FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0053223

Facility Name: Bethany Terrace Nrsg 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: 02/13/1969

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2015 to 12/31/2015 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) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	211	Skilled (SNF)	211	77,015	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	730	5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	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	21,720	23,919	7,404	53,043	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,720	23,919	7,404	53,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.23%

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 211 and days of care provided 6,757

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	577,128	60,772	20,155	658,055		658,055		658,055			1
2	Food Purchase		253,255		253,255		253,255	2,035	255,290			2
3	Housekeeping	234,040	64,013		298,053		298,053	142	298,195			3
4	Laundry	90,401	14,307	3,392	108,100		108,100		108,100			4
5	Heat and Other Utilities			221,310	221,310		221,310	1,536	222,846			5
6	Maintenance	138,360	1,104	275,252	414,716		414,716	28,982	443,698			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,039,929	393,451	520,109	1,953,489		1,953,489	32,695	1,986,184			8
	B. Health Care and Programs											
9	Medical Director			37,190	37,190		37,190		37,190			9
10	Nursing and Medical Records	3,914,779	210,063	32,560	4,157,402		4,157,402	(18,079)	4,139,323			10
10a	Therapy	95,389			95,389		95,389		95,389			10a
11	Activities	173,297	25,172	2,284	200,753		200,753	300	201,053			11
12	Social Services	94,248		3,978	98,226		98,226	(685)	97,541			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Alloc of Benefi							14,450	14,450			15
16	**TOTAL Health Care and Programs**	4,277,713	235,235	76,012	4,588,960		4,588,960	(4,014)	4,584,946			16
	C. General Administration											
17	Administrative	195,598		860,714	1,056,312		1,056,312	(839,783)	216,529			17
18	Directors Fees											18
19	Professional Services			207,202	207,202		207,202	33,280	240,482			19
20	Dues, Fees, Subscriptions & Promotions			43,087	43,087		43,087	(13,149)	29,938			20
21	Clerical & General Office Expenses	424,605	306	274,875	699,786		699,786	(89,750)	610,036			21
22	Employee Benefits & Payroll Taxes			982,549	982,549		982,549	(31,041)	951,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,274	10,274		10,274	713	10,987			24
25	Other Admin. Staff Transportation			4,317	4,317		4,317		4,317			25
26	Insurance-Prop.Liab.Malpractice			121,724	121,724		121,724	5,035	126,759			26
27	Other (specify):* Mgmt Alloc of Benefi							57,694	57,694			27
28	**TOTAL General Administration**	620,203	306	2,504,742	3,125,251		3,125,251	(877,001)	2,248,250			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,937,845	628,992	3,100,863	9,667,700		9,667,700	(848,320)	8,819,380			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 Nrsg Centre #0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			34,194	34,194		34,194	602,598	636,792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,331	31,331		31,331	933,184	964,515			32
33	Real Estate Taxes			451,848	451,848		451,848	2,744	454,592			33
34	Rent-Facility & Grounds			1,013,586	1,013,586		1,013,586	(1,013,586)				34
35	Rent-Equipment & Vehicles			24,846	24,846		24,846	2,814	27,660			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,555,805	1,555,805		1,555,805	527,754	2,083,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368,376	901,795	1,270,171		1,270,171		1,270,171			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			396,040	396,040		396,040		396,040			42
43	Other (specify):* **Non-Allowable Cos**	128,503		679,810	808,313		808,313	(808,313)				43
44	**TOTAL Special Cost Centers**	128,503	368,376	1,977,645	2,474,524		2,474,524	(808,313)	1,666,211			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,066,348	997,368	6,634,313	13,698,029		13,698,029	(1,128,879)	12,569,150			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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				4
5	Telephone, TV & Radio in Resident Rooms	(60,015)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(121,063)	30		9
10	Interest and Other Investment Income	(566)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,793)	43		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	(130)	43		18
19	Entertainment				19
20	Contributions	(79,424)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(224,916)	43		24
25	Fund Raising, Advertising and Promotional	(251,133)	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 Page 5A	(244,343)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (988,383)		$	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)	(140,496)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (140,496)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,128,879)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Bethany Terrace Nrsg Centre

