

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 7/16/1982

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ 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: Steve 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 7/1/2024 to 6/30/2025 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) 12/10/2025 (Date)
(Type or Print Name) Steve 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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Ending: 6/30/2025

n/a

Date started 07/16/1982

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

Facility Name & ID Number

Bethshan Association

0027086

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	298,126	22,275	6,523	326,924		326,924		326,924			1
2	Food Purchase		207,144		207,144		207,144		207,144			2
3	Housekeeping	110,875	26,108	12,367	149,350		149,350		149,350			3
4	Laundry	17,783	984		18,767		18,767		18,767			4
5	Heat and Other Utilities			50,056	50,056		50,056		50,056			5
6	Maintenance	42,156	21,650	35,545	99,351		99,351		99,351			6
7	Other (specify):* Garbage services			5,993	5,993		5,993		5,993			7
8	TOTAL General Services	468,940	278,161	110,484	857,585		857,585		857,585			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,517,565	63,936	31,467	2,612,968		2,612,968		2,612,968			10
10a	Therapy	125,103	1,834	8,308	135,245		135,245		135,245			10a
11	Activities	106,198	36,682		142,880		142,880		142,880			11
12	Social Services	19,372		100	19,472		19,472		19,472			12
13	CNA Training											13
14	Program Transportation		10,482		10,482		10,482		10,482			14
15	Other (specify):* See Pg 24	151,158	18,060		169,218		169,218		169,218			15
16	TOTAL Health Care and Programs	2,919,396	130,994	39,875	3,090,265		3,090,265		3,090,265			16
	C. General Administration											
17	Administrative	110,216			110,216		110,216	(8,135)	102,081			17
18	Directors Fees											18
19	Professional Services			56,342	56,342		56,342	(37)	56,305			19
20	Dues, Fees, Subscriptions & Promotions			5,964	5,964		5,964		5,964			20
21	Clerical & General Office Expenses	118,331	7,603	10,130	136,064		136,064	(2,149)	133,915			21
22	Employee Benefits & Payroll Taxes			673,477	673,477		673,477	(1,999)	671,478			22
23	Inservice Training & Education			5,466	5,466		5,466		5,466			23
24	Travel and Seminar			572	572		572		572			24
25	Other Admin. Staff Transportation			536	536		536		536			25
26	Insurance-Prop.Liab.Malpractice			52,169	52,169		52,169		52,169			26
27	Other (specify):* See Pg 24		895		895		895		895			27
28	TOTAL General Administration	228,547	8,498	804,656	1,041,701		1,041,701	(12,320)	1,029,381			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,616,883	417,653	955,015	4,989,551		4,989,551	(12,320)	4,977,231			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
ID # 0027086
Schedule V supplemental information
FY2025

<u>Description of expense</u>	<u>amount</u>
-------------------------------	---------------

Ln 15 - Other

col 1: Program Director/Administrator wages	\$ 151,158
col 2: DSP Training supplies	\$ 18,060

Ln 27 - Other

Board/Association meeting-decor and food	\$ 504
consultants/vendors- Christmas gifts	294
flowers for funerals	80
credit card-late fee-Home Depot	<u>17</u>
Ln 27 Total	\$ 895

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			128,876	128,876		128,876		128,876			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(43,898)	(43,898)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			128,876	128,876		128,876	(43,898)	84,978			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			238,904	238,904		238,904		238,904			42
43	Other (specify):* Uncoll. Fees for svc			3,851	3,851		3,851		3,851			43
44	TOTAL Special Cost Centers			242,755	242,755		242,755		242,755			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,616,883	417,653	1,326,646	5,361,182		5,361,182	(56,218)	5,304,964			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(43,898)	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	(8,135)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,185)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,218)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (56,218)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	fundraising payroll preparation	(37)	19	3
4	fundraising clerical wages	(2,149)	21	4
5	fundraising wages Workers Comp	(147)	22	5
6	fundraising wages 403b contribution	(470)	22	6
7	fundraising wages payroll taxes	(929)	22	7
8	fundraising wages health insurance	(453)	22	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,185)		49

Summary A

6/30/2025

[illegible]

Summary B

Facility Name & ID Number

0027086

7/1/2024

6/30/2025

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

[illegible]

