies	Percent of Revenue	100	Various	16,848		18	3,033	6
7	17	Corporate finance purchased svcs	Percent of Revenue	100	Various	21,238		18	3,823	7
8	17	Corporate finance other expenses	Percent of Revenue	100	Various	2,542		18	458	8
9	17	Corporate finance other fees	Percent of Revenue	100	Various	30,110		18	5,420	9
10	22	Corporate finance empl benefits	Percent of Revenue	100	Various	46,101		18	8,298	10
11	22	Unemployment	Percent of Cost	100	Various	17,433		5	912	11
12	22	Health insurance	Percent of Cost	100	Various	365,857		3	12,313	12
13	22	Pension	Percent of Cost	100	Various	170,859		97	165,976	13
14	22	Workman's compensation	Percent of Cost	100	Various	65,424		7	4,682	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,052,971	$ 1,699,325		$ 491,632	25

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **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:** 10/1/2010 **Ending:** 9/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 James Gregory

TELEPHONE (773) 989-1469 FAX #: (773) 989-1377

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 10/1/2010 Ending: 9/30/2011

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	TERRLAND TRIANGLE		1996	92,064	2
3	TOTALS	183,600		$ 281,873	3

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		514,605	6
7			2000	2000	284,128	7,103	40	7,103		56,062	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		311,858	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		288,385	35
36	ASSET DEPRECIATION --1995			1995	85,023	2,186	Various	2,186		77,766	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: 10/1/2010 Ending: 9/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 45,772	Various	$ 45,772	$	$ 1,400,184	37
38	ASSET DEPRECIATION -- 1997	1997	23,920		Various			23,920	38
39	ASSET DEPRECIATION -- 1998	1998	194,014	9,072	Various	9,072		135,896	39
40	ASSET DEPRECIATION -- 1999	1999	413,588	20,167	Various	20,167		276,810	40
41	ASSET DEPRECIATION -- 2000	2000	45,113	1,814	Various	1,814		41,151	41
42	ASSET DEPRECIATION -- 2001	2001	541,459	31,005	Various	31,005		326,350	42
43	ASSET DEPRECIATION -- 2002	2002	598,201	57,918	Various	57,918		528,192	43
44	ASSET DEPRECIATION -- 2003	2003	353,918	32,138	Various	32,138		261,045	44
45	ASSET DEPRECIATION -- 2004	2004	1,886,501	105,276	Various	105,276		765,519	45
46	ASSET DEPRECIATION -- 2005	2005	254,538	16,793	Various	16,793		104,225	46
47	ASSET DEPRECIATION -- 2006	2006	57,081	5,679	Various	5,679		29,369	47
48	ASSET DEPRECIATION -- 2007	2007	2,404,047	208,744	Various	208,744		956,713	48
49	REMODELING ANDERSON	2008	1,291,074	64,554	20	64,554		242,077	49
50	CABLE TV AIR CONDITIONING	2008	2,511	251	10	251		941	50
51	ACTIVATE 6 ANAOLOG LINES IN SYSTEM	2008	3,186	319	10	319		1,169	51
52	ACTIVATE 6 ANAOLOG LINES IN TELEPHONE	2008	3,186	319	10	319		1,169	52
53	CABLE TV AIR CONDITIONING	2008	2,511	251	10	251		920	53
54	REMODELING BENDIX	2008	41,309	2,065	20	2,065		7,228	54
55	NEW OXYGEN PADS AND FRONT LOT ASHPHALT WORK	2008	75,150	9,394	8	9,394		32,096	55
56	ROOF UPGRADES	2008	15,860	1,586	10	1,586		5,419	56
57	PHYSICAL THERAPY WORK STATION INSTALLATION	2008	15,980	799	20	799		2,597	57
58	FRONT ENTRANCE WORK AND FENCE WORK	2008	15,550	1,037	15	1,037		3,284	58
59	REMODELING BENDIX WING	2008	20,124	1,006	20	1,006		3,186	59
60	REMODELING PHYSICAL THERAPY	2008	29,400	1,470	20	1,470		4,655	60
61	LANDSCAPING FRONT ENTRANCE TERRACE	2008	5,035	504	10	504		1,595	61
62	LANDSCAPING NORTH LOT	2008	12,120	1,212	10	1,212		3,838	62
63	SINK IN BENDIX	2008	3,550	178	20	178		563	63
64	UPGRADE OXYGEN SYSTEM	2008	43,300	4,330	10	4,330		13,351	64
65	NURSES STATION NORTH TERRACE SUITES	2008	7,122	475	15	475		1,425	65
66	PLUMBING PIPING	2009	6,837	342	20	342		798	66
67	ASHBURY HALLWAY REMODELING	2009	4,350	290	15	290		604	67
68	2 DOORS HALLWAY & INSTALLATION	2009	10,528	702	15	702		1,462	68
69	BEAUTY SALON	2009	69,800	4,653	15	4,653		9,694	69
70	TOTAL (lines 4 thru 69)		$ 19,071,218	$ 683,331		$ 683,331	$	$ 13,180,400	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: 10/1/2010 Ending: 9/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 19,071,218	$ 683,331		$ 683,331	$	$ 13,180,400	1
2	CARPET & BASEBOARD REPLACEMENT FOR SYLVESTER	2009	20,868	3,478	5	3,478		6,956	2
3	BATHROOM HEATER FOR SYLVESTER SUITES SOUTH	2010	2,800	140	15	140		280	3
4	LAMINATED FLOORING FURNISH & INSTALL	2010	4,280	178	10	178		356	4
5	REPAIR TO PT HVAC UNIT ROOF - TOP	2010	12,980	162	20	162		324	5
6	ASSET DEPRECIATION -- (LESS THAN $2500)	2010	303,573	7,387	Various	7,387		274,984	6
7	UPGRADE FIRE ALARM SYSTEM	2011	2,592	108	10	108		216	7
8	REMODEL DENTAL OFFICE	2011	10,945	410	20	410		820	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,429,256	$ 695,194		$ 695,194	$	$ 13,464,336	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: 10/1/2010 Ending: 9/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 2,335,831	$ 129,324	$ 129,324	$	VARIOUS	$ 1,728,305	71
72	Current Year Purchases	20,124	3,814	3,814		VARIOUS	3,814	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,355,955	$ 133,138	$ 133,138	$		$ 1,732,119	75

