

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0012229</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Bethesda Home and Retirement Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.																																															
Address: <u>2833 Nordica Ave</u> <u>Chicago</u> <u>60634</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(773) 622-6144</u> Fax # <u>(773) 622-8261</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																																				
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	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																																																
Date of Initial License for Current Owners: <u>06/06/59</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code <u>501 (c)(3)</u></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td>☐</td><td>_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 (c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	☐	_____			☐	Limited Liability Co.	☐	_____			☐	Trust	☐	_____			☐	Other	☐	_____
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		☐	Trust	☐	_____																																												
		☐	Other	☐	_____																																												
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Bethesda Home and Retirement Center

0012229 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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>46</u>	Skilled (SNF)	<u>46</u>	<u>16,790</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>67</u>	Intermediate (ICF)	<u>67</u>	<u>24,455</u>	3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,885</u>	5
6		ICF/DD 16 or Less			6
7	<u>162</u>	TOTALS	<u>162</u>	<u>59,130</u>	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>2,028</u>	<u>5,340</u>	<u>5,003</u>	<u>12,371</u>	8
9	SNF/PED					9
10	ICF	<u>3,783</u>	<u>5,785</u>		<u>9,568</u>	10
11	ICF/DD					11
12	SC		<u>3,504</u>		<u>3,504</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,811</u>	<u>14,629</u>	<u>5,003</u>	<u>25,443</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.03%

D. How many bed-hold days during this year were paid by the Department? None (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) None

F. Does the facility maintain a daily midnight census? Yes

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

I. On what date did you start providing long term care at this location?
Date started 1925

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 46 and days of care provided 5,003

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Bethesda Home and Retirement Center # 0012229 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	279,732	47,009	146,237	472,978		472,978		472,978			1
2	Food Purchase		193,240		193,240		193,240	(6,468)	186,772			2
3	Housekeeping	134,943	46,390	378	181,711		181,711		181,711			3
4	Laundry	22,145	13,600		35,745		35,745		35,745			4
5	Heat and Other Utilities			167,096	167,096		167,096		167,096			5
6	Maintenance	149,415		190,203	339,618		339,618	8,257	347,875			6
7	Other (specify):*											7
8	TOTAL General Services	586,235	300,239	503,914	1,390,388		1,390,388	1,789	1,392,177			8
	B. Health Care and Programs											
9	Medical Director			8,469	8,469		8,469		8,469			9
10	Nursing and Medical Records	1,727,509	179,188	342,730	2,249,427		2,249,427		2,249,427			10
10a	Therapy		313	479,957	480,270		480,270		480,270			10a
11	Activities	99,028	19,453	18,422	136,903		136,903		136,903			11
12	Social Services	76,130		280	76,410		76,410		76,410			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,902,667	198,954	849,858	2,951,479		2,951,479		2,951,479			16
	C. General Administration											
17	Administrative	127,950			127,950		127,950		127,950			17
18	Directors Fees											18
19	Professional Services			210,861	210,861		210,861	(18,242)	192,619			19
20	Dues, Fees, Subscriptions & Promotions			24,011	24,011		24,011	(175)	23,836			20
21	Clerical & General Office Expenses	431,312	37,417	91,249	559,978		559,978	(89,912)	470,066			21
22	Employee Benefits & Payroll Taxes			812,595	812,595		812,595		812,595			22
23	Inservice Training & Education			5,426	5,426		5,426		5,426			23
24	Travel and Seminar			8,081	8,081		8,081		8,081			24
25	Other Admin. Staff Transportation			1,014	1,014		1,014		1,014			25
26	Insurance-Prop.Liab.Malpractice			120,428	120,428		120,428		120,428			26
27	Other (specify):*											27
28	TOTAL General Administration	559,262	37,417	1,273,665	1,870,344		1,870,344	(108,329)	1,762,015			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,048,164	536,610	2,627,437	6,212,211		6,212,211	(106,540)	6,105,671			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			445,425	445,425		445,425	17,445	462,870			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			165,171	165,171		165,171	(4,806)	160,365			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,200	10,200		10,200		10,200			35
36	Other (specify):*											36
37	TOTAL Ownership			620,796	620,796		620,796	12,639	633,435			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		217,407		217,407		217,407		217,407			39
40	Barber and Beauty Shops			13,635	13,635		13,635		13,635			40
41	Coffee and Gift Shops			4,985	4,985		4,985	(7,573)	(2,588)			41
42	Provider Participation Fee			125,517	125,517		125,517		125,517			42
43	Other (specify):* Non-Allow Costs	82,433		142,356	224,789		224,789	(224,789)				43
44	TOTAL Special Cost Centers	82,433	217,407	286,493	586,333		586,333	(232,362)	353,971			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,130,597	754,017	3,534,726	7,419,340		7,419,340	(326,263)	7,093,077			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(6,468)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,621)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,445	30		9
10	Interest and Other Investment Income	(4,806)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(210)	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	2	43		18
19	Entertainment	(6,568)	43		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	(47,285)	43		24
25	Fund Raising, Advertising and Promotional	(30,985)	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 Pg 5A	(240,767)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (326,263)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (326,263)		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