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
see Ownership-1 for listing of Board members						

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 (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	no payments to "owners" or board members								\$		1
2	no family member employed or compensated										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

Ending: 5/30/2025

(708-371-0833

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	6	Maintenance	Work Orders	1,236	16	\$ 186,012	\$ 181,960	262	\$ 39,430	1
2	15	Director of Programs	# beds	135	16	160,440	160,440	43	51,103	2
3	17	Administration	# beds	135	16	346,023	346,023	43	110,215	3
4	19	Professional Services	# beds	135	16	149,550		43	47,634	4
5	20	Dues/Fees/Subscriptions	# beds	135	16	5,017		43	1,598	5
6	21	Clerical & General Office	# beds	135	16	390,674	362,553	43	124,437	6
7	22	Workers Comp	budgeted salaries	9,144,707	16	108,276		3,571,890	42,292	7
8	22	Other Employee Benefits	# beds	135	16	36,229		43	11,540	8
9	23	In Service Training	# beds	135	16	359		43	114	9
10	24	Seminars and Workshops	# beds	135	16	100		43	32	10
11	25	Staff Travel	# beds	135	16	1,682		43	536	11
12	26	Liability Insurance	# beds	135	16	98,043		43	31,229	12
13	27	Miscellaneous	# beds	135	16	2,658		43	847	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					\$ 1,485,063	\$ 1,050,976		\$ 461,007	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	none						\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	none											6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10	none											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

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

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethshan Association COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027086

CONTACT PERSON REGARDING THIS REPORT Steve Goudzwaard

TELEPHONE 708-371-0800 FAX #: 708-371-0833

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>tax exempt</u>		\$	\$
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 exempt 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

24,602

B. General Construction Type:

Exterior

brick

Frame

metal

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

yes

H. Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

no

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	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	\$ 1,083,136	\$	20-40	\$	\$	\$ 1,083,136
5										
6										
7										
8										
	Improvement Type**									
9										
10	Prior building and Improvement Costs 1983-2021				1,311,534	35,135	20-40	35,135		1,057,299
11	lift station pump			2022	4,944	275	3	275		4,944
12	HVAC-Kitchen			2022	7,791	519	15	519		1,948
13	Regrigerator, walk-in cooler			2022	23,460	1,564	15	1,564		5,865
14	tuckpoint brick above dining room			2022	9,800	980	10	980		3,512
15	plumbing bypass, mixing valve			2022	4,025	402	10	402		1,275
16	paint, front lounge, dining, pods			2022	10,200	1,020	10	1,020		3,145
17	Landscaping, complete replacement			2022	62,950	3,148	20	3,148		11,279
18	Lawn irrigation system			2022	27,480	2,748	10	2,748		9,847
19	Signage			2022	3,200	320	10	320		987
20	gutters, fascia-whole building-aluminum			2023	21,000	1,400	15	1,400		3,617
21	shower-widen & retile-pod 4 rm 19&20			2023	8,900	593	15	593		1,533
22	HVAC-new system- Nursing/Respite			2023	10,090	673	15	673		1,401
23	Bathroom floor tile, vanity, toilet, lighting-bsmnt			2023	6,800	453	15	453		982
24	Fire Sprinkler inerting kit			2024	4,300	1,434	3	1,434		2,269
25	Counter top-Aide station			2024	2,600	173	15	173		231
26	Aide station electrical re-routing/remodeling			2024	8,600	573	15	573		717
27	Fire control-Ansul system electrical upgrade-kitchen			2024	20,361	1,358	15	1,358		1,697
28	HVAC system-American Standard			2024	10,425	695	15	695		753
29	Cabinetry-Aide Station			2024	4,459	297	15	297		396
30	Siding, Soffit, Fascia replacement			2024	10,325	688	15	688		688
31	Gazebo-shingle roof			2024	3,550	237	15	237		355
32	sealcoating parking lot			2024	8,154	4,254	2	4,254		7,799
33	Lighting on Drive & Sign			2025	7,850	98	20	98		98
34	Cabinetry-Training Center			2025	2,373	145	15	145		145
35	Cabinetry-Tall-Training Center			2025	1,688	103	15	103		103
36	Countertop, training center (2)			2025	1,808	110	15	110		110