D. Vehicle Costs. (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)	$ 22,086,209	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 828,332	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 828,332	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)	$ 15,215,580	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: 10/1/2010 Ending: 9/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 25,880 Description: As-needed medical equipment (wound vac, c-pap, other)
(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	N/A		$	$	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: 10/1/2010 Ending: 9/30/2011

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: 10/1/2010 Ending: 9/30/2011

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	10A.3	hrs	$	3,583	$ 238,823	$	3,583	$ 238,823	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs		983	79,106		983	79,106	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.3	hrs		6,034	400,957		6,034	400,957	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): Therapy dept manager	10A.3	2080	81,142				2,080	81,142	12
13	Other (specify): Therapy dept supplies	10A.3					1,223		1,223	13
14	TOTAL			$ 81,142	10,600	$ 718,886	$ 1,223	12,680	$ 801,251	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: 10/1/2010 Ending: 9/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2011 (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	$ 1,050	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (106,000))	1,377,986		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,216,915)		8
9	Other(specify): See Supplemental Schedule	165,302		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 327,423	$	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	19,429,256		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,375,080		16
17	Accumulated Depreciation (book methods)	(15,215,580)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	1,353,318		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,223,947	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,551,370	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,880	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 36,880	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	671,047		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 671,047	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 707,927	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,843,458	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,551,385	$	48

*(See instructions.)