ID# 0053223

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (42,110)	43	1
2	Sequestration Expenses	(78,815)	43	2
3	Patient Personal Items	(7,400)	43	3
4	Adjustment from prior years	5,888	43	4
5	Medicaid May/June Adjs	(52,615)	43	5
6	Pharmacy - House Stock	(32,478)	43	6
7	Meals & Entertainment	(7,725)	43	7
8	Offset Misc Income	(19,591)	21	8
9	Expense Assets Under $2500	5,699	6	9
10	Disallow Lobbying Expense	(14,526)	20	10
11	Disallow Travel/Seminar Expense	(670)	24	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(244,343)		49

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
See PG6 - Supp		See PG6 - Supp		See PG6 - Supp		

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	6	Repairs & Maintenance	$	MG Property Holdings	100.00%	$ 22,652	$ 22,652	1
2	V	19	Professional Fees		MG Property Holdings	100.00%	1,580	1,580	2
3	V	19	Legal Fees		MG Property Holdings	100.00%	2,158	2,158	3
4	V	30	Depreciation		MG Property Holdings	100.00%	718,634	718,634	4
5	V	32	Interest		MG Property Holdings	100.00%	932,189	932,189	5
6	V	34	Rent	1,013,586	MG Property Holdings	100.00%		(1,013,586)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,013,586			$ 1,677,213	$ * 663,627	14

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	3	Housekeeping Supplies	$	Legacy Healthcare Financial Services, LLC	100.00%	$ 142	$ 142	15
16	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,536	1,536	16
17	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	3,504	3,504	17
18	V	11	Activities Program		Legacy Healthcare Financial Services, LLC	100.00%	288	288	18
19	V	17	Administrative Salary - Mgmt Alloc	860,714	Legacy Healthcare Financial Services, LLC	100.00%	2,184	(858,530)	19
20	V	19	Profesional Fees		Legacy Healthcare Financial Services, LLC	100.00%	28,862	28,862	20
21	V	20	Dues, Fees, Subscriptions		Legacy Healthcare Financial Services, LLC	100.00%	1,272	1,272	21
22	V	21	Clerical & General Wages		Legacy Healthcare Financial Services, LLC	100.00%	143,515	143,515	22
23	V	21	Clerical & General Other	210,000	Legacy Healthcare Financial Services, LLC	100.00%	14,575	(195,425)	23
24	V	24	Seminars		Legacy Healthcare Financial Services, LLC	100.00%	1,281	1,281	24
25	V	26	Insurance Expense		Legacy Healthcare Financial Services, LLC	100.00%	971	971	25
26	V	27	Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services, LLC	100.00%	39,584	39,584	26
27	V	30	Depreciation Expense		Legacy Healthcare Financial Services, LLC	100.00%	2,173	2,173	27
28	V	32	Interest Expense		Legacy Healthcare Financial Services, LLC	100.00%	17	17	28
29	V	33	Real Estate Taxes		Legacy Healthcare Financial Services, LLC	100.00%	2,744	2,744	29
30	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%	10,212	10,212	30
31	V	35	Equipment Rental		Legacy Healthcare Financial Services, LLC	100.00%	1,981	1,981	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,070,714			$ 254,841	$ * (815,873)	39

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	30	Depreciation	$	Legacy Real Properties, LLC		$ 2,854	$ 2,854	15
16	V	32	Interest		Legacy Real Properties, LLC		1,544	1,544	16
17	V	34	Rent	10,212	Legacy Real Properties, LLC			(10,212)	17
18	V								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			$ 10,212			$ 4,398	$ * (5,814)	39