Report Period Beginning:

ID# 0012229

Ending:

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Marketing Expense	\$ (86,324)	43	1
2	Cable TV	(10,310)	43	2
3	Medicare X-Ray & Lab Services	(31,886)	43	3
4	Real estate taxes - Florida property	(1,005)	43	4
5	Life Enrichment Outings & Dinners	2,131	43	5
6	Real estate taxes - rental houses	(11,690)	43	6
7	Volunteer Expense	(659)	43	7
8	Offset jury duty revenue	(206)	21	8
9	Offset thrift shop revenue	(1,714)	21	9
10	Offset gift shop revenue	(7,573)	41	10
11	Offset Miscellaneous Income	(25,049)	21	11
12	Marketing Salary	(56,322)	21	12
13	Reclass to R&M	8,257	6	13
14	Chamber of Commerce dues	(175)	20	14
15	Non-allowable legal	(18,242)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(240,767)		49

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
		N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V		N/A						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			\$			\$0	\$ *	39

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

Facility Name & ID Number Bethesda Home and Retirement Center # 0012229 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	N/A										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 Bethesda Home and Retirement Center # 0012229 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 _____
Street Address N/A _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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						\$	\$			1
2										2
3					N/A					3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	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	IHFA Revenue Bonds 1999a		X	Renovations/Improvements	Interest-Var.	11/01/99	\$ 3,880,000	\$ 1,910,000	09/01/14	0.0625	\$ 130,390	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Fifth Third Bank		X	Working Capital	\$7,660.44	10/26/09	397,100	239,546	10/26/14	0.0591	22,746	6
7	Fifth Third Bank		X	Equipment	\$2,222 plus int.	2/26/2011	80,000	26,667	2/26/14	0.0325	1,879	7
8	Fifth Third Bank		X	Working Capital	Interest Monthly	10/26/10	250,000	250,000	10/26/12	Prime		8
9	TOTAL Facility Related				\$7,660.44		\$ 4,607,100	\$ 2,426,213			\$ 155,015	9
	B. Non-Facility Related*											
10								Offset interest income			(4,806)	10
11								Amortization of Bonds			10,156	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 5,350	14
15	TOTALS (line 9+line14)						\$ 4,607,100	\$ 2,426,213			\$ 160,365	15

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

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

B. Real Estate Taxes

[illegible]

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethesda Home and Retirement Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012229

CONTACT PERSON REGARDING THIS REPORT Paul Roberts

TELEPHONE (773) 836-3208 FAX #: (773) 622-8261

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(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.	<u>N/A-not for profit</u>	<u>N/A</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

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? N/A YES NO

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,403

B. General Construction Type: Exterior Brick Frame _____ Number of Stories Four

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).

Apartment Buildings - 13 Units

Land - Sayre Avenue (formerly rental houses)

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: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: _____