Facility Name & ID Number Bethany Terrace Nursing Centre **#** 0015651 **Report Period Beginning:** 10/1/2010 **Ending:** 9/30/2011

XV. BALANCE SHEET - Supplemental Schedule

Line 9 - Other Current Assets

Description	Amount
IDPA Participation Fees	$ 112,614
BT Bethany Terrace	52,688
	$ 165,302

Line 36 - Other Current Liabilities

Description	Amount
Investment Contract Liability	$ 658,703
Bethany Terrace Resident	10,243
Memorial Fund	2,101
	$ 671,047

Line 23 - Other Long Term Assets

Description	Amount
Assisted Living	$ 153,002
Capitalized Interest	676,250
Deferred Bond Issuance Expense	364,102
Amortization of Borrng Cost	(130,037)
Project Fund Series 2009	290,001
	$ 1,353,318

Facility Name & ID Number Bethany Terrace Nursing Centre **#** 0015651 **Report Period Beginning:** ###### **Ending:** 9/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,711,351	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,711,351	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(149,520)	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) **Adjust equity investment contract liab**	281,622	15
16	Other (describe) **Rounding**	5	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 132,107	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)**	$ 7,843,458	24 *

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

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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	$ 11,288,297	1
2	Discounts and Allowances for all Levels	(3,547,595)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,740,702	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,023,945	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,023,945	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	994	12
13	Barber and Beauty Care	4,145	13
14	Non-Patient Meals	37,007	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	90,658	19
20	Radiology and X-Ray	36,796	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 169,600	23
	D. Non-Operating Revenue		
24	Contributions	5,297	24
25	Interest and Other Investment Income***	112,616	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 117,913	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	(92,649)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (92,649)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,959,511	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,138,267	31
32	Health Care	5,295,929	32
33	General Administration	2,062,359	33
	B. Capital Expense		
34	Ownership	942,307	34
	C. Ancillary Expense		
35	Special Cost Centers	670,169	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)***	$ 11,109,031	40
41	**Income before Income Taxes (line 30 minus line 40)****	(149,520)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (149,520)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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:** **10/1/2010** **Ending:** **9/30/2011**

SCHEDULE XVII. INCOME STATEMENT - Supplemental Schedule

Line 28 - Other Revenue

Description	Amount
Bad debts, net of recoveries	$ (94,708)
Miscellaneous income - patient accounts	15
Miscellaneous income - administration	349
Miscellaneous income - rebates	556
Miscellaneous income - health information management	1,139
	$ (92,649)

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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	1,888	1,928	$ 78,157	$ 40.54	1
2	Assistant Director of Nursing	1,696	2,080	81,668	39.26	2
3	Registered Nurses	38,531	43,110	1,281,398	29.72	3
4	Licensed Practical Nurses	23,245	25,901	650,391	25.11	4
5	CNAs & Orderlies	113,762	123,852	1,753,222	14.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,514	2,788	46,433	16.65	8
9	Activity Director	1,824	2,000	39,658	19.83	9
10	Activity Assistants	3,814	4,319	56,285	13.03	10
11	Social Service Workers	3,150	3,422	71,145	20.79	11
12	Dietician	1,924	2,200	79,621	36.19	12
13	Food Service Supervisor	3,670	4,168	56,690	13.60	13
14	Head Cook	5,597	6,124	74,222	12.12	14
15	Cook Helpers/Assistants	4,423	4,688	46,924	10.01	15
16	Dishwashers					16
17	Maintenance Workers	3,508	3,909	90,348	23.11	17
18	Housekeepers	24,847	27,379	297,574	10.87	18
19	Laundry	7,004	7,868	87,367	11.10	19
20	Administrator	2,216	2,400	122,086	50.87	20
21	Assistant Administrator					21
22	Other Administrative	10,088	11,083	142,767	12.88	22
23	Office Manager	1,294	1,552	47,475	30.59	23
24	Clerical	9,959	10,769	134,094	12.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	200	200	37,000	185.00	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,161	2,251	50,608	22.48	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	35,983	39,059	458,881	11.75	33
34	TOTAL (lines 1 - 33)	303,299	333,049	$ 5,784,014 *	$ 17.37	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	200	21,600	9.3	36
37	Medical Records Consultant	8	1,528	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	5	250	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dementia Consultant	22	1,136	10.3	46
47	Billing Consultant	1	342	19.3	47
48	Worker's Compensation Management		2,532	19.3	48
49	TOTAL (lines 35 - 48)	236	$ 27,388		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,381	$ 69,410	10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	596	10,830	10.3	52
53	TOTAL (lines 50 - 52)	2,977	$ 80,240		53

