

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 Morton Grove 60053 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: ☒ 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
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In the event there are further questions about this report, please contact:

Name: James Gregory Telephone Number: (773) 989-1469

Email Address:

Facility Name & ID Number Bethany Terrace Nursing Centre# 0015651 Report Period Beginning: 10/1/2011 Ending: 09/30/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,698</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>170</u>	Intermediate (ICF)	<u>170</u>	<u>62,220</u>	3
4		Intermediate/DD			4
5	<u>2</u>	Sheltered Care (SC)	<u>2</u>	<u>732</u>	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,650	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,501</u>	<u>835</u>	<u>11,386</u>	<u>13,722</u>	8
9	SNF/PED					9
10	ICF	<u>9,457</u>	<u>15,977</u>	<u>4,412</u>	<u>29,846</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,958	16,812	15,798	43,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 43.29%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

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

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/13/1965

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 103

and days of care provided

9,257Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 09/30/2012 Fiscal Year: 09-30-2012

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

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	603,786	26,137		629,923		629,923		629,923		1
2	Food Purchase		281,782		281,782		281,782	(33,339)	248,443		2
3	Housekeeping	285,742	58,567	149	344,458		344,458		344,458		3
4	Laundry	106,770	(45,684)		61,086		61,086		61,086		4
5	Heat and Other Utilities			297,671	297,671		297,671		297,671		5
6	Maintenance	54,536	37,516	166,344	258,396		258,396		258,396		6
7	Other (specify):*										7
8	TOTAL General Services	1,050,834	358,318	464,164	1,873,316		1,873,316	(33,339)	1,839,977		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	4,014,379	332,335	21,447	4,368,161		4,368,161	(830)	4,367,331		10
10a	Therapy	56,092	1,527	775,680	833,299		833,299		833,299		10a
11	Activities	80,154	1,659	7,686	89,499		89,499		89,499		11
12	Social Services	63,656	12	96	63,764		63,764		63,764		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,251,281	335,533	826,509	5,413,323		5,413,323	(830)	5,412,493		16
	C. General Administration										
17	Administrative			417,062	417,062	130,863	547,925	(21,844)	526,081		17
18	Directors Fees										18
19	Professional Services			21,457	21,457		21,457	(788)	20,669		19
20	Dues, Fees, Subscriptions & Promotions			27,626	27,626		27,626		27,626		20
21	Clerical & General Office Expenses	364,428	23,388	115,908	503,724	(130,863)	372,861		372,861		21
22	Employee Benefits & Payroll Taxes			1,325,487	1,325,487		1,325,487	(5,541)	1,319,946		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,605	5,605		5,605	(2,000)	3,605		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			122,976	122,976		122,976		122,976		26
27	Other (specify):*										27
28	TOTAL General Administration	364,428	23,388	2,036,121	2,423,937		2,423,937	(30,173)	2,393,764		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,666,543	717,239	3,326,794	9,710,576		9,710,576	(64,342)	9,646,234		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			782,898	782,898		782,898		782,898			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			23,331	23,331		23,331		23,331			35
36	Other (specify):*											36
37	TOTAL Ownership			806,229	806,229		806,229		806,229			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		590,543	37,600	628,143		628,143		628,143			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			764	764		764	(764)				41
42	Provider Participation Fee			249,683	249,683		249,683		249,683			42
43	Other (specify):*	57,181	597	55,632	113,410		113,410	(113,410)				43
44	TOTAL Special Cost Centers	57,181	591,140	343,679	992,000		992,000	(114,174)	877,826			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,723,724	1,308,379	4,476,702	11,508,805		11,508,805	(178,516)	11,330,289			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	Amount	To Line	From Line
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Administrator wages	\$ 130,863	17	21
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		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(33,137)	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	(202)	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	(113,410)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(4,382)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (151,131)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,385)	VII B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (27,385)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (178,516)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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

Report Period Beginning: 10/1/2011

Ending: 09/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Revenue Offset - Medical Records	\$ (830)	10	1
2	Unsupported Legal Expenses	(788)	19	2
3	Unsupported Seminar Expenses	(2,000)	24	3
4	Revenue Offset - Gift shop to the extent of expenses	(764)	41	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				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	(4,382)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Terrace Nursing Centre

0015651

Report Period Beginning:

10/1/2011

Ending:

09/30/2012

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(33,339)	0	0	0	0	0	0	0	0	0	0	(33,339)	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	(33,339)	0	0	0	0	0	0	0	0	0	0	(33,339)	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	(830)	0	0	0	0	0	0	0	0	0	0	(830)	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	(830)	0	0	0	0	0	0	0	0	0	0	(830)	16
	C. General Administration													
17	Administrative	0	311,393	(333,237)	0	0	0	0	0	0	0	0	(21,844)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(788)	0	0	0	0	0	0	0	0	0	0	(788)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	203,529	(209,070)	0	0	0	0	0	0	0	0	(5,541)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	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	(2,788)	514,922	(542,307)	0	0	0	0	0	0	0	0	(30,173)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(36,957)	514,922	(542,307)	0	0	0	0	0	0	0	0	(64,342)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(764)	0	0	0	0	0	0	0	0	0	0	(764)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(113,410)	0	0	0	0	0	0	0	0	0	0	(113,410)	43
44	TOTAL Special Cost Centers	(114,174)	0	0	0	0	0	0	0	0	0	0	(114,174)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(151,131)	514,922	(542,307)	0	0	0	0	0	0	0	0	(178,516)	45

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
<u>Bethany Methodist Corporation</u>	<u>100%</u>			<u>Methodist Hospital</u>	<u>Chicago</u>	<u>Hospital</u>
				<u>of Chicago</u>		
				<u>Chestnut Square</u>	<u>Glenview</u>	<u>Senior Living</u>
				<u>Bethany Retirement</u>	<u>Chicago</u>	<u>Independent Living</u>
				<u>Community</u>		
				<u>Terrace Gardens</u>	<u>Morton Grove</u>	<u>Assisted Living</u>
				<u>Partners in Home Hea</u>	<u>Glenview</u>	<u>Home Health Agenc</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 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	<u>Corporate salary</u>	\$	<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	\$ <u>95,656</u>	\$ <u>95,656</u>	1
2	V	17	<u>Corporate finance salaries</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>136,620</u>	<u>136,620</u>	2
3	V	17	<u>Corporate other</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>31,824</u>	<u>31,824</u>	3
4	V	17	<u>Corporate professional fees</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>16,913</u>	<u>16,913</u>	4
5	V	17	<u>Corporate finance other fees</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>24,111</u>	<u>24,111</u>	5
6	V	17	<u>Corporate finance supplies</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>2,915</u>	<u>2,915</u>	6
7	V	17	<u>Corporate finance purchased services</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>3,356</u>	<u>3,356</u>	7
8	V	17	<u>Corporate finance other expenses</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>(2)</u>	<u>(2)</u>	8
9	V	22	<u>Corporate employee benefits</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>6,375</u>	<u>6,375</u>	9
10	V	22	<u>Corporate finance employee benefits</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>8,787</u>	<u>8,787</u>	10
11	V	22	<u>Unemployment</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>1,407</u>	<u>1,407</u>	11
12	V	22	<u>Health insurance</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>8,055</u>	<u>8,055</u>	12
13	V	22	<u>Pension</u>		<u>Bethany Methodist Corporation</u>	<u>100.00%</u>	<u>178,905</u>	<u>178,905</u>	13
14	Total			\$			\$ <u>514,922</u>	\$ * <u>514,922</u>	14