*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		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	HVAC-Tranc-Pod 2	2025	\$ 12,641	\$ 421	15	\$ 421	\$	\$ 421	37
38	Roof-pod roofs/shingled	2025	66,985	1,396	20	1,396		1,396	38
39	Roof-flat roof entire bldg	2025	104,875	2,185	20	2,185		2,185	39
40	door plates SS-pod 2 (12)	2025	4,777	133	15	133		133	40
41	Wall guard, rails & caps (pod 2 lounge)	2025	9,418	157	20	157		157	41
42	Wall covering panels (pod 2 lounge)	2025	5,499	92	20	92		92	42
43	Wall guard, rails (dining room)	2025	9,547	40	20	40		40	43
44	Garden, Sensory w/ concrete posts	2025	4,440		20				44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									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)		\$ 2,899,986	\$ 63,819		\$ 63,819	\$	\$ 2,210,555	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	\$290,201	\$36,183	\$36,183	\$		\$180,398	71
72	Current Year Purchases	90,959	2,876	2,876			2,876	72
73	Fully Depreciated Assets	462,638	723	723			462,638	73
74								74
75	TOTALS	\$843,798	\$39,782	\$39,782	\$		\$645,912	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	resident outings	FordVans 2009-2020	2010-2020	\$141,492	\$7,179	\$7,179	\$		\$125,940	76
77	resident outings	18 Odyssey, '24 Sienna	2018 & 2024	98,201	6,678	6,678			38,659	77
78	Maintenance	Chevy superduty 2021&2022	2021 & 2022	17,869	3,574	3,574			11,814	78
79	Prog Director	Honda CRV & Civic	2021 & 2023	39,221	7,844	7,844			27,353	79
80	TOTALS			\$296,783	\$25,275	\$25,275	\$		\$203,766	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,040,567	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$128,876	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$128,876	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,060,233	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Automatic sliding door	\$9,999	92
93	Wall coverings	13,381	93
94			94
95		\$23,380	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: none
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ 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	none		\$	\$	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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

CNAs are not required for ICF services. DSPs are trained

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

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

12345678										
	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
	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	\$ (5,633,231)	\$ 3,731,051	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	333,789	1,121,814	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,824	31,998	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>accrued interest receivable</u>		2,867	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (5,287,618)	\$ 4,887,730	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		9,976,953	12
13	Land		1,134,175	13
14	Buildings, at Historical Cost	2,899,986	9,603,041	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,140,581	2,542,104	16
17	Accumulated Depreciation (book methods)	(3,060,233)	(6,894,251)	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): <u>deposit on assets purchased</u>	23,380	42,559	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,003,714	\$ 16,404,581	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (4,283,904)	\$ 21,292,311	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,447	\$ 20,826	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,052	576,602	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,046	18,441	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	1,659	4,844	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Day Program fees payable</u>	71,535	99,333	36
37	<u>SSI/VA recoupment payable</u>	60	210	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 292,799	\$ 720,256	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 292,799	\$ 720,256	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,576,703)	\$ 20,572,055	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (4,283,904)	\$ 21,292,311	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,674,926)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,674,926)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(907,646)	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)	\$ (907,646)	17
	B. Transfers (Itemize):		
18	cabinets-basement training room-transferred from Bldg fund	2,373	18
19	counter top-training cabinets-transferred from Bldg fund	1,808	19
20	Cabinet, tall-training room-transferred from Bldg fund	1,688	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 5,869	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,576,703)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,217,491	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,217,491	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	35,684	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,684	23
	D. Non-Operating Revenue		
24	Contributions	9,677	24
25	Interest and Other Investment Income***	43,898	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,575	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain/loss on asset disposal-insurance claim proceeds</u>	146,786	28
28a		0	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 146,786	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,453,536	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	857,585	31
32	Health Care	3,090,265	32
33	General Administration	1,041,701	33
	B. Capital Expense		
34	Ownership	128,876	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	238,904	36
	D. Other Expenses (specify):		
37	<u>Uncollectable Fees for Services</u>	3,851	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,361,182	40
41	Income before Income Taxes (line 30 minus line 40)**	(907,646)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (907,646)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,470,913.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) <u>Social Security benefits - patient credits</u>	675,730.00	50
51	Other-(specify) <u>VA benefit - patient credits</u>	13,250.00	51
52	Other-(specify) <u>Payments from Hospice for residential services</u>	57,598.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,217,491	56

