

		FOR BHF USE					

LL1

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: 0027086

Facility Name: Bethshan Association

Address: 12927 South Monitor Palos Heights 60463
Number City Zip Code

County: Cook

Telephone Number: (708) 371-0800 Fax # (708) 371-0833

HFS ID Number:

Date of Initial License for Current Owners: 7/16/82 BI / 2/7/86 BII

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(c)(3)

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven Goudzwaard Telephone Number: (708) 371-0800
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 7/1/11 to 6/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Steven J. Goudzwaard
(Title) Director of Finance

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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 Bethshan Association# 0027086 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 _____

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	45	Intermediate/DD	45	16,470	4
5		Sheltered Care (SC)			5
6	11	ICF/DD 16 or Less	0	1,951	6
7	56	TOTALS	45	18,421	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,904			15,904	11
12	SC					12
13	DD 16 OR LESS	1,858			1,858	13
14	TOTALS	17,762			17,762	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.42%

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

482 (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)
_____F. Does the facility maintain a daily midnight census? yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 7/16/82 / 2/7/86

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 _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 2012 Fiscal Year: 2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	131,848	10,761	7,330	149,939		149,939		149,939		1
2	Food Purchase		127,621		127,621		127,621		127,621		2
3	Housekeeping	62,952	15,935	5,211	84,098		84,098		84,098		3
4	Laundry	11,720	5,212		16,932		16,932		16,932		4
5	Heat and Other Utilities			38,915	38,915		38,915		38,915		5
6	Maintenance	45,536	15,363	33,528	94,427		94,427		94,427		6
7	Other (specify):* scavenger			5,227	5,227		5,227		5,227		7
8	TOTAL General Services	252,056	174,892	90,211	517,159		517,159		517,159		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,435,451	52,635	11,469	1,499,555	(35,312)	1,464,243		1,464,243		10
10a	Therapy	106,270	2,759	5,886	114,915		114,915		114,915		10a
11	Activities	62,615	10,246		72,861		72,861		72,861		11
12	Social Services	23,092			23,092		23,092		23,092		12
13	CNA Training		1,311		1,311	35,312	36,623		36,623		13
14	Program Transportation		21,924		21,924		21,924		21,924		14
15	Other (specify):* Program Director	84,312			84,312		84,312		84,312		15
16	TOTAL Health Care and Programs	1,711,740	88,875	25,755	1,826,370		1,826,370		1,826,370		16
	C. General Administration										
17	Administrative	98,911			98,911		98,911		98,911		17
18	Directors Fees										18
19	Professional Services			22,533	22,533		22,533		22,533		19
20	Dues, Fees, Subscriptions & Promotions			9,089	9,089		9,089		9,089		20
21	Clerical & General Office Expenses	39,849	6,916	12,326	59,091		59,091	(10,454)	48,637		21
22	Employee Benefits & Payroll Taxes			519,557	519,557		519,557	(1,596)	517,961		22
23	Inservice Training & Education			455	455		455		455		23
24	Travel and Seminar			4,304	4,304		4,304	(419)	3,885		24
25	Other Admin. Staff Transportation			1,184	1,184		1,184		1,184		25
26	Insurance-Prop.Liab.Malpractice			43,310	43,310		43,310		43,310		26
27	Other (specify):* miscellaneous		2,178		2,178		2,178	(1,200)	978		27
28	TOTAL General Administration	138,760	9,094	612,758	760,612		760,612	(13,669)	746,943		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,102,556	272,861	728,724	3,104,141		3,104,141	(13,669)	3,090,472		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.

Bethshan Association I & II
ID # 0027086 & 0030528
Schedule V, ISFR Reclassifications
FY2011

To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	\$	35,312.00
From:	Nursing & Medical Records	Sch V, Ln 10			

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			118,379	118,379		118,379		118,379			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,349	5,349		5,349	26,318	31,667			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			53,300	53,300		53,300		53,300			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			177,028	177,028		177,028	26,318	203,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,485	192,485		192,485		192,485			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			192,485	192,485		192,485		192,485			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,102,556	272,861	1,098,237	3,473,654		3,473,654	12,649	3,486,303			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.)