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

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.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$	CARRY FORWARD TOTALS FROM PREVIOUS PAGE		\$ 514,922	\$ 514,922	15
16	V	22	Workman's compensation		Bethany Methodist Corporation	100.00%	1,376	1,376	16
17	V	17	Corporate transfers	333,237	Bethany Methodist Corporation	100.00%		(333,237)	17
18	V	22	Corporate employee benefits transfers	210,446	Bethany Methodist Corporation	100.00%		(210,446)	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			\$ 543,683			\$ 516,298	\$ * (27,385)	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: 10/1/2011 Ending: 09/30/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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: 10/1/2011 Ending: 9/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Corporate salaries	Percent of Cost	100	Various	\$ 966,226	\$ 966,226	10	\$ 95,656	1
2	17	Professional fees	Percent of Cost	100	Various	170,839		10	16,913	2
3	17	Other expenses	Percent of Cost	100	Various	321,457		10	31,824	3
4	22	Employee benefits	Percent of Cost	100	Various	84,327		8	6,375	4
5	17	Corporate finance salaries	Percent of Revenue	100	Various	759,001	759,001	18	136,620	5
6	17	Corporate finance supplies	Percent of Revenue	100	Various	16,196		18	2,915	6
7	17	Corporate finance purchased svcs	Percent of Revenue	100	Various	18,644		18	3,356	7
8	17	Corporate finance other expenses	Percent of Revenue	100	Various	(13)		18	(2)	8
9	17	Corporate finance other fees	Percent of Revenue	100	Various	133,952		18	24,111	9
10	22	Corporate finance empl benefits	Percent of Revenue	100	Various	48,815		18	8,787	10
11	22	Unemployment	Percent of Cost	100	Various	8,374		17	1,407	11
12	22	Health insurance	Percent of Cost	100	Various	47,941		17	8,054	12
13	22	Pension	Percent of Cost	100	Various	1,064,767		17	178,881	13
14	22	Workman's compensation	Percent of Cost	100	Various	8,189		17	1,376	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,648,715	\$ 1,725,227		\$ 516,273	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		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.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 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 2012 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:			
2007		8	
2008		9	
2009		10	
2010		11	
2011		12	

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Bethany Terrace Nursing Centre

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0015651

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

(NONE)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	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:

10/1/2011

Ending:

09/30/2012

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		531,747	6
7			2000	2000	284,128	7,103	40	7,103		88,788	7
8			2001	2001	201,057	5,026	40	5,026		258,186	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	896		Various			896	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	5,580	Various	5,580		317,438	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	2,187	Various	2,187		290,572	35
36	ASSET DEPRECIATION --1995			1995	85,023	2,580	Various	2,580		80,346	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

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	\$	Various	\$	\$	\$ 1,400,184	37
38	ASSET DEPRECIATION -- 1997	1997	10,983		Various			10,983	38
39	ASSET DEPRECIATION -- 1998	1998	194,014	9,170	Various	9,170		145,066	39
40	ASSET DEPRECIATION -- 1999	1999	413,588	7,937	Various	7,937		284,747	40
41	ASSET DEPRECIATION -- 2000	2000	45,113	166	Various	166		41,317	41
42	ASSET DEPRECIATION -- 2001	2001	541,459	22,781	Various	22,781		349,131	42
43	ASSET DEPRECIATION -- 2002	2002	598,201	52,132	Various	52,132		580,324	43
44	ASSET DEPRECIATION -- 2003	2003	353,918	30,039	Various	30,039		291,084	44
45	ASSET DEPRECIATION -- 2004	2004	1,863,592	183,995	Various	183,995		949,514	45
46	ASSET DEPRECIATION -- 2005	2005	254,538	9,715	Various	9,715		113,940	46
47	ASSET DEPRECIATION -- 2006	2006	57,081	197	Various	197		29,566	47
48	ASSET DEPRECIATION -- 2007	2007	2,404,047	187,167	Various	187,167		1,030,559	48
49	ASSET DEPRECIATION -- 2008	2008	1,589,912	84,341	Various	84,341		326,418	49
50	PLUMBING PIPING	2009	6,837	342	20	342		1,283	50
51	ASHBURY HALLWAY REMODELING	2009	4,350	290	15	290		894	51
52	2 DOORS HALLWAY & INSTALLATION	2009	10,528	702	15	702		2,164	52
53	BEAUTY SALON	2009	69,800	4,653	15	4,653		14,347	53
54	CARPET & BASEBOARD REPLACEMENT FOR SYLVESTER	2009	20,868	1,441	5	1,441		5,612	54
55	BATHROOM HEATER FOR SYLVESTER SUITES SOUTH	2010	2,800	140	15	140		420	55
56	LAMINATED FLOORING FURNISH & INSTALL	2010	4,280	178	10	178		534	56
57	REPAIR TO PT HVAC UNIT ROOF - TOP	2010	12,980	162	20	162		486	57
58	ASSET DEPRECIATION -- (LESS THAN \$2500)	2010	303,573	7,387	Various	7,387		282,371	58
59	UPGRADE FIRE ALARM SYSTEM	2011	2,592	259	10	259		367	59
60	REMODEL DENTAL OFFICE	2011	10,945	547	20	547		957	60
61	(LABOR/MATERIALS - BUILD PARTITION WALL, INSTALL DOOR, CABINETS W/COUNTER TOP,								61
62	PLUMBING, SINK, DENTAL APPARATUS, REMOVE/STORE OLD DENTAL CHAIRS, MOVE JUNCTION BOX FROM WALL TO FLOOR)								62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 19,388,042	\$ 660,524		\$ 660,524	\$	\$ 14,090,730	70