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2	Food	$	Progressive Healthcare Consulting	100.00%	$ 2,035	$ 2,035	15
16	V	6	Repairs & Maintenance - Salary	2,660	Progressive Healthcare Consulting	100.00%	4	(2,656)	16
17	V	6	Repairs & Maintenance - Other		Progressive Healthcare Consulting	100.00%	1,123	1,123	17
18	V	10	Medical & Nursing Supply		Progressive Healthcare Consulting	100.00%	3	3	18
19	V	10	Nursing Salary	95,865	Progressive Healthcare Consulting	100.00%	77,783	(18,082)	19
20	V	12	Activities Program		Progressive Healthcare Consulting	100.00%	12	12	20
21	V	12	Clergy Salary	2,653	Progressive Healthcare Consulting	100.00%	1,968	(685)	21
22	V	43	Admissions Salary	61,128	Progressive Healthcare Consulting	100.00%	90,481	29,353	22
23	V	15	Emp Ben - Nursing		Progressive Healthcare Consulting	100.00%	14,450	14,450	23
24	V	17	Admin Salary - Non Owner	76,774	Progressive Healthcare Consulting	100.00%	95,521	18,747	24
25	V	19	Professional Fees		Progressive Healthcare Consulting	100.00%	680	680	25
26	V	20	Dues, Fees, Subscriptions		Progressive Healthcare Consulting	100.00%	105	105	26
27	V	21	Clerical & General	19,597	Progressive Healthcare Consulting	100.00%	1,348	(18,249)	27
28	V	24	Seminars		Progressive Healthcare Consulting	100.00%	102	102	28
29	V	27	Emp Ben - Mgmt Alloc		Progressive Healthcare Consulting	100.00%	18,110	18,110	29
30	V	26	Insurance		Progressive Healthcare Consulting	100.00%	4,064	4,064	30
31	V	35	Auto Rental		Progressive Healthcare Consulting	100.00%	833	833	31
32	V	22	Employee Benefits	31,041	Progressive Healthcare Consulting	100.00%		(31,041)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 289,718			$ 308,622	$ * 18,904	39

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	6	Repairs & Maintenance	$ 9,698	ReMED Services, LLC	100.00%	$ 8,358	$ (1,340)	15
16	V								16
17	V								17
18	V								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			$ 9,698			$ 8,358	$ * (1,340)	39

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Chaim Rajchenbach	40.50	Astoria Place Living & Rehab	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	Menachem Shabat	40.50	Bella Terra Morton Grove	Morton Grove	Financial Srvcs, LLC			2
3	The Rajchenbach 2015 Family Trust	3	Chalet Living & Rehab Center	Chicago				3
4	Ronald Shabat	3	Elmbrook Nursing	Elmhurst	Legacy Real	Skokie	Real Estate	4
5	Yair Zuckerman	10	The Grove of Evanston, LLC	Evanston	Properties, LLC			5
6	Ross Bottner	3	The Villa at Evergreen	Evergreen Park				6
7			The Grove of Fox Valley	Aurora	Grove Healthcare	Skokie	Real Estate	7
8			The Grove of LaGrange Park LLC	LaGrange Park	Properties, LLC			8
9			The Grove at the Lake	Zion				9
10			Lakefront Nursing & Rehab Center, LLC	Chicago	ReMED Services,	Skokie	Medical	10
11			The Grove at Lincoln Park Living & Rehab	Chicago	LLC		Equipment Sales	11
12			Avantara Long-Grove	Long Grove				12
13			The Grove North Living & Rehab Center	Skokie	Progressive	Skokie	Consulting	13
14			The Grove of Northbrook	Northbrook	Healthcare			14
15			Warren Barr North Shore	Highland Park	Consulting			15
16			Avantara Park Ridge	Park Ridge				16
17			Peterson Park Associates Ltd. Partnetship	Chicago	MG Property	Morton Grove	Real Estate	17
18			Warren Barr South Loop	Chicago	Holdings, LLC			18
19			Warren Barr	Chicago				19
20			Aurora Supportive Living	Aurora	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21								21
22					ProPay	Evanston	Payroll Services	22
23								23
24					ML Group Design	Skokie	Asset Mgmt Fees	24
25								25
26					ML Enterprise	Skokie	Asset Mgmt Fees	26
27								27
28								28
29								29
30								30