		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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	26,318	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,454)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,215)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 12,649		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 12,649		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Bethshan Association

ID# 0027086

Report Period Beginning: 7/1/11

Ending: 6/30/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non Direct Care Seminars	\$ (419)	24	1
2	Fundraising Employee Benefits	(1,596)	22	2
3	Miscellaneous	(1,200)	27	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				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	(3,215)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(10,454)	0	0	0	0	0	0	0	0	0	0	(10,454)	21
22	Employee Benefits & Payroll Taxes	(1,596)	0	0	0	0	0	0	0	0	0	0	(1,596)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(419)	0	0	0	0	0	0	0	0	0	0	(419)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,200)	0	0	0	0	0	0	0	0	0	0	(1,200)	27
28	TOTAL General Administration	(13,669)	0	0	0	0	0	0	0	0	0	0	(13,669)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,669)	0	0	0	0	0	0	0	0	0	0	(13,669)	29

Summary B

6/30/12

												SUMMARY
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)
Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
Interest	26,318	0	0	0	0	0	0	0	0	0	0	26,318 32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
TOTAL Ownership	26,318	0	0	0	0	0	0	0	0	0	0	26,318 37
Ancillary Expense												
E. Special Cost Centers												
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
Coffee and Gift Shops	0	0	0	0								

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
Bethshan Association	100%	Tibstra House	South Holland	Bethshan Foundation	Palos Heights	Charitable Corp

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								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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Brian Dobben, President	BOD						1
2	Ira Slagter, Vice President	BOD						2
3	Donald Poortenga, Treasurer	BOD						3
4	Kim Lagestee-Mulder, Secretary	BOD						4
5	Wayne Boss	BOD						5
6	Jori Brink	BOD						6
7	Judy Gill	BOD						7
8	Tom Lemmenes	BOD						8
9	Ann Payne	BOD						9
10	Julie Sather	BOD						10
11	Howard VanDyke	BOD						11
12	James VanKampen	BOD						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

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											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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES

X

NO

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

Name of Related Organization

Street Address

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	6	Maintenance	# beds	130	13	\$ 144,193	\$ 118,393	50	\$ 55,459	1
2	14	Program Transportation	# beds	130	13	40,984		50	15,763	2
3	17	Administration	# beds	130	13	257,168	257,168	50	98,911	3
4	19	Professional Services	# beds	130	13	39,195		50	15,075	4
5	20	Dues/Fees/Subscriptions	# beds	130	13	13,532		50	5,205	5
6	21	Clerical & General Office	# beds	130	13	130,842	103,607	50	50,324	6
7	22	Workers Comp	budgeted salaries	4,453,507	13	100,032		2,133,395	47,919	7
8	22	Other Employee Benefits	# beds	130	13	16,963		50	6,524	8
9	23	In Service Training	# beds	130	13	571		50	220	9
10	24	Seminars & Workshop	# beds	130	13	3,131		50	1,204	10
11	25	Staff Travel	# beds	130	13	2,391		50	920	11
12	26	Liability Insurance	# beds	130	13	33,500		50	12,885	12
13	27	Miscellaneous	# beds	130	13	4,541		50	1,747	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					\$ 787,043	\$ 479,168		\$ 312,156	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	Bess Tolsma		X	start-up capital		6/26/81	\$ 10,000	\$	on demand	0.1000	\$ 695	1	
2	various noteholders		X	start-up capital		various	121,200	101,200	on demand	0.0400	4,654	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 131,200	\$ 101,200			\$ 5,349	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 131,200	\$ 101,200			\$ 5,349	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Promissory Noteholders
BETHSHAN ASSOCIATION
PROMISSORY NOTE SCHEDULE
FOR FY 2012

