

		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: 0012229

Facility Name: Bethesda Home & Retirement Center

Address: 2833 North Nordica Avenue Chicago 60634
Number City Zip Code

County: Cook

Telephone Number: (773) 622-6144 Fax # (773) 622-8261

HFS ID Number:

Date of Initial License for Current Owners: 06/06/59

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Bethesda Home & Retirement Center# 0012229 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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>46</u>	Skilled (SNF)	<u>46</u>	<u>16,836</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>67</u>	Intermediate (ICF)	<u>67</u>	<u>24,522</u>	3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,934</u>	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,292	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>2,053</u>	<u>5,785</u>	<u>3,829</u>	<u>11,667</u>	8
9	SNF/PED					9
10	ICF	<u>5,280</u>	<u>4,460</u>		<u>9,740</u>	10
11	ICF/DD					11
12	SC		<u>2,766</u>		<u>2,766</u>	12
13	DD 16 OR LESS					13
14	TOTALS	7,333	13,011	3,829	24,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 40.77%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Adult Day Care

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 ☐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 3,829Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

	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	286,501	46,767	136,226	469,494		469,494		469,494			1
2	Food Purchase		220,146		220,146		220,146	(7,021)	213,125			2
3	Housekeeping	149,883	48,326	4,776	202,985		202,985		202,985			3
4	Laundry	24,081	10,773		34,854		34,854		34,854			4
5	Heat and Other Utilities			164,557	164,557		164,557		164,557			5
6	Maintenance	101,236		203,805	305,041		305,041		305,041			6
7	Other (specify):*											7
8	TOTAL General Services	561,701	326,012	509,364	1,397,077		1,397,077	(7,021)	1,390,056			8
	B. Health Care and Programs											
9	Medical Director			10,875	10,875		10,875		10,875			9
10	Nursing and Medical Records	1,861,304	176,976	171,609	2,209,889		2,209,889		2,209,889			10
10a	Therapy											10a
11	Activities	122,769	23,451	18,282	164,502		164,502		164,502			11
12	Social Services	86,134			86,134		86,134		86,134			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Adult Day Care			3,788	3,788		3,788		3,788			15
16	TOTAL Health Care and Programs	2,070,207	200,427	204,554	2,475,188		2,475,188		2,475,188			16
	C. General Administration											
17	Administrative	129,808			129,808		129,808		129,808			17
18	Directors Fees											18
19	Professional Services			172,707	172,707		172,707	(22,145)	150,562			19
20	Dues, Fees, Subscriptions & Promotions			22,355	22,355		22,355		22,355			20
21	Clerical & General Office Expenses	418,840	41,616	84,460	544,916		544,916	(77,307)	467,609			21
22	Employee Benefits & Payroll Taxes			760,932	760,932		760,932		760,932			22
23	Inservice Training & Education			4,800	4,800		4,800		4,800			23
24	Travel and Seminar			4,904	4,904		4,904		4,904			24
25	Other Admin. Staff Transportation			127	127		127		127			25
26	Insurance-Prop.Liab.Malpractice			116,858	116,858		116,858		116,858			26
27	Other (specify):*											27
28	TOTAL General Administration	548,648	41,616	1,167,143	1,757,407		1,757,407	(99,452)	1,657,955			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,180,556	568,055	1,881,061	5,629,672		5,629,672	(106,473)	5,523,199			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			461,038	461,038		461,038	13,197	474,235			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			117,243	117,243		117,243	(2,583)	114,660			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,483	9,483		9,483		9,483			35
36	Other (specify):*											36
37	TOTAL Ownership			587,764	587,764		587,764	10,614	598,378			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		190,108	424,841	614,949		614,949		614,949			39
40	Barber and Beauty Shops			13,547	13,547		13,547		13,547			40
41	Coffee and Gift Shops			5,727	5,727		5,727	(5,727)				41
42	Provider Participation Fee			170,209	170,209		170,209		170,209			42
43	Other (specify):* Non-Allowable Co	81,357		149,160	230,517		230,517	(230,517)				43
44	TOTAL Special Cost Centers	81,357	190,108	763,484	1,034,949		1,034,949	(236,244)	798,705			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,261,913	758,163	3,232,309	7,252,385		7,252,385	(332,103)	6,920,282			45