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Yair Zuckerman	Owner	Administrative	10.00	See Att Sch 7A	2.66	6.65	Salary	$ 2,184	L17, C7	1
2	Ross Bottner	Owner	Administrative	3.00	See Att Sch 7A	2.48	6.20	Salary	12,403	L21, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,587		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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: Legacy Healthcare Financial Services, LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	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	3	Housekeeping Supplies	Bed Days Available	1,253,624	23	$ 2,296	$	77,745	$ 142	1
2	5	Utilities	Bed Days Available	1,253,624	23	24,766		77,745	1,536	2
3	6	Repairs & Maintenance	Bed Days Available	1,253,624	23	56,504		77,745	3,504	3
4	11	Activities Program	Bed Days Available	1,253,624	23	4,642		77,745	288	4
5	17	Administrative Salary - Mgmt All	Hours	40	20	32,807	32,807	3	2,184	5
6	19	Profesional Fees	Bed Days Available	1,253,624	23	465,391		77,745	28,862	6
7	20	Dues, Fees, Subscriptions	Bed Days Available	1,253,624	23	20,516		77,745	1,272	7
8	21	Clerical & General Wages	Bed Days Available	1,253,624	23	2,314,153	2,314,153	77,745	143,515	8
9	21	Clerical & General Other	Bed Days Available	1,253,624	23	235,020		77,745	14,575	9
10	24	Seminars	Bed Days Available	1,253,624	23	20,662		77,745	1,281	10
11	26	Insurance Expense	Bed Days Available	1,253,624	23	15,655		77,745	971	11
12	27	Employee Benefits - Mgmt Alloc	Bed Days Available	1,253,624	23	638,286		77,745	39,584	12
13	30	Depreciation Expense	Bed Days Available	1,253,624	23	35,040		77,745	2,173	13
14	32	Interest Expense	Bed Days Available	1,253,624	23	267		77,745	17	14
15	33	Real Estate Taxes	Bed Days Available	1,253,624	23	44,250		77,745	2,744	15
16	34	Rent Expense	Bed Days Available	1,253,624	23	164,669		77,745	10,212	16
17	35	Equipment Rental	Bed Days Available	1,253,624	23	31,945		77,745	1,981	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,106,869	$ 2,346,960		$ 254,841	25

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: Progressive Healthcare Consulting
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	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	2	Food	Bed Days Available	1,167,679	20	$ 30,560	$	77,745	$ 2,035	1
2	6	Repairs & Maintenance - Salary	Bed Days Available	1,167,679	20	65	65	77,745	4	2
3	6	Repairs & Maintenance - Other	Bed Days Available	1,167,679	20	16,865		77,745	1,123	3
4	10	Medical & Nursing Supply	Bed Days Available	1,167,679	20	47		77,745	3	4
5	10	Nursing Salary	Bed Days Available	1,167,679	20	1,168,252	1,168,252	77,745	77,783	5
6	12	Activities Program	Bed Days Available	1,167,679	20	187		77,745	12	6
7	12	Clergy Salary	Bed Days Available	1,167,679	20	29,559	29,559	77,745	1,968	7
8	43	Admissions Salary	Bed Days Available	1,167,679	20	1,358,960	1,358,960	77,745	90,481	8
9	15	Emp Ben - Nursing	Bed Days Available	1,167,679	20	217,026		77,745	14,450	9
10	17	Admin Salary - Non Owner	Bed Days Available	1,167,679	20	1,434,659	1,434,659	77,745	95,521	10
11	19	Professional Fees	Bed Days Available	1,167,679	20	10,207		77,745	680	11
12	20	Dues, Fees, Subscriptions	Bed Days Available	1,167,679	20	1,577		77,745	105	12
13	21	Clerical & General	Bed Days Available	1,167,679	20	20,243		77,745	1,348	13
14	24	Seminars	Bed Days Available	1,167,679	20	1,535		77,745	102	14
15	27	Emp Ben - Mgmt Alloc	Bed Days Available	1,167,679	20	272,007		77,745	18,110	15
16	26	Insurance	Bed Days Available	1,167,679	20	61,041		77,745	4,064	16
17	35	Auto Rental	Bed Days Available	1,167,679	20	12,512		77,745	833	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,635,302	$ 3,991,495		$ 308,622	25

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: ReMED Services, LLC
Street Address: 3450 8A
City / State / Zip Code:
Phone Number: ( )
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	6	Repairs & Maintenance	Direct Allocation			$	$		$ 8,358	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$ 8,358	25