NAME	SSN	NOTE #	AMOUNT	Dates Intere Int. Rate	
Donald R. Tiemens Living Trust Agreement dated July 21, 2010	344-30-6570	483	\$10,000.00	1-Aug-11	4%
				1-Feb-12	4%
Winnie Chilton	328-18-7085	487	\$10,000.00	1-Aug-11	4%
				1-Feb-12	4%
(redeemed 4/13/2012; 73 days)			(\$10,000.00)	13-Apr-12	4%
John B. & Linda L. Meyer Jt Ten WROS	322-32-8736	438	\$10,000.00	1-Sep-11	4%
				1-Mar-12	4%
Cornelius and Eldene Dykstra	347-24-4480	448	\$10,000.00	1-Sep-11	4%
				1-Mar-12	4%
David & Amy Tiemersma	335-70-8853	452	\$2,000.00	1-Sep-11	4%
				1-Mar-12	4%
Robert J or Charlotte Parrish	338-18-7986	453	\$10,000.00	1-Sep-11	4%
				1-Mar-12	4%
Lois J Ooms Living Trust	355-38-0051	455	\$5,000.00	1-Sep-11	4%
				1-Mar-12	4%
Herbert &/or Estelle Ooms Living Trust dated 10/17/92	326-18-3083	502	\$10,000.00	1-Sep-11	4%
				1-Mar-12	4%
Clarence or Eleanor or Laurie (Teggelaar) Ouwenga	344-30-6146	458-459	\$8,000.00	1-Sep-11	4%
				1-Mar-12	4%
Dexter and Laura Boersma	343-54-2991	461	\$5,000.00	1-Sep-11	4%
				1-Mar-12	4%
Jean DeYoung, Ttee of the William DeYoung Survivor's Trust dated 1/18/00	316-24-6520	503	\$10,000.00	1-Sep-11	4%
				1-Mar-12	4%
Helen M Stalman (note donated on 6/8/2012, plus 100 days interest of \$109.59)	339-22-3463	463	\$10,000.00	1-Sep-11	4%
				1-Mar-12	4%
Beverly Joyce Renz	349-34-4841	466	\$4,000.00	1-Oct-11	4%
				1-Apr-12	4%
Edith S. Hanneman, TTEE under the Edith S. Hanneman declaration of	343-16-3943	471&479	\$10,000.00	1-Oct-11	4%
				1-Apr-12	4%
Harriette VanBeveren or Aldena VanBeveren	354-14-8636	481	\$7,200.00	1-Oct-11	4%
				1-Apr-12	4%
Bess Tolsma or Betty Schurman or Mary Boerema (redeemed to Mary Boerema 2/9/12)	340-22-9646	251	\$10,000.00	1-Dec-11	10%
				9-Feb-12	10%
Bethshan I Notes			\$101,200.00		

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Bethshah Association

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0027086

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24602 & 8693

B. General Construction Type:

Exterior brick

Frame metal

Number of Stories 1

C. Does the Operating Entity?

BI(a) Own the Facility

(b) Rent from a Related Organization.

BI(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	none			\$	1
2					2
3	TOTALS			\$	3