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - Line 32 Other

	Description	1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage
32 A	Central Service Tech	1,891	2,081	$ 35,251	$ 16.94
32 B	Food Service Workers	32,164	34,898	343,175	9.83
32 C	Community Outreach / Marketing	1,928	2,080	80,455	38.68
	Total Line 32	35,983	39,059	$ 458,881	$ 11.75

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marya Jordan	Administrator		$ 122,086
(Reclassification from Schedule V, line 21, col. 1)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,086

B. Administrative - Other

Description	Amount
Corporate Transfers	$ 423,466
(Before adjustments)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 423,466
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Billing Consulting	$ 342
Pappas and Bell LLC	Legal Services	148
Cambridge Integrated Services	Workers Comp Mgmt	2,532
Ravenswood Dental Group	Consulting	68
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 3,090

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,424
Unemployment Compensation Insurance	17,433
FICA Taxes	408,512
Employee Health Insurance	365,824
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursement	2,838
Pension	165,976
Group Life Insurance	6,065
Routine Physical	14
Corporate Finance Benefits	8,298
Allocated Corporate Benefits	3,560
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,043,944

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

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	
Various Department Dues & Subscription	7,254
Life Service Network	3,636
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,890

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	952
Seminar Expense	3,515
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,467

**See instructions.

Facility Name & ID Number Bethany Terrace Nursing Center # 0015651 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

Date	Payee	Topic	Attendee	Job Class	Location	Fee
06/16/2011	Arlington Medical Supply	HCP BLS CPR classes	Various Employees	Direct Care	Bethany Terrace	$ 150
04/21/2011	Arlington Medical Supply	CPR Class	Various Employees	Direct Care	Bethany Terrace	145
03/29/2011	Arlington Medical Supply	CPR Class	Various Employees	Direct Care	Bethany Terrace	145
02/14/2011	Arlington Medical Supply	CPR Class	Various Employees	Direct Care	Bethany Terrace	100
11/19/2010	Arlington Medical Supply	HCP BLS CPR classes	Various Employees	Direct Care	Bethany Terrace	140
11/19/2010	Arlington Medical Supply	CPR Class	Various Employees	Direct Care	Bethany Terrace	220
01/01/2011	Life Services Network	Assisted Living Regulation Workshop	Marya Jordan, David Randle	Administrator	Bethany Terrace	350
06/22/2011	HCMS	Skilled Nursing Documentation Stratagies for Success	Jean Olsen, Pattie Mikes	DON & ADON	Auroa, Il	330
9/7-9/9/2011	Life Services Network	MDS RAC-CT 3.0 Certification	Jean Olsen	DON	Woodridge Il	560
02/28/2011	Life Services Network	Annual Convention	Various Employees	Administrative	Woodridge Il	1,155
09/16/11	Cynthia Chow & associates	Dietary Continuing Education Seminar	Gloria Parcellano	Dietician	Chicago	220
					Subtotal - Seminars	**3,515**
	Education Related Mileage Reimbursements					952
					Total Travel & Seminars	**$ 4,467**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: ####### Ending: #######

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	N/A		$		$	$	$	$	$	$	$	$	$
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:** 10/1/2010 **Ending:** #

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 - $3,636**

(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? **10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,255** Line **10.2**

(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. $ **149,059**
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. $ **26,666**

(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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Crowe Horwath 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.