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	The Private Bank	X		Mortgage	$36,666.00	9/10/14	$ 18,800,000	$ 14,797,727	9/10/17	Libor+0.0475	$ 741,909	1
2	Greystone	X		Mortgage	Interest Only	9/30/14	2,350,000	1,856,500	12/31/17	0.1100	189,466	2
3	Capex	X		Mortgage	N/A	9/30/14	17,826	17,826	9/30/17	Libor+0.0475	814	3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Operations LOC	Interest Only	9/30/15	0	1,138,000	9/29/16	0.0499	29,266	6
7									Int for Liability Insurance		2,065	7
8												8
9	TOTAL Facility Related				$36,666.00		$ 21,167,826	$ 17,810,053			$ 963,520	9
	B. Non-Facility Related*											
10								Allocated from Legacy HC Financial Serv			17	10
11								Allocated from Legacy Real Property			1,544	11
12								Offset Interest Income			(566)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 995	14
15	TOTALS (line 9+line14)						$ 21,167,826	$ 17,810,053			$ 964,515	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** - **Line #** N/A

*** 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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 562,500	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.)	2014	$ 451,848	2
3. Under or (over) accrual (line 2 minus line 1).		$ (110,652)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 562,500	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
	Allocated from Managment Co.	2,744	
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.		$ 454,592	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014	451,848	12

Per real estate tax professional estimated taxes are $451,848.
Accrual based on unpaid estimated 2015 taxes due in 2016.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bella Terra Morton Grove COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053223

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

TELEPHONE (773) 248-6000 FAX #: (773) 248-9703

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Estimated per tax professional	Skilled nursing facility	$ 451,848.00	$ 451,848.00
2.	10-35-104-076-0000	Real estate entity	$ 39,271.59	$ 2,744.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 491,119.59	$ 454,592.00

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? X 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] (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	2014	$ 866,800	1
2	Allocated from Legacy Real Property, LLC			5,074	2
3	TOTALS	183,600		$ 871,874	3

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	ALLOCATION OF PURCHASE PRICE		2014	1965	$ 13,963,360	$	40	$ 349,084	$ 349,084	$ 436,355	4
5	Allocated from Legacy Real Properties				39,310		30	1,337	1,337	8,517	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION OF PURCHASE PRICE			2014	200,000		30	6,667	6,667	8,333	9
10											10
11	Parking Lot Work: Milling, Install Primer Level, Patch			2015	38,487	1,283	15	1,283		1,283	11
12	Pave and Stripe - Orange Area										12
13	New trees, shrubs, bushes - Bella Terra North Sign Fork			2015	18,000	600	15	600		600	13
14	New Wood Flooring Installed			2015	14,969	249	30	249		249	14
15	Pro-Tech Roofing			2015	60,500	1,008	30	1,008		1,008	15
16											16
17	TriCore Environmental - Parking Lot			2015	34,180	570	30	570		570	17
18											18
19	Fire Alarm Panel - Mechanical Room			2015	6,118	102	30	102		102	19
20											20
21	Inspect and Rejuvenate Cooling Tower - Roof			2015	6,964	116	30	116		116	21
22											22
23	Carpet - Main Hallway			2015	13,636	227	30	227		227	23
24											24
25	Install Satellite Service for facility with 19 receivers			2015	2,866	48	30	48		48	25
26											26
27	Install Tile Flooring - Resident Rooms			2015	22,394	373	30	373		373	27
28											28
29	Facility signage - Front of Building			2015	19,331	322	30	322		322	29
30											30
31	Remove roof flashing, Install insulation and .060 mil. TPO			2015	4,800	80	30	80		80	31
32	Roof system - Over ramp area										32
33											33
34	2,212 Ivory Plank - Hallway			2015	5,123	85	30	85		85	34
35											35
36											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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Wood Plank Flooring - Hallway	2015	$ 9,343	$ 156	30	$ 156	$	$ 156	37
38									38
39	Redwood Sales Contract - Hallway	2015	39,491	658	30	658		658	39
40									40
41	Remove Wallpaper, Repair and Paint Walls. Install new	2015	9,820	164	30	164		164	41
42	doors. - Dining Room, Busn Office, PT Office								42
43									43
44	Install Tile on Floor and Walls - Craft Room	2015	3,928	65	30	65		65	44
45									45
46	Hot Water Piping & Boiler Repair - Mechanical Room	2015	5,270	88	30	88		88	46
47									47
48									48
49	To Reconcile to Book Depreciation			2,181			(2,181)		49
50									50
51									51
52	Allocated from Legacy Healthcare Financial Services, LLC	2012	1,768		20	115	115	354	52
53	Allocated from Legacy Healthcare Financial Services, LLC	2013	5,656		20	369	369	848	53
54	Allocated from Legacy Healthcare Financial Services, LLC	2014	552		20	36	36	55	54
55	Allocated from Legacy Healthcare Financial Services, LLC	2015	761		20	50	50	38	55
56	Allocated from Legacy Real Properties	2009	22,324		20	331	331	6,418	56
57	Allocated from Legacy Real Properties	2010	6,788		20	101	101	1,495	57
58	Allocated from Legacy Real Properties	2011	9,648		20	143	143	2,412	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 14,565,387	$ 8,376		$ 364,428	$ 356,052	$ 471,020	70