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	45		1982	1982	\$ 1,116,585	\$ 15,634	20-40	\$ 15,634		\$ 958,813
5										
6										
7										
8										
	Improvement Type**									
9	Remodeling & Improvements BI				121,518	4,130	20-40	4,130		102,893
10	fixed equipment				46,021	1,982	10 - 40	1,982		40,927
11	Addition: PT, nursing, office, & maintenance			1993	385,632	9,641	40	9,641		183,175
12	Landscaping				18,201	694	20	694		17,289
13	Automated door			1999	12,958		10			12,958
14	Garage				7,000	73	15 - 20	73		6,857
15	site improvements BI				123,474	2,108	10 - 20	2,108		111,564
16	water & sewer improvements				22,009	734	30	734		21,549
17	Woodfold accordian folding partition			2000	2,720		10			2,720
18	Gas heater - Paul Supply BI			2001	2,593		10			2,593
19	Ceramic Tile - diningroom BI			2001	3,187		10			3,187
20	Flat roofs (4) BI			2002	26,100	1,740	15	1,740		19,130
21	Bathroom remodeling BI			2002	133,435	8,896	15	8,896		91,922
22	Rooms painted (4 pods) BI			2002	6,840	456	15	456		4,753
23	Ceramic tile - livingroom BI			2002	4,250	283	15	283		2,989
24	Briggs generator BI			2002	2,995		8			2,995
25	Smoking shelter BI			2002	3,972	180	10	180		3,972
26	Fire alarm upgrade BI			2003	9,969	997	10	997		9,852
27	Whirlpool room remodeling BI			2003	6,750	450	15	450		4,075
28	Roof - (BI garage)			2004	2,030	135	15	135		1,109
29	Roof - (BI-north)			2005	7,765	518	15	518		3,913
30	Bathroom remodeling BI			2006	8,860	886	10	886		5,615
31	Furnace & A/C - Pod 1 & 4			2006	13,086	1,636	8	1,636		10,235
32	Fire System BI			2006	1,759	176	10	176		1,060
33	Fire Doors (5) BII			2006		183	10	183		
34	Ceramic Tile Hallways BII			2006		331	10	331		
35	Whirlpool bath remodeling (Pod 4)			2007	8,600	573	15	573		3,377
36	Fire alarm CPU board BI			2007	1,745	175	10	175		981

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Lennox Condensor BI	2007	\$ 2,165	\$ 217	10	\$ 217	\$	\$ 1,094	37
38	Pergola	2007	2,000	200	10	200		1,178	38
39	Landscaping	2007	4,509	451	10	451		2,637	39
40	Lennox Elite HVAC BI	2008	14,650	977	15	977		4,838	40
41	Paint Kitchen BI	2008	3,900	390	10	390		1,604	41
42	Kitchen Stainless Wall Panels BI	2008	2,040	136	15	136		549	42
43	Bathroom remodeling & design (3) (BII)	2008		1,948	15	1,948			43
44	Automatic Door (BII)	2008		311	5	311			44
45	Driveway Seal Coat BI	2008	3,650		2			3,650	45
46	Rheem Water Heater	2009	5,917	591	10	591		1,595	46
47	Water Heater	2010	778	78	10	78		120	47
48	Sealcoating and Striping Parking Lot	2010	3,504	701	5	701		1,279	48
49	Building Alarm Panel	2011	860	57	15	57		75	49
50	Exterior Wood replacement	2012	4,825	422	10	422		422	50
51	Exterior Eaves & Trim	2012	4,550	355	10	355		356	51
52	Kitchen Door & Panic Hardware	2012	1,700	62	10	62		62	52
53	Metal Hall Door	2012	1,100	40	10	40		40	53
54	Lennox Air Conditioner	2012	2,990	52	15	52		52	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,159,192	\$ 59,599		\$ 59,599	\$	\$ 1,650,054	70

**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	\$152,761	\$19,490	\$19,490	\$		\$82,356	71
72	Current Year Purchases	51,132	3,863	3,863			3,863	72
73	Fully Depreciated Assets	575,213	3,633	3,633			575,213	73
74								74
75	TOTALS	\$779,106	\$26,986	\$26,986	\$		\$661,432	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	client transportation	vans	2003-2011	\$161,161	\$25,799	\$25,799	\$	5	\$117,115	76
77	Executive Director	Toyota Prius	2010	7,435	1,899	1,899		5	3,492	77
78	Maintenance	Ford superduty/Ford F150	2009/2011	19,341	4,096	4,096		5	7,656	78
79	maint/client transp.	Silverado/Minibus/lift van	1996-2005	disposed					disposed	79
80	TOTALS			\$187,937	\$31,794	\$31,794	\$		\$128,263	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)	\$3,126,23581
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$118,37982
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$118,37983**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,439,74985