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	905	1,040	\$ 56,109	\$ 53.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,695	6,210	244,989	39.45	3
4	Licensed Practical Nurses	6,712	7,287	262,752	36.06	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	2,219	2,555	125,103	48.96	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	2,088	61,599	29.50	9
10	Activity Assistants	1,727	1,891	44,599	23.58	10
11	Social Service Workers	350	386	19,372	50.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,496	2,732	99,545	36.44	14
15	Cook Helpers/Assistants	9,021	9,589	198,581	20.71	15
16	Dishwashers					16
17	Maintenance Workers	1,324	1,449	42,156	29.09	17
18	Housekeepers	4,144	4,645	110,875	23.87	18
19	Laundry	1,160	1,195	17,783	14.88	19
20	Administrator	585	661	54,112	81.86	20
21	Assistant Administrator					21
22	Other Administrative	650	709	56,104	79.13	22
23	Office Manager					23
24	Clerical	3,580	3,983	118,331	29.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	7,985	8,530	229,718	26.93	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	67,347	72,952	1,723,997	23.63	30
31	Medical Records					31
32	Other Health C: Prgm director	2,289	2,689	151,158	56.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,997	130,591	\$ 3,616,883 *	\$ 27.70	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	107	\$ 6,523	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	4,800	10-3	39
40	Physical Therapy Consultant	4	476	10a-3	40
41	Occupational Therapy Consultant	10	2,912	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	41	4,920	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	2	100	12-3	45
46	Other(specify) psychiatrist	9	1,478	10-3	46
47	Medicine Administration		3,189	10-3	47
48					48
49	TOTAL (lines 35 - 48)	221	\$ 24,398		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				51
52	Certified Nurse Assistants/Aides	1,080	22,000	10-3	52
53	TOTAL (lines 50 - 52)	1,080	\$ 22,000		53

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

** See instructions.

Facility Name & ID Number		Bethshan Association		STATE OF ILLINOIS		Page 21		
				# 0027086		Report Period Beginning: 7/1/2024		
						Ending: 6/30/2025		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries		Ownership		D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount	
Julie Sather	Executive Director	0	\$ 54,112	Workers' Compensation Insurance	\$ 42,145	IDPH License Fee	\$	
Steve Goudzwaard	Finance Director	0	51,880	Unemployment Compensation Insurance		Advertising: Employee Recruitment	2,520	
Joseph Lanenga	Exec Director Emeritus	0	4,224	FICA Taxes	266,051	Health Care Worker Background Check	2,793	
				Employee Health Insurance	273,449	(Indicate # of checks performed 31)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)		
				403b contributions - employer	64,099	Employee professional fees, notary fees	472	
				Employee t-shirts	1,594	AG990, SOS, NFP filing fees	36	
				Employee physicals and vaccines	11,151	CLIA fees, CPI membership	143	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee awards, food, events, inservice gifts, etc	10,995			
(List each licensed administrator separately.)			\$ 110,216	Staff wellness challenge	1,496	Less: Public Relations Expense	()	
B. Administrative - Other				other misc employee benefits	498	PAC and Lobbying payments	()	
Description			Amount			All non-allowable advertising	()	
			\$					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 671,478	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,964	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services				Personal Use of Auto (Program Dir	14 & 30	\$ 2,726	Out-of-State Travel	\$
Vendor/Payee	Type		Amount	Personal Use of Auto (Maintenance)	14 & 30	3,205		
CapinCrouse	Audit and Accounting		\$ 16,679	Personal Use of Auto (Dir of Finance	25 & 30	2,606		
Paycom	Payroll Services		15,227					
Don Moss/Ahead of our Time	Information Svs Provider		1,306					
Informability	IT System Services		2,361				In-State Travel	
Mane Ideas	Website Design		239					
Open Systems, Sumac license	Accounting Software Maint		2,765					
Constant Contact	email Service Subscription		70					
Jackson Lewis PC	403b Legal Services		3,641				Seminar Expense	572
Hinshaw & Culvertson LLP	Legal Services		7,950					
Jensen & Halstead LTD	Interior Decorator		2,482					
Pretzel & Stouffer, Chartered	Legal Services		3,566					
Yearli	1099 filing service		56				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$ 8,537	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 56,342			TOTAL	\$ 572	
				* Attach copy of IMRF notifications		**See instructions.		