4. Dates Incurred: N/A

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1919</u>	<u>\$ 11,392</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 11,392</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1925	1925	\$ 182,722	\$		\$		\$ 182,722	4
5			1955	1955	657,001	10,108	65	10,108		568,563	5
6	162		1991	1991	2,123,475	42,470	50	42,470		889,504	6
7			1997	1997	263,808	13,190	20	13,190		174,800	7
8											8
	Improvement Type**										
9	Various		1956		4,130	64	64	64		3,530	9
10	Various		1957		4,771					4,771	10
11	Various		1958		14,177	141	62	141		12,984	11
12	Various		1960		27,510					27,510	12
13	Various		1966		15,090					15,090	13
14	Various		1970		434					434	14
15	Various		1975		5,599					5,599	15
16	Various		1976		10,615					10,615	16
17	Various		1978		12,100					12,100	17
18	Various		1985		8,596					8,596	18
19	Various		1986		1,436,330	64,751	25	64,751		1,148,713	19
20	Various		1987		6,537	218	30	218		5,339	20
21	Various		1988		50,000		20			50,000	21
22	Various		1991		1,358,192	46,356	Various	46,356		935,253	22
23	Various		1992		180,765					180,765	23
24	Various		1993		125,270					125,270	24
25	Various		1994		4,298					4,298	25
26	Various		1995		132,332		Various			132,332	26
27	Various		1996		136,115	6,631	Various	6,631		106,984	27
28	Various		1997		123,231	8,238	Various	8,238		123,231	28
29	Various		1998		124,461	9,605	Various	9,605		124,461	29
30	Various		1999		215,640		Various			215,640	30
31	Various		2000		1,119,263	57,254	Various	57,254		643,720	31
32											32
33											33
34											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwegian Lutheran Bethesda D/B/A Bethesda Home and Retirement Cent# 0012229 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Improvements - Office	2001	\$ 4,721	\$	5	\$		\$ 4,721	37
38 Carpeting	2001	810		5			810	38
39 Stair Landing	2001	7,180	718	10	718		7,180	39
40 Door Replacement	2001	18,583	1,858	10	1,858		18,583	40
41 Stair Landing	2001	1,260	63	20	63		677	41
42 Fire Alarm Study	2001	5,000	250	20	250		2,625	42
43 4th Floor Door Replacement	2001	4,972	249	20	249		2,571	43
44 Center Bldg Nurses Station	2001	11,803	1,180	10	1,180		11,803	44
45 3N Nurse Call System	2001	2,109	211	10	211		2,109	45
46 Roof Repair	2001	6,830	683	10	683		6,830	46
47 Signage	2001	2,270	227	10	227		2,270	47
48 Roof Repair	2001	19,407	1,941	10	1,941		19,407	48
49 Faucets	2001	9,116	912	10	912		9,116	49
50 Ceiling Repair	2001	1,563	156	10	156		1,563	50
51 Telephone Wiring	2001	1,535	154	10	154		1,535	51
52 Concrete Landing	2001	8,900	297	30	297		3,266	52
53 Boiler Replacement	2001	900	30	30	30		330	53
54 Boiler Replacement	2001	4,053	135	30	135		1,474	54
55 Ceiling	2001	405	14	30	14		151	55
56 Boiler Project	2001	582	19	30	19		201	56
57 Viking Room Lighting	2001	2,191	219	10	219		2,191	57
58 Draperies	2001	1,155	116	10	116		1,155	58
59 Fire Alarm	2001	1,297	130	10	130		1,297	59
60 Walk-in Freezer	2001	942	94	10	94		942	60
61 Carpeting	2001	3,580		5			3,580	61
62 Draperies	2001	1,968		5			1,968	62
63 Floor Coverings	2001	4,595		5			4,595	63
64 Carpeting	2001	7,160		5			7,160	64
65 Draperies	2001	1,088		3			1,088	65
66 Carpeting	2001	2,770		5			2,770	66
67 Security Camera	2001	160		5			160	67
68 Security System	2001	13,500		5			13,500	68
69								69
70 TOTAL (lines 4 thru 69)		\$ 8,494,867	\$ 268,682		\$ 268,682	\$	\$ 5,850,452	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bethesda Home and Retirement Center