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Elim Christian Services
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:	1976	16	7/1/01	\$ 53,300	3	3	3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 53,300			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$
- Description:
- (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					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning7/1/11

Ending4/30/12

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$ 0
13.	/2014	\$ 0
14.	/2015	\$ 0

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,311		1,311
3	Classroom Wages (a)		10,307		10,307
4	Clinical Wages (b)		20,797		20,797
5	In-House Trainer Wages (c)		4,208		4,208
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 36,623	\$	\$ 36,623
10	SUM OF line 9, col. 1 and 2 (e)	\$	36,623		

COMPLETED	
1. From this facility	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

(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		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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	\$ (2,032,268)	\$ 26,355	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,103,786	1,596,417	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,225	29,724	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (916,257)	\$ 1,652,496	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		744,175	13
14	Buildings, at Historical Cost	2,159,192	6,531,800	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	967,043	1,974,936	16
17	Accumulated Depreciation (book methods)	(2,439,749)	(4,544,794)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 686,486	\$ 4,706,117	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (229,771)	\$ 6,358,613	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 257,290	\$ 374,826	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	101,200	661,409	29
30	Accrued Salaries Payable	115,110	270,016	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,741	6,408	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,312	13,048	33
34	Deferred Compensation	657	1,609	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 478,310	\$ 1,327,316	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		613,550	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 613,550	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 478,310	\$ 1,940,866	46
47	TOTAL EQUITY(page 18, line 24)	\$ (708,081)	\$ 4,417,747	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (229,771)	\$ 6,358,613	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (678,505)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (678,505)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(408,432)	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) disposition of pooled company	284,204	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (124,228)	17
	B. Transfers (Itemize):		
18	Building repairs & improvements	15,165	18
19	Furnishings & Equipment	39,223	19
20	Vehicles	40,264	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 94,652	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (708,081)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethshan Association# 0027086Report Period Beginning: 7/1/11Ending: 6/30/12

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	\$ 2,904,813	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,904,813	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy		6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements	56,955	11	
12 Gift and Coffee Shop		12	
13 Barber and Beauty Care		13	
14 Non-Patient Meals		14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs		17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray		20	
21 Other Medical Services	880	21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,835	23	
D. Non-Operating Revenue			
24 Contributions	128,822	24	
25 Interest and Other Investment Income***	(26,318)	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 102,504	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 <u>miscellaneous</u>	70	28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 70	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,065,222	30	

	1	2	
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	517,159	31	
32 Health Care	1,826,370	32	
33 General Administration	760,612	33	
B. Capital Expense			
34 Ownership	177,028	34	
C. Ancillary Expense			
35 Special Cost Centers		35	
36 Provider Participation Fee	192,485	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,473,654	40	
41 Income before Income Taxes (line 30 minus line 40)**	(408,432)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (408,432)	43	

	1	2	
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 2,402,682	44	
45 Private Pay - Net Inpatient Revenue		45	
46 Medicare - Net Inpatient Revenue		46	
47 Other-(specify) <u>RR/SS/VA</u>	440,741	47	
48 Other-(specify) <u>client fees/other third party</u>	61,390	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,904,813	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.