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

		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	(7,021)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,947)	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	13,197	30		9
10	Interest and Other Investment Income	(2,583)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(400)	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	(1,127)	43		18
19	Entertainment	(2,208)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,145)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,500)	43		24
25	Fund Raising, Advertising and Promotional	(22,202)	43		25
	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	(202,167)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (332,103)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (332,103)		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

Bethesda Home & Retirement Center

ID# 0012229

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Marketing Expense	\$ (85,965)	43	1
2	Cable TV	(9,553)	43	2
3	Medicare X-Ray & Lab Services	(20,697)	43	3
4	Real estate taxes - Florida property	(360)	43	4
5	Life Enrichment Outings & Dinners	2,611	43	5
6	Real estate taxes - rental houses	(10,853)	43	6
7	Volunteer Expense	(263)	43	7
8	Offset jury duty revenue	(34)	21	8
9	Offset thrift shop revenue	(29)	21	9
10	Offset gift shop revenue	(5,698)	41	10
11	Offset Miscellaneous Income	(7,916)	21	11
12	Marketing Salary	(63,410)	21	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	(202,167)		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

X 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			\$	N/A		\$	\$	1
2	V								2
3	V								3
4	V								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)

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 Bethesda Home & Retirement Center # 0012229 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 ☒

Name of Related Organization N/A
Street Address _____
City / State / Zip Code _____
Phone Number ()
Fax Number ()

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

	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					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										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	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.	11/1/99	\$ 3,880,000	\$	9/1/14	0.0625	\$ 27,191	1							
2	MB Bank-Series 12 Rev Bonds		X	Renovations/Improvements	\$35,071.41	4/5/12	1,948,200	1,672,637	3/5/17	0.0309	43,812	2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Fifth Third Bank		X	Working Capital	\$7,660.44	10/26/09	397,100		10/26/14	0.0591	3,367	6							
7	Fifth Third Bank		X	Equipment	\$2,222 plus int.	2/26/2011	80,000		2/26/14	0.0325	441	7							
8	MB Financial Bank		X	Working Capital	Interest Monthl	4/30/12	200,000	310,000		Prime	7,953	8							
9	TOTAL Facility Related					\$42,731.85		\$ 6,505,300	\$ 1,982,637			\$ 82,764	9						
	B. Non-Facility Related*																		
10								Offset interest income			(2,583)	10							
11								Amortization of Bonds			34,479	11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$ 31,896	14						
15	TOTALS (line 9+line14)							\$ 6,505,300	\$ 1,982,637			\$ 114,660	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Bethesda Home & 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 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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. N/A-not for profit	N/A	\$	\$
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? 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 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: 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: N/A 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>	1
2					2
3	TOTALS			<u>\$ 11,392</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		578,671	5
6	162		1991	1991	2,123,475	42,470	50	42,470		931,974	6
7			1997	1997	263,808	13,190	20	13,190		187,990	7
8											8
	Improvement Type**										
9	Various		1956		4,130		64		x	4,130	9
10	Various		1957		4,771					4,771	10
11	Various		1958		14,177	141	62	141		13,125	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		1,213,464	19
20	Various		1987		6,537	218	30	218		5,557	20
21	Various		1988		50,000		20			50,000	21
22	Various		1991		1,358,192	46,356	Various	46,356		981,609	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		113,615	27
28	Various		1997		123,231		Various			123,231	28
29	Various		1998		124,461		Various			124,461	29
30	Various		1999		215,640		Various			215,640	30
31	Various		2000		1,119,263	57,254	Various	57,254		700,974	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