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

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		\$ 19,388,042	\$ 660,524		\$ 660,524	\$	\$ 14,090,730	1
2	LAWN SPRINKLER SYSTEM REPAIR	2012	3,800	106	15	106		106	2
3	REPLACE DAMAGED SIDEWALK	2012	1,380	72	8	72		72	3
4	NEW ELECTRIC LINE FOR NEW DISH MACHINE	2012	3,500	117	20	117		117	4
5	STEEL DOOR AND FRAME	2012	1,584	33	20	33		33	5
6	ELECTRIC REPAIR	2012	9,400	196	20	196		196	6
7	(LABOR/MATERIALS - INSTALL THINWALL TO GENERATOR ON ROOF, JUNCTION BOXES & COVERS, REWIRE CONTROL BOX,								7
8	SHORTEN ROOFTOP A/C UNIT, INSTALL ROOFTOP EXHAUST FAN HOUSING & RELATED WIRING/CIRCUIT BREAKERS)								8
9	REBUILD DOOR FRAME/REMOVE DOOR/REPLACE BRICK	2012	3,112	26	20	26		26	9
10	BOILER WATER LEAK REPAIR	2012	504	38	10	38		38	10
11	REPAIRED WATER LINE	2012	675	51	10	51		51	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	TOTAL (lines 1 thru 33)		\$ 19,411,997	\$ 661,163		\$ 661,163	\$	\$ 14,091,369	34

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

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	\$2,090,869	\$116,419	\$116,419	\$	VARIOUS	\$1,675,044	71
72	Current Year Purchases	63,358	5,316	5,316		3 - 15	5,316	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,154,227	\$121,735	\$121,735	\$		\$1,680,360	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)	\$21,867,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$782,898	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$782,898	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)	\$15,790,854	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	Fire Alarm	\$114,886	92
93	Fire Sprinkling System	364,016	93
94			94
95		\$478,902	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 23,331
- Description: Various nursing equipment.
- (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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

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)	\$			

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.

HFS 3745 (N-4-99)

IL478-2471

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	\$	2,866	\$ 257,673	\$	2,866	\$ 257,673	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs		1,061	85,388		1,061	85,388	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.3	hrs		6,509	432,568		6,509	432,568	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.1	1320	56,092				1,320	56,092	12
13	Other (specify): Therapy dept supplies	10A.2					1,527		1,527	13
14	TOTAL			\$ 56,092	10,436	\$ 775,629	\$ 1,527	11,756	\$ 833,248	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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 76,000)	3,535,214		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)	(1,662,273)		8
9	Other(specify): See Supplemental Schedule	184,282		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,058,273	\$	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	19,411,997		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,173,352		16
17	Accumulated Depreciation (book methods)	(15,790,854)		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	661,466		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,737,834	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,796,107	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 113,682	\$	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)	\$ 114,682	\$	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	662,559		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 662,559	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 777,241	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,018,866	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,796,107	\$	48

*(See instructions.)

XV. BALANCE SHEET - Supplemental Schedule

Line 9 - Other Current Assets		Line 43 - Other Long-Term Liabilities	
Description	Amount	Description	Amount
IDPA Participation Fees	\$ 102,878	Investment Contract Liability	\$ 650,215
BT Bethany Terrace	81,404	Bethany Terrace Resident	10,243
	<u>\$ 184,282</u>	Memorial Fund	2,101
			<u>\$ 662,559</u>