0012229

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,494,867	\$ 268,682		\$ 268,682	\$	\$ 5,850,452	1
2	Faucets	2002	8,805	881	10	881		8,805	2
3	Plumbing Work	2002	810		5			810	3
4	Carpet/Vinyl Flooring	2002	2,095		5			2,095	4
5	Major Repairs	2002	1,558		5			1,558	5
6	Combination Locks	2002	5,092		5			5,092	6
7	Safety Gate	2002	1,383		10	138	138	828	7
8	Wall Rails	2002	1,387		10	139	139	834	8
9	Architect Fees	2002	643		10	64	64	384	9
10	Improvements-Activity Room	2002	54,789		10	5,479	5,479	32,874	10
11	Improvements-Activity Room	2002	811		10	81	81	486	11
12	1st Floor Flooring	2002	1,680	168	10	168		1,680	12
13	Flooring 1N	2002	11,650		5			11,650	13
14	Flooring 2N	2002	4,965		5			4,965	14
15	Electrical Work	2002	594		10	59	59	354	15
16	Brick Work	2002	1,020		10	102	102	612	16
17	Door Electrical Work	2002	510		10	51	51	306	17
18	Drywall and Hardware	2002	921		10	92	92	552	18
19	Ceiling Tile	2002	639		10	64	64	384	19
20	Access Control	2002	637		10	64	64	384	20
21	Access Control	2002	955		10	96	96	576	21
22	Dampers	2002	1,174		10	117	117	702	22
23	Freezer Repairs	2002	1,040		10	104	104	624	23
24	Elevator Repairs	2002	705		10	71	71	426	24
25	Sprinkler Repairs	2002	565		10	57	57	342	25
26	Freezer Repairs	2002	1,023		10	102	102	612	26
27	Freezer Repairs	2002	1,030		10	103	103	618	27
28	Landscaping	2003	62,514	4,168	15	4,168		35,080	28
29	Landscaping	2003	108	7	15	7		59	29
30	Landscaping	2003	40,940	2,729	15	2,729		22,970	30
31	Landscaping	2003	22,495	1,500	15	1,500		12,650	31
32	Auditorium Construction	2003	385,633	25,709	15	25,709		231,381	32
33	Fire Alarm	2003	58,250	3,883	15	3,883		32,035	33
34	TOTAL (lines 1 thru 33)		\$ 9,171,288	\$ 307,727		\$ 314,710	\$ 6,983	\$ 6,263,180	34

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

Facility Name & ID Number Bethesda Home and Retirement Center

0012229

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,171,288	\$ 307,727		\$ 314,710	\$ 6,983	\$ 6,263,180	1
2	Construction Monitoring	2003	18,954	1,264	15	1,264		10,428	2
3	Fire Alarm	2003	344,942	22,996	15	22,996		197,833	3
4	Auditorium Sound System	2003	1,840		5			1,840	4
5	Chiller	2003	12,733	849	15	849		7,146	5
6	Chiller	2003	25,467	1,698	15	1,698		14,291	6
7	A/C's	2003	4,840		5			4,840	7
8	A/C's	2003	1,234		5			1,234	8
9	Parking Lot resurfacing	2003	1,542		10	154	154	924	9
10	Smoke Detectors	2003	599		10	60	60	360	10
11	Circulator Pump	2003	1,071		10	107	107	642	11
12	Valve Bodies & Actuators	2003	1,017		10	102	102	612	12
13	Elevator Door Lock	2003	521		10	52	52	312	13
14	Faucets	2003	551		10	55	55	330	14
15	Walk-in Freezer Repair	2003	1,093		10	109	109	654	15
16	Carpet/Vinyl Flooring	2003	1,610		10	161	161	966	16
17	Carpet/Vinyl Flooring	2003	1,405		10	141	141	846	17
18	Roof/Gutter Repair	2003	15,190		10	1,519	1,519	9,114	18
19									19
20	Insolar Windows	2004	17,900	1,790	10	1,790		12,978	20
21	Nexus Technologies	2004	2,340	156	15	156		1,248	21
22	Convergint Technologies	2004	3,250	217	15	217		1,736	22
23	Studio One	2004	9,876	988	10	988		7,904	23
24	Noland Sales - Carpeting	2004	37,170		6			37,170	24
25									25
26	Elevator Upgrade	2006	203,667	5,092	20	5,092		25,643	26
27	Hot Water Heater Repairs	2006	27,730	2,773	5	2,773		19,411	27
28	Repair of Water Booster Pumps	2006	13,557	1,356	5	1,356		9,491	28
29	Fire Alarm Upgrade	2006	2,600	260	5	260		1,820	29
30	Elevator Electrical Repair	2006	7,871	332	12	332		2,316	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,931,858	\$ 347,498		\$ 356,941	\$ 9,443	\$ 6,635,269	34