Facility Name & ID Number Bethesda Home & Retirement Center

0012229

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	
37	Improvements - Office	2001	\$ 4,721	\$	5	\$	\$	\$ 4,721	37
38	Carpeting	2001	810		5			810	38
39	Stair Landing	2001	7,180		10			7,180	39
40	Door Replacement	2001	18,583		10			18,583	40
41	Stair Landing	2001	1,260	63	20	63		740	41
42	Fire Alarm Study	2001	5,000	250	20	250		2,875	42
43	4th Floor Door Replacement	2001	4,972	249	20	249		2,820	43
44	Center Bldg Nurses Station	2001	11,803		10			11,803	44
45	3N Nurse Call System	2001	2,109		10			2,109	45
46	Roof Repair	2001	6,830		10			6,830	46
47	Signage	2001	2,270		10			2,270	47
48	Roof Repair	2001	19,407		10			19,407	48
49	Faucets	2001	9,116		10			9,116	49
50	Ceiling Repair	2001	1,563		10			1,563	50
51	Telephone Wiring	2001	1,535		10			1,535	51
52	Concrete Landing	2001	8,900	297	30	297		3,563	52
53	Boiler Replacement	2001	900	30	30	30		360	53
54	Boiler Replacement	2001	4,053	135	30	135		1,609	54
55	Ceiling	2001	405	14	30	14		165	55
56	Boiler Project	2001	582	19	30	19		220	56
57	Viking Room Lighting	2001	2,191		10			2,191	57
58	Draperies	2001	1,155		10			1,155	58
59	Fire Alarm	2001	1,297		10			1,297	59
60	Walk-in Freezer	2001	942		10			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	\$ 242,176		\$ 242,176	\$	\$ 6,093,228	70

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

Facility Name & ID Number Bethesda Home & Retirement Center

0012229

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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		\$ 8,494,867	\$ 242,176		\$ 242,176	\$	\$ 6,093,228	1
2	Faucets	2002	8,805		10			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	966	7
8	Wall Rails	2002	1,387		10	139	139	973	8
9	Architect Fees	2002	643		10	64	64	448	9
10	Improvements-Activity Room	2002	54,789		10	5,479	5,479	38,353	10
11	Improvements-Activity Room	2002	811		10	81	81	567	11
12	1st Floor Flooring	2002	1,680		10			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	413	15
16	Brick Work	2002	1,020		10	102	102	714	16
17	Door Electrical Work	2002	510		10	51	51	357	17
18	Drywall and Hardware	2002	921		10	92	92	644	18
19	Ceiling Tile	2002	639		10	64	64	448	19
20	Access Control	2002	637		10	64	64	448	20
21	Access Control	2002	955		10	96	96	672	21
22	Dampers	2002	1,174		10	117	117	819	22
23	Freezer Repairs	2002	1,040		10	104	104	728	23
24	Elevator Repairs	2002	705		10	71	71	497	24
25	Sprinkler Repairs	2002	565		10	57	57	399	25
26	Freezer Repairs	2002	1,023		10	102	102	714	26
27	Freezer Repairs	2002	1,030		10	103	103	721	27
28	Landscaping	2003	62,514	4,168	15	4,168		39,248	28
29	Landscaping	2003	108	7	15	7		66	29
30	Landscaping	2003	40,940	2,729	15	2,729		25,699	30
31	Landscaping	2003	22,495	1,500	15	1,500		14,150	31
32	Auditorium Construction	2003	385,633	25,709	15	25,709		257,090	32
33	Fire Alarm	2003	58,250	3,883	15	3,883		35,918	33
34	TOTAL (lines 1 thru 33)		\$ 9,171,288	\$ 280,172		\$ 287,155	\$ 6,983	\$ 6,550,935	34