Line 23 - Other Long Term Assets	
Description	Amount
Construction in Progress (Fire Alarm)	\$ 114,886
Construction in Progress (Fire Sprinklers)	364,016
Deferred Bond Issuance Expense	364,102
Amortization of Bond Cost	(181,538)
	<u>\$ 661,466</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,843,458	1
2	Restatements (describe):		2
3	FS Auditor Adjustment - Project Fund Series 2009	(290,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,553,458	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,931	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 166,931	17
	B. Transfers (Itemize):		
18	Investment Contract Liability Reclassified to Affiliate	290,111	18
19	Adjust Equity to Calculated	8,366	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 298,477	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,018,866	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethany Terrace Nursing Centre# 0015651Report Period Beginning: 10/1/2011Ending: 09/30/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 11,982,596	1	
2 Discounts and Allowances for all Levels	(3,850,528)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,132,068	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	3,499,951	6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,499,951	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	1,021	12	
13 Barber and Beauty Care	3,887	13	
14 Non-Patient Meals	33,137	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	105,942	19	
20 Radiology and X-Ray	16,698	20	
21 Other Medical Services		21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,685	23	
D. Non-Operating Revenue			
24 Contributions	4,034	24	
25 Interest and Other Investment Income***	88,894	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 92,928	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 <u>See Supplemental Schedule</u>	(209,896)	28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (209,896)	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,675,736	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,873,316	31	
32 Health Care	5,413,323	32	
33 General Administration	2,423,937	33	
B. Capital Expense			
34 Ownership	806,229	34	
C. Ancillary Expense			
35 Special Cost Centers	628,907	35	
36 Provider Participation Fee	249,683	36	
D. Other Expenses (specify):			
37 <u>Community Outreach - Marketing Wages & Expenses</u>	113,410	37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,508,805	40	
41 Income before Income Taxes (line 30 minus line 40)**	166,931	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 166,931	43	

	1		2
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 1,935,800	44	
45 Private Pay - Net Inpatient Revenue	4,513,184	45	
46 Medicare - Net Inpatient Revenue	926,885	46	
47 Other-(specify) <u>Blue Cross - Net Inpatient Revenue</u>	44,669	47	
48 Other-(specify) <u>Commercial Insurance, Charity, Other - Net Inpatient</u>	711,530	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,132,068	49	

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

SCHEDULE XVII. INCOME STATEMENT - Supplemental Schedule

Line 28 - Other Revenue

<u>Description</u>	<u>Amount</u>
Bad debts	\$ (210,928)
Miscellaneous income - rebates	202
Miscellaneous income - medical records	830
	<u>\$ (209,896)</u>

Facility Name & ID Number Bethany Terrace Nursing Centre# 0015651

Report Period Beginning:

10/1/2011

Ending:

09/30/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,008	2,339	\$ 98,859	\$ 42.27	1
2	Assistant Director of Nursing	2,120	2,775	93,023	33.52	2
3	Registered Nurses	44,671	48,960	1,419,410	28.99	3
4	Licensed Practical Nurses	23,181	24,934	614,343	24.64	4
5	CNAs & Orderlies	119,990	131,253	1,648,193	12.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,908	2,214	36,173	16.34	8
9	Activity Director	1,976	2,160	42,022	19.45	9
10	Activity Assistants	3,018	3,195	38,132	11.93	10
11	Social Service Workers	2,712	3,128	63,656	20.35	11
12	Dietician	2,221	2,525	82,681	32.74	12
13	Food Service Supervisor	5,614	6,120	72,028	11.77	13
14	Head Cook	5,992	7,031	78,653	11.19	14
15	Cook Helpers/Assistants	6,269	6,598	61,306	9.29	15
16	Dishwashers					16
17	Maintenance Workers	2,625	3,498	54,536	15.59	17
18	Housekeepers	25,618	27,954	285,742	10.22	18
19	Laundry	9,115	9,945	106,770	10.74	19
20	Administrator	1,992	2,437	130,683	53.62	20
21	Assistant Administrator					21
22	Other Administrative	3,215	3,427	116,052	33.86	22
23	Office Manager					23
24	Clerical	8,651	9,178	147,804	16.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director			37,000		27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,148	2,346	47,926	20.43	31
32	Other Health Care <u>See Supplemental</u>	2,970	4,255	82,433	19.37	32
33	Other(specify) <u>See Supplemental</u>	34,414	38,061	366,299	9.62	33
34	TOTAL (lines 1 - 33)	312,428	344,333	\$ 5,723,724 *	\$ 16.62	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		21,600	9.3	36
37	Medical Records Consultant	8	1,944	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	5	300	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)				46
47	<u>Demential Consultant</u>	22	1,144	10.3	47
48					48
49	TOTAL (lines 35 - 48)	35	\$ 24,988		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	423	\$ 12,350	10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	110	2,011	10.3	52
53	TOTAL (lines 50 - 52)	533	\$ 14,361		53