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

Facility Name & ID Number Bethesda Home and Retirement Center

0012229

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,931,858	\$ 347,498		\$ 356,941	\$ 9,443	\$ 6,635,269	1
2	Major repairs to Boiler	2007	13,099	1,310	10	1,310		5,432	2
3	Re-key Administrative Wing	2007	3,607	721	5	721		2,944	3
4	Tuckpointing West and North Buildings	2007	4,500	450	10	450		1,875	4
5	Garbage Disposal	2007	4,303	861	5	861		3,516	5
6									6
7	Removed nursing station, cabinets, electrical and	2008	3,775	755	5	755		2,643	7
8	made into a common area								8
9									9
10	Flooring - Floors 1, 2 & 3	2009	92,142	15,357	6	15,357		38,393	10
11	Tuckpointing West Building	2009	6,150	615	10	615		1,538	11
12	Boiler replacement/repair	2009	6,322	421	15	421		1,053	12
13	Electrical panel work	2009	5,427		15	362	362	905	13
14	Mural and awning	2009	2,947	389	10	389		925	14
15	Parking lot paving	2009	3,675	245	15	245		613	15
16									16
17	Reclass R&M - Air conditioning repairs	2009	8,143		10	814	814	2,035	17
18									18
19	Boiler Replacement	2010	13,479	899	15	899	(450)	1,348	19
20									20
21	Brick Masonry	2011	17,975	999	15	999		999	21
22	Concrete Piers	2011	10,657	118	15	118		118	22
23	Dining room lights & electrical	2011	3,943	197	15	197		197	23
24	Electrical town square	2011	3,846	150	15	150		150	24
25	Elevator fire shield	2011	4,511	101	15	101		101	25
26	Fire Dampers	2011	19,756	463	15	463		463	26
27	Heating Bathrooms	2011	9,667	457	15	457		457	27
28	Kitchen Electrical	2011	6,295	358	15	358		5,936	28
29	Locker Room-carpentry, painting	2011	3,925	262	15	262		262	29
30	Piping Smoke Detectors	2011	4,105	91	15	91		91	30
31	Point of care electrical	2011	3,500	194	15	194		194	31
32	Pumps & Seals	2011	7,957	1,070	15	1,070		1,070	32
33	Restrooms -tiling	2011	4,535	216	15	216		216	33
34	TOTAL (lines 1 thru 33)		\$ 10,200,099	\$ 374,197		\$ 384,816	\$ 10,169	\$ 6,708,743	34

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 10,200,099	\$ 374,197		\$ 384,816	\$ 10,619	\$ 6,708,743	1
2 Roof repair-flashing, tiles, slate	2011	39,088	1,069	15	1,069		1,069	2
3 Windows attic	2011	2,572	50	15	50		50	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 10,241,759	\$ 375,316		\$ 385,935	\$ 10,619	\$ 6,709,862	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	\$623,114	\$44,958	\$51,784	\$6,826	3-10	\$543,616	71
72	Current Year Purchases	98,159	25,151	25,151		3	25,151	72
73	Fully Depreciated Assets	104,131					104,131	73
74								74
75	TOTALS	\$825,404	\$70,109	\$76,935	\$6,826		\$672,898	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	Patient Care	Shuttle Van	1994	\$34,300	\$	\$	\$	5	\$34,300	76
77	Patient Care	Ford Windstar	1999	22,065				5	22,065	77
78										78
79										79
80	TOTALS			\$56,365	\$	\$	\$		\$56,365	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$11,134,920	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$445,425	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$462,870	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$17,445	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,439,125	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	East Building Renovation-Prior	\$1,478,812	\$28,870	\$	86
87	Furnishings	6,074	1,215		87
88					88
89	Land - Sayre Avenue	1,883,678			89
90					90
91	TOTALS	\$3,368,564	\$30,085	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Strategic Planning	\$	92
93	Capitalized Expenses	72,218	93
94			94
95		\$72,218	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				N/A			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 . N/A
N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 10,200 Description: Senior TV equipment lease- \$10,200
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	\$	2,959	\$ 213,060	\$	2,959	\$ 213,060	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		390	28,105		390	28,105	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,281	236,243	313	3,281	236,556	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				217,407		217,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	6,631	\$ 477,408	\$ 217,720	6,631	\$ 695,128	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 538,161	\$ 538,161	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 131,738)	2,287,232	2,287,232	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,012	31,012	6
7	Other Prepaid Expenses	64,392	64,392	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,920,797	\$ 2,920,797	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	236,734	236,734	12
13	Land	26,847	11,392	13
14	Buildings, at Historical Cost	3,174,978	3,227,006	14
15	Leasehold Improvements, at Historical Cost	8,171,471	7,014,753	15
16	Equipment, at Historical Cost	755,572	881,769	16
17	Accumulated Depreciation (book methods)	(7,549,484)	(7,439,125)	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 (spe See Sch 17A	1,958,088	1,958,088	22
23	Other(specify): Bond Costs -NET	20,719	20,719	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,794,925	\$ 5,911,336	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,715,722	\$ 8,832,133	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 212,431	\$ 212,431	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	253,346	253,346	28
29	Short-Term Notes Payable	356,606	356,606	29
30	Accrued Salaries Payable	228,180	228,180	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,821	3,821	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	39,792	39,792	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Liabilities	134,989	134,989	36
37	Accrued Expenses	274,306	274,306	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,503,471	\$ 1,503,471	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	409,607	409,607	39
40	Mortgage Payable			40
41	Bonds Payable	1,660,000	1,660,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,069,607	\$ 2,069,607	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,573,078	\$ 3,573,078	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,142,644	\$ 5,259,055	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,715,722	\$ 8,832,133	48