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 1,150,000	$	$ 230,000	$ 230,000	5	$ 287,500	71
72	Current Year Purchases	199,096	25,818	39,819	14,001	5	39,819	72
73	Fully Depreciated Assets							73
74	See Sch 13A	22,527		2,545	2,545	10	8,688	74
75	TOTALS	$ 1,371,623	$ 25,818	$ 272,364	$ 246,546		$ 336,007	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 16,808,884	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,194	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 636,792	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 602,598	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 807,027	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 124,357	92
93			93
94			94
95		$ 124,357	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: **Bethany Terrace Nrsg Centre**
IDPH License ID Number: **0053223**
Fiscal Year End: **12/31/2015**

Schedule 13A

XI. Ownership Costs
Line 74 - Equipment Costs - Excluding Transportation

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
Allocation from LHFS, Inc	12,291		1,603	1,603	10	2,782
Allocated from Legacy Real Properties	10,236		942	942	10	5,906
TOTAL	22,527	-	2,545	2,545		8,688

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 [X] 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:	N/A			$			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 [X] 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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 26,827 Description: $4, 875 Copiers; $632 Postage Machine; $19,339 Medical Equipment ; $1,981 Alloc from Mgmt Co
    (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	Allocated from Mgmt. Co.		$	$ 833	17
18					18
19					19
20					20
21	TOTAL		$	$ 833	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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

It is the policy of this facility to only hire certified nurses aides.

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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	4,687	$ 337,495	$	4,687	$ 337,495	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		996	71,711		996	71,711	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,579	473,680		6,579	473,680	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				359,578		359,578	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen						8,798		8,798	12
13	Respiratory Ther.	39(3)			116	8,353		116	8,353	13
	Other (specify): Ambulance	39(3)			147	10,556		147	10,556	
14	TOTAL			$	12,525	$ 901,795	$ 368,376	12,525	$ 1,270,171	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 Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 3,017	$ 3,017	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 228,943)	2,513,671	2,513,671	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,734	41,734	6
7	Other Prepaid Expenses	18,946	18,946	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	39,527	414,777	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,616,895	$ 2,992,145	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		871,874	13
14	Buildings, at Historical Cost		14,002,670	14
15	Leasehold Improvements, at Historical Cost	527,362	562,717	15
16	Equipment, at Historical Cost	200,271	1,371,623	16
17	Accumulated Depreciation (book methods)	(35,642)	(807,027)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		2,298,900	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(370,695)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan Fees		199,996	22
23	Other(specify): Construction In Progress	124,357	124,357	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 816,348	$ 18,254,415	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,433,243	$ 21,246,560	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 588,760	$ 594,768	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	672,427	672,427	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,686	15,686	31
32	Accrued Real Estate Taxes(Sch.IX-B)		562,500	32
33	Accrued Interest Payable		82,580	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	540,596	2,429,318	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,817,469	$ 4,357,279	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,138,000	17,810,053	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,138,000	$ 17,810,053	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,955,469	$ 22,167,332	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 477,774	$ (920,772)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,433,243	$ 21,246,560	48

*(See instructions.)