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

Facility Name & ID Number Bethesda Home & Retirement Center

0012229

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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 12B, Carried Forward		\$ 9,171,288	\$ 280,172		\$ 287,155	\$ 6,983	\$ 6,550,935	1
2	Construction Monitoring	2003	18,954	1,264	15	1,264		11,692	2
3	Fire Alarm	2003	344,942	22,996	15	22,996		220,829	3
4	Auditorium Sound System	2003	1,840		5			1,840	4
5	Chiller	2003	12,733	849	15	849		7,995	5
6	Chiller	2003	25,467	1,698	15	1,698		15,989	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	1,078	9
10	Smoke Detectors	2003	599		10	60	60	420	10
11	Circulator Pump	2003	1,071		10	107	107	749	11
12	Valve Bodies & Actuators	2003	1,017		10	102	102	714	12
13	Elevator Door Lock	2003	521		10	52	52	364	13
14	Faucets	2003	551		10	55	55	385	14
15	Walk-in Freezer Repair	2003	1,093		10	109	109	763	15
16	Carpet/Vinyl Flooring	2003	1,610		10	161	161	1,127	16
17	Carpet/Vinyl Flooring	2003	1,405		10	141	141	987	17
18	Roof/Gutter Repair	2003	15,190		10	1,519	1,519	10,633	18
19									19
20	Insolar Windows	2004	17,900	1,790	10	1,790		14,768	20
21	Nexus Technologies	2004	2,340	156	15	156		1,404	21
22	Convergint Technologies	2004	3,250	217	15	217		1,953	22
23	Studio One	2004	9,876	988	10	988		8,892	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		30,735	26
27	Hot Water Heater Repairs	2006	27,730	2,773	5	2,773		22,184	27
28	Repair of Water Booster Pumps	2006	13,557	1,356	5	1,356		10,847	28
29	Fire Alarm Upgrade	2006	2,600	260	5	260		2,080	29
30	Elevator Electrical Repair	2006	7,871	332	12	332		2,648	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,931,858	\$ 319,943		\$ 329,386	\$ 9,443	\$ 6,965,255	34