*(See instructions.)

Norwegian Lutheran Bethesda D/B/A Bethesda Home and Retirement Center
Provider #: 0012229
1/1/2011 to 12/31/2011

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
Line 22 - Other Long Term Assets

Description	Operating	After Consolidation
Land - Sayre Avenue	1,883,678	1,883,678
Cemetery Plots	2,192	2,192
Strategic Planning-CIP (NET)	72,218	72,218
Total	1,958,088	1,958,088

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,270,041	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	(252,169)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,017,872	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	124,772	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)	\$ 124,772	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)	\$ 6,142,644	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Bethesda Home and Retirement Center**# **0012229**Report Period Beginning: **01/01/2011**Ending: **12/31/2011**

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

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,211,446	1
2	Discounts and Allowances for all Levels	(2,152,852)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,058,594	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,045,318	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,045,318	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	7,573	12
13	Barber and Beauty Care	14,675	13
14	Non-Patient Meals	6,468	14
15	Telephone, Television and Radio	17,660	15
16	Rental of Facility Space		16
17	Sale of Drugs	209,703	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,272	19
20	Radiology and X-Ray	5,105	20
21	Other Medical Services	256,741	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 539,197	23
	D. Non-Operating Revenue		
24	Contributions	469,162	24
25	Interest and Other Investment Income***	8,587	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 477,749	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	42,404	28
28a	See Sch 19A	380,850	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 423,254	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,544,112	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,390,388	31
32	Health Care	2,951,479	32
33	General Administration	1,870,344	33
	B. Capital Expense		
34	Ownership	620,796	34
	C. Ancillary Expense		
35	Special Cost Centers	460,816	35
36	Provider Participation Fee	125,517	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,419,340	40
41	Income before Income Taxes (line 30 minus line 40)**	124,772	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 124,772	43

* 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.

Norwegian Lutheran Bethesda D/B/A Bethesda Home and Retirement Center
Provider #: 0012229
01/01/11 to 12/31/11

Schedule 19A

XVII. INCOME STATEMENT
E. Other Revenue (specify):

Line 25	Description	Amount
	Interest on Bank Accounts	-
	Dividend Income - JP Morgan	-
	Interest Income - JP Morgan	4,806
	Realized Gain/Loss - JP Morgan	830
	Change in Unrealized Loss - JP Morgan	2,951
		<u>8,587</u>

Line 28	Description	Amount
	MISCELLANEOUS INCOME	25,049
	APARTMENT LAUNDRY	-
	JURY DUTY INCOME	206
	THRIFT SHOP INCOME	1,714
	GRANTS	10,000
	SPECIAL EVENTS	100
	VENDING INCOME	655
	OTHER	4,680
	Total	<u>42,404</u>

Line 28a	Description	Amount
	MAINTENANCE FEE - APARTMENTS	-
	AMORT OF DEF ENTRANCE FEE	-
	INCOME FROM JOINT VENTURE-LSN RRG	10,163
	INCOME FROM JOINT VENTURE HRA	370,687
	Total	<u>380,850</u>