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	1,846	2,107	\$ 77,202	\$ 36.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,745	8,442	205,948	24.40	3
4	Licensed Practical Nurses	3,474	3,951	86,254	21.83	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	3,059	3,515	106,270	30.23	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,826	2,098	36,692	17.49	9
10	Activity Assistants	1,703	1,938	25,923	13.38	10
11	Social Service Workers	563	616	23,092	37.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,005	2,245	39,042	17.39	14
15	Cook Helpers/Assistants	8,287	8,995	92,806	10.32	15
16	Dishwashers					16
17	Maintenance Workers	1,884	2,126	45,536	21.42	17
18	Housekeepers	3,759	4,282	62,952	14.70	18
19	Laundry	1,295	1,388	11,720	8.44	19
20	Administrator	562	718	47,178	65.71	20
21	Assistant Administrator					21
22	Other Administrative	1,148	1,321	51,733	39.16	22
23	Office Manager					23
24	Clerical	1,911	2,178	39,849	18.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,519	7,195	143,255	19.91	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	70,178	77,501	922,792	11.91	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Program Director	2,130	2,367	84,312	35.62	33
34	TOTAL (lines 1 - 33)	119,894	132,983	\$ 2,102,556 *	\$ 15.81	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	122	\$ 7,330	1-3	35
36	Medical Director	54	8,400	9-3	36
37	Medical Records Consultant	4	325	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	52	3,316	10-3	39
40	Physical Therapy Consultant	15	1,036	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	49	1,950	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	52	2,900	10a-3	45
46	Other(specify) Psychiatrist	23	6,238	10-3	46
47	Psychologist	1	300	10-3	47
48					48
49	TOTAL (lines 35 - 48)	372	\$ 31,795		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	32	1,290	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	32	\$ 1,290		53

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

** See instructions.

STATE OF ILLINOIS

0027086

Report Period Beginning:

7/1/11

Page 21

Ending: 6/30/12

Facility Name & ID Number

Bethshan Association

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		
Joseph Lanenga		Executive Director	0	\$ 47,178	Workers' Compensation Insurance		\$ 52,280	IDPH License Fee		\$		
					Unemployment Compensation Insurance		982	Advertising: Employee Recruitment		678		
					FICA Taxes		153,581	Health Care Worker Background Check		1,022		
					Employee Health Insurance		255,965	(Indicate # of checks performed 29)				
					Employee Meals			Patient Background Checks				
					Illinois Municipal Retirement Fund (IMRF)*			Employee Professional Fees/Dues		1,135		
					Pension		42,229	Sams Club/ATT/filing fees		192		
					Other Employee Benefits		12,924	IARF/Inst on Public Policy		6,062		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 47,178								
B. Administrative - Other									Less: Public Relations Expense		()	
Description				Amount					Non-allowable advertising		()	
Steven Goudzwaard, Director of Finance				\$ 28,981					Yellow page advertising		()	
Jean Voss, Director of Special Projects				22,752					TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,089	
					TOTAL (agree to Schedule V, line 22, col.8)			\$ 517,961				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 51,733	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
C. Professional Services					Description			Line #	Amount	Description		Amount
Vendor/Payee		Type		Amount	personal use of auto (Exec.Dir)				\$ 2,304	Out-of-State Travel		\$
Dreyer Ooms & VanDrunen		audit & accounting		\$ 13,418	personal use of auto (Maint.)				863			
ADP		payroll preparation		1,153						In-State Travel		162
Sandata Technologies		payroll preparation		633								
Open Systems		payroll consulting		620						Seminar Expense		3,723
Paycor		payroll preparation		5,920								
Wessels & Pautsch		legal services		141						Entertainment Expense		()
Informability		computer consultants		648						(agree to Sch. V, line 24, col. 8)		\$ 3,885
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 22,533	TOTAL			\$ 3,167				

* Attach copy of IMRF notifications

**See instructions.

BETHSHAN I & II
SCHEDULE OF STAFF TRAVEL
FY 2012

		<u>TRAVEL</u> <u>EXPENSE</u>	<u>SEMINARS</u> <u>COST</u>
	Staff intra-agency travel for meetings at central office, etc.		
<u>11-600-675 Allocation</u>			
9/30/2011	CMI Education Institute Psychopharmacology Tinley Park, IL Valerie Lynch, DON		189.00
9/12/2011	IBP How the Brain Forms New Habits Oak Brook, IL Laura Kirchhoff, Program Director Angela Klarin, RN	24.00	74.00 79.00
9/16/2011	ARC No More Meltdowns: Managing & Preventing Out-of-Control Behavior Alsip, IL Laura Kirchhoff, Program Director Susan Dennis, DSP Freda Hunt, DSP Kathy Konrath, QSP		145.00 116.00 116.00 116.00
10/17/2011	Safe Food Handlers Food Service Sanitation Orland Park, IL Sally VanHowe, House Manager Arneice Miller, Dietary		170.00 80.00
10/20/2011	Health Professions Institute Aging & Falls Orland Park, IL Nancy Switalski, RN		129.00
11/2/2011	CE International HFS 3745 (N-4-99)		