Facility Name: **Bethany Terrace Nrsg Centre**
IDPH License ID Number: **0053223**
Fiscal Year End: **12/31/2015**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
NH Escrow	-	118,500
NH Environmental Escrow	-	256,750
NH Refund - Transfer	11,397	11,397
NH Security Deposits	28,130	28,130
Total - Line 9	**39,527**	**414,777**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
NH Bad Debt Collection	26,587	26,587
NH Payroll Exchange	2,475	2,475
NH Due to Medicare	(37,080)	(37,080)
NH Accrued Accounting Fees	1,083	1,083
NH State Assessment Fee	47,103	47,103
NH Acc Mgmt Fees	358,633	358,633
NH Due to Others	18,656	18,656
NH Due To/From Related	(15,449)	1,699,037
NH Due To/From MG Prop Hold	82,514	-
NH Due To/From Prior Owner	14,263	271,013
NH ALF Liability	40,740	40,740
NH Due To/From Progressive	1,071	1,071
Total - Line 36	**540,596**	**2,429,318**

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (71,485)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (71,485)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	549,259	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 for rounding**		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 549,259	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)**	$ 477,774	24	*

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

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,559,220	1
2	Discounts and Allowances for all Levels	(1,299,349)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,259,871	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	596,403	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 596,403	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	346,889	17
18	Sale of Supplies to Non-Patients	16,307	18
19	Laboratory	6,582	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 369,778	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	566	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 566	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	20,670	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,670	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,247,288	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,953,489	31
32	Health Care	4,588,960	32
33	General Administration	3,125,251	33
	B. Capital Expense		
34	Ownership	1,555,805	34
	C. Ancillary Expense		
35	Special Cost Centers	2,078,484	35
36	Provider Participation Fee	396,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,698,029	40
41	**Income before Income Taxes (line 30 minus line 40)****	549,259	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 549,259	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,197,581	44
45	Private Pay - Net Inpatient Revenue	6,078,513	45
46	Medicare - Net Inpatient Revenue	2,714,001	46
47	Other-(specify) Insurance	21,964	47
48	Other-(specify) Medicaid Pending	247,812	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,259,871	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No 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.**

^ - This entity is a cash basis taxpayer

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,878	2,804	$ 135,381	$ 48.28	1
2	Assistant Director of Nursing	1,440	1,527	62,588	40.98	2
3	Registered Nurses	38,751	45,106	1,366,425	30.29	3
4	Licensed Practical Nurses	16,980	20,596	500,762	24.31	4
5	CNAs & Orderlies	95,490	116,860	1,550,214	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,544	5,882	95,389	16.22	8
9	Activity Director					9
10	Activity Assistants	14,442	15,317	173,297	11.31	10
11	Social Service Workers	3,755	3,972	94,248	23.73	11
12	Dietician					12
13	Food Service Supervisor	9,401	10,840	158,916	14.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,113	40,541	418,212	10.32	15
16	Dishwashers					16
17	Maintenance Workers	6,277	6,862	138,360	20.16	17
18	Housekeepers	21,244	22,812	234,040	10.26	18
19	Laundry	7,119	8,039	90,401	11.25	19
20	Administrator	2,959	3,053	163,464	53.54	20
21	Assistant Administrator	1,092	1,116	32,134	28.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,470	22,257	424,605	19.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,357	2,491	53,432	21.45	31
32	Other Health C: See Sch 20A	7,881	8,357	245,978	29.43	32
33	Other(specify) See Sch 20A	5,455	5,945	128,503	21.62	33
34	TOTAL (lines 1 - 33)	298,647	344,379	$ 6,066,348 *	$ 17.62	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	Monthly	$ 20,155	1(3)	35
36	Medical Director	Monthly	37,190	9(3)	36
37	Medical Records Consultant	Monthly	3,976	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,284	11(3)	44
45	Social Service Consultant				45
46	Other(specify) MDS Consultant	Monthly	28,584	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 92,189		49