Bethshan Association I
ID # 0027086
Schedule XIX - C, Professional Services
Legal Fee Disclosure
FY2025

\$ 261 Pretzel & Stouffer		ID# 1022-084771		
Invoice Date	Description of Service	Amount (Allowable)	Amount (non-allowable)	
3/17/2025	Reed v. Bethshan - various emails, phone discussion regarding potential next steps and Illinois laws relative to use of records	\$ 261	see note	
\$ 3,305 Pretzel & Stouffer		ID# 369-085668		
Invoice Date	Description of Service	Amount (Allowable)	Amount (non-allowable)	
5/7/2025	L Washington v. Bethshan - review initial complaint, review EEOC charge, review documents and witness statements, initiate settlement negotiations. Various emails, phone discussions, reports.	\$ 1,433	\$ -	-
6/30/2025	L Washington v. Bethshan - review initial complaint, review EEOC charge, review documents and witness statements, initiate settlement negotiations. Various emails, phone discussions, reports.	\$ 1,872	\$ -	-
Total costs of legal defense - Pretzel & Stouffer		\$ 3,566	see note	

\$ 7,583 Hinshaw & Culbertson LLP		ID# 1082262		
Invoice Date	Description of Service	Amount (Allowable)	Amount (non-allowable)	
2/28/2025	Karabatsos v Bethshan - review and analysis of notice, phone communications regarding hearings. Phone conferences with Legal Aid (re: Ombudsmen), client. Draft motions for hearing, prepare statement of facts, arguments regarding involuntary discharge or transfer.	\$ 3,930	\$ -	-
3/31/2025	Karabatsos v Bethshan - reviewed case, orders from Public Health, draft summary judgement motion, review case law, draft argument that Bethshan is incapable of meeting Complainant's medical and welfare needs. Analyze medical records, phone communications, hearing preparation and attendance.	\$ 1,394	\$ -	-
4/30/2025	Karabatsos v Bethshan - review, analysis of records, drafting arguments for hearing and motion for summary judgement.	\$ 1,590	\$ -	-
5/31/2025	Karabatsos v Bethshan - Review, analysis of IDPH notice, draft communications, attending hearing, communicate with administrative law judge.	\$ 670	\$ -	-
6/24/2025	Karabatsos v Bethshan - Attend prehearing conference, attend IDPH hearing.	\$ 367	\$ -	-
Total costs of legal defense - Hinshaw & Culbertson LLP		\$ 7,950	see note	

\$ 11,432 Jackson Lewis PC		ID# 665371		
Invoice Date	Description of Service	Amount (Allowable)	Amount (non-allowable)	
4/8/2025	403b Audit Advice and Counsel; Analyzing Auditor's comments, research Form 5500, review, communications and strategies, preparing board resolutions for plan document changes for the 403b plans.	\$ 922	\$ -	-
5/6/2025	Finalize resolutions, reviewing documents, respond to emails, questions regarding various 403b plan issues and amendments.	\$ 819	\$ -	-
6/10/2025	Research and prepare summary of ACP testing rules, HCE determination, draft plan amendment for eligibility, phone calls, review plan amendments, finalize plan amendments and employee notice	\$ 1,900	\$ -	-
Total costs of legal fees - Jackson Lewis PC (as allocated to Bethshan I)		\$ 3,641	see note	

note: After reading the ISFR instructions, I am believe all costs are allowable. I didn't find any instructions that disallowed these specific type of payments. The charges for legal services relate to defending Bethshan against allegations made by employees and a guardian of a resident. There are also services related to the administration of Bethshan's 403b plan of which all employees are eligible to participate.

XX. GENERAL INFORMATION:

- (1)

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

no
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

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

\$ 43,727 Line 10-2
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 238,904

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ n/a

Has any meal income been offset against related costs? Indicate the amount. \$ n/a
- (12)

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. \$

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?

no

Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (13)

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

Firm Name: CapinCrouse

yes
- (14)

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

yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

yes

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