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

Facility Name & ID Number Bethesda Home & Retirement Center

0012229

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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 12C, Carried Forward		\$ 9,931,858	\$ 319,943		\$ 329,386	\$ 9,443	\$ 6,965,255	1
2	Major repairs to Boiler	2007	13,099	1,310	10	1,310		6,742	2
3	Re-key Administrative Wing	2007	3,607	661	5	661		3,605	3
4	Tuckpointing West and North Buildings	2007	4,500	450	10	450		2,325	4
5	Garbage Disposal	2007	4,303	789	5	789		4,305	5
6									6
7	Removed nursing station, cabinets, electrical and	2008	3,775	755	5	755		3,398	7
8	made into a common area								8
9									9
10	Flooring - Floors 1, 2 & 3	2009	92,142	15,357	6	15,357		53,750	10
11	Tuckpointing West Building	2009	6,150	615	10	615		2,153	11
12	Boiler replacement/repair	2009	6,322	421	15	421		1,474	12
13	Electrical panel work	2009	5,427	362	15	362		1,267	13
14	Mural and awning	2009	2,947	389	10	389		1,314	14
15	Parking lot paving	2009	3,675	245	15	245		858	15
16									16
17	Reclass R&M - Air conditioning repairs	2009	8,143		10	814	814	2,849	17
18									18
19	Boiler Replacement	2010	13,479	899	15	899	(0)	2,247	19
20									20
21	Brick Masonry	2011	17,975	1,198	15	1,198		2,197	21
22	Concrete Piers	2011	10,657	710	15	710		828	22
23	Dining room lights & electrical	2011	3,943	263	15	263		460	23
24	Electrical town square	2011	3,846	256	15	256		406	24
25	Elevator fire shield	2011	4,511	301	15	301		402	25
26	Fire Dampers	2011	19,756	1,317	15	1,317		1,780	26
27	Heating Bathrooms	2011	9,667	644	15	644		1,101	27
28	Kitchen Electrical	2011	6,295	420	15	420		778	28
29	Locker Room-carpentry, painting	2011	3,925	262	15	262		524	29
30	Piping Smoke Detectors	2011	4,105	274	15	274		365	30
31	Point of care electrical	2011	3,500	233	15	233		427	31
32	Pumps & Seals	2011	7,957	1,591	5	1,591		2,661	32
33	Restrooms -tiling	2011	4,535	302	15	302		518	33
34	TOTAL (lines 1 thru 33)		\$ 10,200,099	\$ 349,967		\$ 360,224	\$ 10,257	\$ 7,063,989	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 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 12D, Carried Forward		\$ 10,200,099	\$ 349,967		\$ 360,224	\$ 10,257	\$ 7,063,989	1
2	Roof repair-flashing, tiles, slate	2011	39,088	2,606	15	2,606		3,675	2
3	Windows attic	2011	2,572	171	15	171		221	3
4									4
5	Damper shield plates	2012	5,143	314	15	314		314	5
6	Replace drain pipe over activities	2012	5,890	360	15	360		360	6
7	Elevator repairs	2012	2,687	149	15	149		149	7
8	Replace fire dampers	2012	8,428	421	15	421		421	8
9	New Roof/Masonry-North Building	2012	73,890	3,040	15	3,040		3,040	9
10	Air/Heat Registers	2012	37,691	1,352	15	1,352		1,352	10
11	Roof repairs-West & North Buildings	2012	11,420	254	15	254		254	11
12	Ehhayst system-West Building	2012	63,021	1,401	15	1,401		1,401	12
13									13
14	To reconcile to the financial statements			3,886			(3,886)		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)		\$ 10,449,929	\$ 363,921		\$ 370,292	\$ 6,371	\$ 7,075,176	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	\$721,273	\$71,500	\$78,326	\$6,826	3-10	\$647,093	71
72	Current Year Purchases	195,774	25,617	25,617		3	25,617	72
73	Fully Depreciated Assets	104,131					104,131	73
74								74
75	TOTALS	\$1,021,178	\$97,117	\$103,943	\$6,826		\$776,841	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										77
78										78
79										79
80	TOTALS			\$ 34,300	\$	\$	\$		\$ 34,300	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)			\$	11,516,799
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	461,038
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	474,235
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	13,197
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	7,886,317

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	95,628	93
94			94
95		\$95,628	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:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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 \$

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?
16. Rental Amount for movable equipment: \$ 9,483 Description: Senior TV equipment lease
- ☐ YES☐ NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ N/A	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	39(3)	hrs	\$	2,696	\$ 194,104	\$	2,696	\$ 194,104	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		299	21,510		299	21,510	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,903	209,049	47	2,903	209,096	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				190,061		190,061	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			\$	5,898	\$ 424,663	\$ 190,108	5,898	\$ 614,771	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (157,586)	\$ (157,586)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 96,503)	2,155,961	2,155,961	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,370	34,370	6
7	Other Prepaid Expenses	14,065	14,065	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,046,810	\$ 2,046,810	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	239,902	239,902	12
13	Land	29,039	11,392	13
14	Buildings, at Historical Cost	3,174,978	3,227,006	14
15	Leasehold Improvements, at Historical Cost	8,379,641	7,222,923	15
16	Equipment, at Historical Cost	953,502	1,055,478	16
17	Accumulated Depreciation (book methods)	(8,008,177)	(7,886,317)	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 (spt See Sch 17A	1,979,306	1,979,306	22
23	Other(specify): Bond Costs -NET	77,976	77,976	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,826,167	\$ 5,927,666	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,872,977	\$ 7,974,476	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,229	\$ 184,229	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	304,222	304,222	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	270,295	270,295	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,915	6,915	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,733	3,733	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch. 17A	91,483	91,483	36
37	Accrued Expenses	212,767	212,767	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,073,644	\$ 1,073,644	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	310,000	310,000	39
40	Mortgage Payable			40
41	Bonds Payable	1,672,637	1,672,637	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,982,637	\$ 1,982,637	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,056,281	\$ 3,056,281	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,816,696	\$ 4,918,195	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,872,977	\$ 7,974,476	48

*(See instructions.)