C. CONTRACT NURSES

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

Facility Name: **Bethany Terrace Nrsg Centre**
IDPH License ID Number: **0053223**
Fiscal Year End: **12/31/2015**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Alzheimer Supervisor	2,439	2,554	63,835	$ 25.00
MDS/Care Plan Coordinator	5,442	5,803	182,143	$ 31.39
Total - Line 32 Other Health Care (specify):	**7,881**	**8,357**	**245,978**	**$ 29.43**

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Director	116	122	3,125	$ 25.64
Public Rel/Marketing	5,339	5,823	125,378	$ 21.53
Total - Line 33 Other (specify):	**5,455**	**5,945**	**128,503**	**$ 21.62**

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shai Berdugo	Administrator	0	$ 57,932
Shalom Lichtman	Asst Administrator	0	78,124
Sinead O'Sullivan	Asst Administrator	0	36,925
Kalman Lebovics	Asst Administrator	0	22,617
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 195,598

B. Administrative - Other

Description	Amount
Management Fees	$ 860,714
(Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 860,714
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C	Professioanl Services	$ 207,202
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 207,202

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 151,782
Unemployment Compensation Insurance	109,691
FICA Taxes	441,864
Employee Health Insurance	256,905
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Payroll Taxes	7,189
Tuition Reimbursement	
PTO Adjustment	(51,445)
Other Benefits	32,852
Employee Retirement	2,670
TOTAL (agree to Schedule V, line 22, col.8)	$ 951,508

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	$ 1,423
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 72)	860
Patient Background Checks 210	2,523
Illinois Council on Long Term Care	25,087
Miscellaneous Licenses & Fees	10,062
Miscellaneous Dues & Subscriptions	3,132
Allocated from Mgmt Co	1,377
Less : Lobbying Expense	(14,526)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,938

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,274
Allocated from Mgmt. Co	1,383
Non-Allowable	(670)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,987

**See instructions.

Facility Name: **Bethany Terrace Nrsg Centre**
IDPH License ID Number: **0053223**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Adam Zollinger	Consultant	150
Legacy Healthcare	Consultant	4,795
Accruals	Processing	(2,729)
Creative Technoly Solutions	Processing	9,679
Direct Supply	Processing	165
Health Data Systems, Inc.	Processing	4,073
Legacy reimbursements	Processing	11,072
Miscellaneous	Processing	3,931
Point B Communications	Processing	864
Prime Care Technologies	Processing	1,815
Taibe Juni	Processing	1,000
Wescom Solutions	Processing	15,986
RSM	Accounting	24,654
ML Group	Asset Mgmt	18,000
Paycor	Professional	481
Accurate Scale Company	Professional	819
Achieve Accrediation	Professional	16,580
Deborah Cole Byrd	Professional	2,198
Environmental Monitoring	Professional	3,345
Prepaid Expenses	Professional	2,050
First Real Estate Services LTD	Professional	1,200
Global Water Technology Inc.	Professional	2,012
Idrew Embroidery	Professional	2,975
Illinois Rytes Corp.	Professional	12,021
Joint Commission	Professional	7,655
Legacy	Professional	25,192

Madison Specifics	Professional	9,150
Meyer Magence	Professional	1,327
Miscellaneous	Professional	(11,844)
ML Group Design	Professional	17,254
Parther Engineering	Professional	4,575
Paycor	Professional	22,390
Personnel Planners	Professional	1,652
Peterson Pulaski Business	Professional	(4,575)
Talent Achieve Group LLC	Professional	10,500
Gutnicki	Legal	(37,408)
Meltzer, Ourtill & Steele	Legal	1,020
Much Shelist	Legal	13,736
Neal, Gerber & Eisenberg	Legal	4,045
Stone McGuire & Siegel	Legal	230
Stone Pogrund & Korey	Legal	5,168
Total (agree to Schedule V, line 19, column 3)		207,202
Allocated from Management Company	Legal Fees	2,158
Allocated from Management Company	Professional Services	31,122
Total (agree to Schedule V, line 19, column 8)		240,482

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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													N/A
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethany Terrace Nrsg Centre # 0053223 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council for Long-Term Care $25,087**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,709** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **396,040**
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? **No** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM US LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.