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

		1	2**	3	4
		# of Hrs.	# of Hrs.	Reporting Period	Average
		Actually	Paid and	Total Salaries,	Hourly
	Description	Worked	Accrued	Wages	Wage
32 A	Central Service Tech	1,650	2,288	26,341	11.51
32 B	Physical Therapy Mgmt / Supervisor	1,320	1,967	56,092	28.52
	Total Line 32	2,970	4,255	\$ 82,433	\$ 19.37

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - Line 33 Other

		1	2**	3	4
		# of Hrs.	# of Hrs.	Reporting Period	Average
		Actually	Paid and	Total Salaries,	Hourly
	Description	Worked	Accrued	Wages	Wage
33 A	Food Service Workers	32,566	35,798	\$ 309,118	\$ 8.64
33 B	Community Outreach / Marketing	1,848	2,263	57,181	25.27
	Total Line 32	34,414	38,061	\$ 366,299	\$ 9.62

STATE OF ILLINOIS

0015651

Report Period Beginning:

10/1/2011

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Ending: 09/30/2012

Facility Name & ID Number

Bethany Terrace Nursing Centre

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>Marya Jordon (10/1/11 - 5/19/12)</td> <td>Administrator</td> <td>0</td> <td>\$ 59,887</td> </tr> <tr> <td>Frank Bensema (5/19/12 - Present)</td> <td>Administrator</td> <td>0</td> <td>70,976</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 130,863</td> </tr> </table>				Name	Function	Ownership %	Amount	Marya Jordon (10/1/11 - 5/19/12)	Administrator	0	\$ 59,887	Frank Bensema (5/19/12 - Present)	Administrator	0	70,976																	TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 130,863	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 255,826</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>14,974</td> </tr> <tr> <td>FICA Taxes</td> <td>413,457</td> </tr> <tr> <td>Employee Health Insurance</td> <td>435,456</td> </tr> <tr> <td>Employee Meals</td> <td> </td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td> </td> </tr> <tr> <td>Group Life Insurance</td> <td>5,266</td> </tr> <tr> <td>Tuition Reimbursement</td> <td>900</td> </tr> <tr> <td>Pension</td> <td>178,905</td> </tr> <tr> <td>Other Benefits</td> <td>15,162</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 1,319,946</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 255,826	Unemployment Compensation Insurance	14,974	FICA Taxes	413,457	Employee Health Insurance	435,456	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Group Life Insurance	5,266	Tuition Reimbursement	900	Pension	178,905	Other Benefits	15,162							TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,319,946	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$ </td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td> </td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed)</td> <td> </td> </tr> <tr> <td>Patient Background Checks</td> <td> </td> </tr> <tr> <td>Miscellaneous Dues & Subscriptions</td> <td>8,951</td> </tr> <tr> <td>Software Subscription</td> <td>9,793</td> </tr> <tr> <td>Association Dues</td> <td>5,240</td> </tr> <tr> <td>Membership & Service Fees</td> <td>3,642</td> </tr> <tr><td> </td><td> </td></tr> <tr> <td>Less: Public Relations Expense</td> <td>()</td> </tr> <tr> <td>Non-allowable advertising</td> <td>()</td> </tr> <tr> <td>Yellow page advertising</td> <td>()</td> </tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 27,626</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment		Health Care Worker Background Check (Indicate # of checks performed)		Patient Background Checks		Miscellaneous Dues & Subscriptions	8,951	Software Subscription	9,793	Association Dues	5,240	Membership & Service Fees	3,642			Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 27,626
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HFS 3745 (N-4-99)

IL478-2471

Page 21, C. Profession Fee Services - Detail of legal invoices

[illegible]

Total Legal Invoices (rounded)	\$	12,145	[A]	Total Unallowable Legal Expenses (rounded)	\$	788
Unallowable legal expenses		(788)				
Net Legal Services	\$	11,357				
Total Legal Expenses per General Ledger	\$	12,145	[B]			
Variance	\$	-	[A] - [B]			

Facility Name & ID Number

Bethany Terrace Nursing Centre

0015651

Report Period Beginning:

10/1/2011

Ending:

[illegible]

Supplement

9/30/2012

[illegible]

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$5,240
- (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?

N/A
- (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?

3 - 20 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 24,037

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.

\$ 249,683

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.

\$ 22,091
- (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?

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.

\$ N/A
- (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 out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.