Norwegian Lutheran Bethesda D/B/A Bethesda Home and Retirement Center
Provider #: 0012229
1/1/2012 to 12/31/2012

Schedule 17A

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

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Land - Sayre Avenue	1,883,678	1,883,678
Cemetery Plots	-	-
Strategic Planning-CIP (NET)	95,628	95,628
Total	<u>1,979,306</u>	<u>1,979,306</u>

Line 36 - Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Valic Retirement Plan 403B	3,575	3,575
Due to HRA	8,750	8,750
Deferred Rev. - AT&T Cell Tower Lease	79,158	79,158
Total	<u>91,483</u>	<u>91,483</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,142,644	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,142,644	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(325,948)	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)	\$ (325,948)	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)	\$ 5,816,696	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethesda Home & Retirement Center# 0012229Report Period Beginning: 01/01/2012Ending: 12/31/2012

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	\$ 6,961,481	1
2	Discounts and Allowances for all Levels	(2,211,064)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,750,417	3
	B. Ancillary Revenue		
4	Day Care	18,540	4
5	Other Care for Outpatients		5
6	Therapy	903,547	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 922,087	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	8,375	12
13	Barber and Beauty Care	15,685	13
14	Non-Patient Meals	7,021	14
15	Telephone, Television and Radio	17,096	15
16	Rental of Facility Space		16
17	Sale of Drugs	180,843	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,566	19
20	Radiology and X-Ray	2,595	20
21	Other Medical Services	243,093	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 488,274	23
	D. Non-Operating Revenue		
24	Contributions	537,825	24
25	Interest and Other Investment Income***	913	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 538,738	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	12,598	28
28a	<u>See Sch 19A</u>	214,323	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 226,921	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,926,437	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,397,077	31
32	Health Care	2,475,188	32
33	General Administration	1,757,407	33
	B. Capital Expense		
34	Ownership	587,764	34
	C. Ancillary Expense		
35	Special Cost Centers	864,740	35
36	Provider Participation Fee	170,209	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,252,385	40
41	Income before Income Taxes (line 30 minus line 40)**	(325,948)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (325,948)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 881,511	44
45	Private Pay - Net Inpatient Revenue	2,486,479	45
46	Medicare - Net Inpatient Revenue	784,607	46
47	Other-(specify) <u>Sheltered Care Revenue</u>	597,820	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,750,417	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.

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

Schedule 19A

XVII. INCOME STATEMENT

E. Other Revenue (specify):

Line 25	Description	Amount
	368.50 Dividend Income - JP Morgan	2
	368.80 Interest Income - JP Morgan	2,581
	369.00 Realized Gain/Loss - JP Morgan	(1,670)
		<u>913</u>

Line 28	Description	Amount
	315.00 MISCELLANEOUS INCOME	7,916
	316.10 JURY DUTY INCOME	34
	321.00 THRIFT SHOP INCOME	1,376
	329.00 GRANTS	2,400
	333.00 SPECIAL EVENTS	329
	343.00 VENDING INCOME	543
	Total	<u><u>12,598</u></u>