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	3,547	3,764	\$ 163,002	\$ 43.31	1
2	Assistant Director of Nursing	3,421	3,765	128,620	34.16	2
3	Registered Nurses	10,502	12,176	415,226	34.10	3
4	Licensed Practical Nurses	10,300	11,546	282,432	24.46	4
5	CNAs & Orderlies	55,129	61,734	738,229	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,941	6,527	99,028	15.17	10
11	Social Service Workers	3,230	3,394	76,130	22.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,275	23,514	279,732	11.90	15
16	Dishwashers					16
17	Maintenance Workers	5,727	6,594	149,415	22.66	17
18	Housekeepers	10,516	12,108	134,943	11.14	18
19	Laundry	1,982	2,282	22,145	9.70	19
20	Administrator	1,893	1,945	127,950	65.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,283	13,656	374,990	27.46	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					31
32	Other Health Care: Marketing	1,804	2,080	56,322	27.08	32
33	Other(specify) Development	4,588	5,554	82,433	14.84	33
34	TOTAL (lines 1 - 33)	153,138	170,639	\$ 3,130,597 *	\$ 18.35	34

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	Monthly	\$ 146,237	1(3)	35
36	Medical Director	Monthly	8,469	9(3)	36
37	Medical Records Consultant	Monthly	750	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,917	10(3)	39
40	Physical Therapy Consultant	Monthly	319	10A(3)	40
41	Occupational Therapy Consultant	Monthly	2,230	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	672	11(3)	44
45	Social Service Consultant	Monthly	280	12(3)	45
46	Other(specify) Chaplain	Monthly	12,000	11(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 174,874		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,242	\$ 72,831	10(3)	50
51	Licensed Practical Nurses	3,147	124,694	10(3)	51
52	Certified Nurse Assistants/Aides	4,643	110,710	10(3)	52
53	TOTAL (lines 50 - 52)	9,032	\$ 308,235		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Julie Boggess	Administrator	0	\$ 127,950	Workers' Compensation Insurance		\$ 194,115	IDPH License Fee	\$
				Unemployment Compensation Insurance		3,000	Advertising: Employee Recruitment	2,290
				FICA Taxes		227,747	Health Care Worker Background Check	
				Employee Health Insurance		306,560	(Indicate # of checks performed 0)	
				Employee Meals			Patient Background Checks	15 180
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	7,446
				Employee Retirement		34,586	Miscellaneous Dues & Subscriptions	8,171
				Staff Bonus		32,352	LSN & AAHSA Dues	5,924
				Employee Relations		9,999	Less Chamber of Commerce dues	(175)
				Employee Life Insurance		4,236		
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 812,595	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,836
B. Administrative - Other								
Description			Amount					
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Sch 21A			\$ 210,861	N/A		\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	8,081
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
			\$ 210,861				TOTAL	\$ 8,081

* Attach copy of IMRF notifications

**See instructions.

Bethesda Home and Retirement Center
Provider #: 0012229
1/1/2011 to 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Wolf & Company	Accounting	53,020
McGladrey & Pullen LLP	Accounting	9,750
IVANS	Computer	926
Equilibrium	Computer	55,255
Trustwave	Computer	998
CDW Government	Computer	2,668
Comcast Cable	Computer	507
American Express Phones	Computer	565
McAfee Annual Fee	Computer	293
Wescom Solutions, Inc.	Computer	20,734
Verizon Wireless	Computer	6,481
OnShift	Computer	3,310
Unemployment Consultants	State U/C Consulting	2,500
Frost, Ruttenberg & Rothblatt, P.C.	Accounting	985
Ziegler Capital Markets Group	Bond Trust Fees	357
Bank of New York	Bond Trust Fees	5,442
Fitch, Inc.	Bond Trust Fees	1,200
Bank of New York Meilon	Bond Trust Fees	1,950
Klein Dubb & Holleb	Legal	18,242
Ungaretti & Harris	Legal	18,151
Michael J. Goldstein & Assoc. Ltd.	Legal	337
Life Safety Resources	Legal	5,790
Fist Kart Katz and Regan Ltd.	Legal	1,400
Total (agree to Schedule V, line 19, column 3)		210,861
Disallow non-allowable legal fees		(18,242)
Total (agree to Schedule V, line 19, column 8)		<u><u>192,619</u></u>

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. LSN & AASHA Dues-\$5,924
- (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? 4 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,621 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 125,517
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. \$ 6,468
- (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? N/A

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? N/A

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? N/A
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: Wolf & Company
- (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.