	Nutritional Approach to Treating Autism, ADHD, & Food Allergies		
	Oak Lawn, IL		
	Angela Klarin, RN		94.00
	JoFrances Jones		100.00
11/4-5/11	CIDDNA		
	11th Annual IL DD Nurses Conference		
	Bloomington, IL		
	Valerie Lynch, DON	89.00	100.00
	Doris Marshall, RN		110.00
11/7/2011	Healthcare Enrichment Institute		
	Nursing Documentation Law & Ethics		
	Oak Lawn, IL		
	Kelli Blakemore, RN		75.00
1/14-22/201	BNA		
	Train the Trainer		
	Palos Hills, IL		
	Valerie Lynch, DON		375.00
1/16/2012	UIC		
	iPad Apps for AAC and Visual Strategies		
	Chicago, IL		
	Beth Toeset, QSP		100.00
1/17/2012	Illiois Council on Long Term Care		
	No Contact, No Drug Behavior De-escalation		
	Oak Lawn, IL		
	Kathy Konrath, QSP	3.72	165.00
1/4/2012	ARC		
	10th Annual QSP Leadersip Conference		
	Alsip, IL		
	Amy Tiemersma, LCSW		68.21
	Frea Mars, Program Director		67.50
1/23/2012	Safe Food Handlers		
	Food Service Sanitation		
	Alsip, IL		
	Diana Roush, Dietary		170.00

2/1/2012	CCIT Portrait of Dementia: Helping People Live Well Palos Heights, IL Kathy Konrath, QSP	15.00
2/11/2012	TCC Dementia Seminar Palos Heights, IL Kathy Konrath, QSP	1.60
3/9/2012	IBP Listening to the Body: Understanding the Language of Stress-Related Symptoms Oak Brook, IL Kelli Blakemore, RN	79.00
5/14/2012	IBP Why We Worry: Understanding & Treating Anxiety Disorders Oak Brook, IL Katherina Konrath, QSP	22.94 74.00
5/17/2012	CMI Education Institute Psychopharmacology: What you need to know about Psychiatric Medications Oak Brook, IL Dawn VanGroningen, Assistant DC	20.64 79.99
6/7-9/2012	APTA Annual Conference Tampa, FL Teresa Walus, OT/PT	255.71
8/1/2012	Safe Food Handlers Food Service Sanitation Alsip, IL Kathy Rohan, Dietary	80.00
9/27/2011	ARC Bringing it all Together: Living with Autism Tinley Park, IL Laura Kirchhoff, Program Director Christine Konior, DON	56.07 121.12

Beth Toeset, QSP	162.00
Maria Quiroga, DSP	162.00

161.90	3,723.60	3,885.50
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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													
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?
If YES, give association name and amount.

no
- (3)

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

no
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

no
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

yes
5 years
- (6)

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

\$ 13,681 Line 10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

no
- (9)

Are you presently operating under a sublease agreement?

YES X NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 192,485
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

yes

- (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?
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.

no
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
n/a
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

no

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

no

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%

d.

Have vehicle usage logs been maintained?

no

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

no

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

yes
Dreyer, Ooms, & Van Drunen Ltd

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

n/a

Bethshan Association I & II
ID # 0027086 & 0030528
Schedule XX (12) Explanation of Salary Allocation
FY2012

Freya Mars (Ln 15-1)	Program Director Salary	\$ 21,440
(Ln 10-1)	QMRP & DSP Salary	\$ 8,174