Line 28a	Description	Amount
	346.00 INCOME FROM JOINT VENTURE-LSN RRG	194,022
	347.00 INCOME FROM JOINT VENTURE HRA	20,301
	Total	<u><u>214,323</u></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	2,080	2,080	\$ 85,174	\$ 40.95	1
2	Assistant Director of Nursing	6,011	6,178	161,636	26.16	2
3	Registered Nurses	14,893	14,893	460,649	30.93	3
4	Licensed Practical Nurses	13,395	13,395	316,982	23.66	4
5	CNAs & Orderlies	71,323	71,323	836,863	11.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	56,331	27.08	9
10	Activity Assistants	6,531	6,531	66,438	10.17	10
11	Social Service Workers	4,202	4,035	86,134	21.35	11
12	Dietician					12
13	Food Service Supervisor	23,213	24,315	286,501	11.78	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,583	4,867	101,236	20.80	17
18	Housekeepers	14,456	14,539	149,883	10.31	18
19	Laundry	1,955	2,038	24,081	11.82	19
20	Administrator	2,080	2,080	129,808	62.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,586	11,773	286,911	24.37	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: <u>Marketing/HR</u>	4,160	4,160	131,929	31.71	32
33	Other(specify) <u>Development</u>	3,785	4,139	81,357	19.66	33
34	TOTAL (lines 1 - 33)	186,333	188,426	\$ 3,261,913 *	\$ 17.31	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	\$ 136,226	1(3)	35
36	Medical Director	Monthly	10,875	9(3)	36
37	Medical Records Consultant	Monthly	845	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,751	10(3)	39
40	Physical Therapy Consultant	Monthly	133	39(3)	40
41	Occupational Therapy Consultant	Monthly	45	39(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	882	11(3)	44
45	Social Service Consultant				45
46	Other(specify) <u>Chaplain</u>	Monthly	12,000	11(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 164,757		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	578	\$ 31,216	10(3)	50
51	Licensed Practical Nurses	1,668	63,487	10(3)	51
52	Certified Nurse Assistants/Aides	3,134	72,310	10(3)	52
53	TOTAL (lines 50 - 52)	5,380	\$ 167,013		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Bethesda Home & Retirement Center

0012229

Report Period Beginning:

01/01/2012

Page 21

Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Boggess	Administrator	0	\$ 129,808
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 129,808

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

Vendor/Payee	Type	Amount
See Sch 21A		\$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 132,977
Unemployment Compensation Insurance	1,510
FICA Taxes	240,248
Employee Health Insurance	301,601
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	37,295
Staff Bonus	35,500
Employee Relations	8,054
Employee Life Insurance	3,747
TOTAL (agree to Schedule V, line 22, col.8)	\$ 760,932

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	2,543
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	38 450
Miscellaneous Licenses & Fees	7,931
Miscellaneous Dues & Subscriptions	8,561
LSN & AAHSA Dues	2,870
Less Chamber of Commerce dues	
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,355

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,904
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,904

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Norwegian Lutheran Bethesda D/B/A Bethesda Home and Retirement Center
Provider #: 0012229
1/1/2012 to 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULES
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Wolf & Company	Accounting	37,285
McGladrey LLP	Accounting	15,645
Grant Thornton	Accounting	2,250
Equilibrium	Computer	16,909
Trustwave	Computer	998
CDW Government	Computer	771
Comcast Cable	Computer	865
Careworx Inc	Computer	166
Ivans, Inc.	Computer	2,748
American Express phone	Computer	523
Verizon Wireless	Computer	10,282
Techsmith Corp	Computer	30
CCC Technologies	Computer	10,202
Wescom Solutions, Inc.	Computer	19,350
OnShift	Computer	3,240
Unemployment Consultants	State U/C Consulting	2,000
Ziegler Capital Markets Group	Bond Trust Fees	680
Bank of New York	Bond Trust Fees	4,017
Fitch, Inc.	Bond Trust Fees	400
Frost Ruttenberg & Rothblatt	Accounting	1,591
Klein Dubb & Holleb	Legal	16,605
Ungaretti & Harris	Legal	8,547
Michael J. Goldstein & Assoc. Ltd.	Legal	236
MTS Consulting, LLC	Legal	380
Life Safety Resources	Legal	8,447
Kukarich	Legal	5,000
Lutheran Services	Legal	540
Unisource	Legal	1,500
Osefa Cruz Herendez	Legal	1,500

Total (agree to Schedule V, line 19, column 3) #####

Disallow non-allowable legal fees

(22,145)

Total (agree to Schedule V, line 19, column 8)

#####

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$2,870
- (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. \$ 31,634 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. \$ 170,209
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. \$ 7,021
- (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 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.