

		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: 0035196

Facility Name: Tibstra House

Address: 271 E 161st Street South Holland 60473

NumberCityZip Code

County: Cook

Telephone Number: 708-596-4442 Fax # 708-596-4486

HFS ID Number:

Date of Initial License for Current Owners: 1/24/1990

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:

Name: Steve GoudzwaardTelephone Number: 708-371-0800Email 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)		(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

Facility Name & ID Number

Tibstra House

#

0035196

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	5,301							5,301	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,301							5,301	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

90.77%

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

455

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census?

yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

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

YES

NO

X

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

Date started

1/24/1990

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

YES

Date

NO

X

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

YES

NO

X

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

2025

Fiscal Year:

2025

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

Facility Name & ID Number Tibstra House # 0035196 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	44,358	5,237	1,571	51,166		51,166		51,166			1
2	Food Purchase		55,138		55,138		55,138		55,138			2
3	Housekeeping	51,893	3,570	3,333	58,796		58,796		58,796			3
4	Laundry		878		878		878		878			4
5	Heat and Other Utilities			11,478	11,478		11,478		11,478			5
6	Maintenance	16,783	4,465	11,588	32,836		32,836		32,836			6
7	Other (specify):* Garbage services			2,113	2,113		2,113		2,113			7
8	TOTAL General Services	113,034	69,288	30,083	212,405		212,405		212,405			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	571,137	7,449	1,536	580,122		580,122		580,122			10
10a	Therapy	5,888		358	6,246		6,246		6,246			10a
11	Activities	57,823	4,638		62,461		62,461		62,461			11
12	Social Services	2,902			2,902		2,902		2,902			12
13	CNA Training											13
14	Program Transportation			6,062	6,062		6,062		6,062			14
15	Other (specify):* Admin & Dir of Prgm	92,804			92,804		92,804		92,804			15
16	TOTAL Health Care and Programs	730,554	12,087	7,956	750,597		750,597		750,597			16
	C. General Administration											
17	Administrative	41,030			41,030		41,030	(3,027)	38,003			17
18	Directors Fees											18
19	Professional Services			16,005	16,005		16,005	(14)	15,991			19
20	Dues, Fees, Subscriptions & Promotions			2,400	2,400		2,400		2,400			20
21	Clerical & General Office Expenses	42,968	2,664	4,920	50,552		50,552	(800)	49,752			21
22	Employee Benefits & Payroll Taxes			196,798	196,798		196,798	(596)	196,202			22
23	Inservice Training & Education			844	844		844		844			23
24	Travel and Seminar			212	212		212		212			24
25	Other Admin. Staff Transportation			199	199		199		199			25
26	Insurance-Prop.Liab.Malpractice			18,483	18,483		18,483		18,483			26
27	Other (specify):* miscellaneous		448		448		448		448			27
28	TOTAL General Administration	83,998	3,112	239,861	326,971		326,971	(4,437)	322,534			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	927,586	84,487	277,900	1,289,973		1,289,973	(4,437)	1,285,536			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			42,134	42,134		42,134		42,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			42,134	42,134		42,134		42,134			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			72,056	72,056		72,056		72,056			42
43	Other (specify):* Uncoll. Fees for svc			465	465		465		465			43
44	TOTAL Special Cost Centers			72,521	72,521		72,521		72,521			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	927,586	84,487	392,555	1,404,628		1,404,628	(4,437)	1,400,191			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				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	(3,027)	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	(1,410)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,437)		\$	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))	\$ (4,437)		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 paryoll preparation	(14)	19	3
4	fundraising clerical wages	(800)	21	4
5	fundraising wages Workers Comp	(36)	22	5
6	fundraising wages 403b contribution	(175)	22	6
7	fundraising wages payroll taxes	(231)	22	7
8	fundraising wages health insurance	(154)	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	(1,410)		49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[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	Bethshan Association I	Palos Heights	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 payment 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

Facility Name & ID Number Tibstra House # 0035196 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Bethshan Association
Street Address 12927 S Monitor Ave
City / State / Zip Code Palos Heights, IL 60463
Phone Number (708-371-0800
Fax Number (708-371-0833

	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	Work Orders	1,236	16	\$ 186,012	\$ 181,960	114	\$ 17,156	1
2	15	Director of Programs	# beds	135	16	160,440	160,440	16	19,015	2
3	17	Administration	# beds	135	16	346,023	346,023	16	41,010	3
4	19	Professional Services	# beds	135	16	149,550		16	17,724	4
5	20	Dues/Fees/Subscriptions	# beds	135	16	5,017		16	595	5
6	21	Clerical & General Office	# beds	135	16	390,674	362,553	16	46,302	6
7	22	Workers Comp	budgeted salaries	9,144,707	16	108,276		886,904	10,501	7
8	22	Other Employee Benefits	# beds	135	16	36,229		16	4,294	8
9	23	In Service Training	# beds	135	16	359		16	43	9
10	24	Seminars and Workshops	# beds	135	16	100		16	12	10
11	25	Staff Travel	# beds	135	16	1,682		16	199	11
12	26	Liability Insurance	# beds	135	16	98,043		16	11,620	12
13	27	Miscellaneous	# beds	135	16	2,658		16	315	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		\$ 168,786	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													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

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

FACILITY IDPH LICENSE NUMBER 0035196

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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: 2,985 B. General Construction Type: Exterior brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [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).
none

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 X 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 [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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	16-bed ICF	18,000		1989		\$ 25,000	
2							
3	TOTALS	18,000				\$ 25,000	

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	16		1990	1990	\$408,781	\$10,260	40	\$10,260		\$362,612
5										
6										
7										
8										
	Improvement Type**									
9										
10	Prior building and Improvement Costs 1990-2021				217,777	9,855	10 to 40	9,855		183,392
11	Roof - new with tearoff			2023	26,693	1,334	10	1,334		3,448
12	Generator-Generac 30kw whole house			2023	12,197	1,220	20	1,220		2,948
13	Siding, Soffit, fascia, gutters for garage			2023	10,150	677	10	677		1,748
14	sidewalk - East exit			2023	1,900	127	15	127		380
15	Fire Alarm system-whole building			2024	25,168	1,678	15	1,678		2,517
16	Landscaping-whole perimeter			2024	25,725	1,715	15	1,715		2,715
17	Door, Front + hardware			2025	3,600	15	20	15		15
18	no improvements in 2021 or 2022									
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									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)		\$ 731,991	\$ 26,881		\$ 26,881	\$	\$ 559,775	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	\$ 31,394	\$ 3,550	\$ 3,550	\$	5-10yr	\$ 19,704	71
72	Current Year Purchases	16,422	2,413	2,413		5-10yr	2,413	72
73	Fully Depreciated Assets	78,751	151	151		5-10yr	78,751	73
74								74
75	TOTALS	\$ 126,567	\$ 6,114	\$ 6,114	\$		\$ 100,868	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	Ford Starcraft, 2016	2017	\$ 46,626	\$	\$	\$	5	\$ 46,626	76
77	resident outings	Honda Odyssey 2023	2023	35,407	7,081	7,081		5	13,573	77
78	maintenance	Chevy superduty 2021&2022	2021 & 2022	7,162	1,433	1,433			4,773	78
79	program director	Honda Civic 2023	2023	3,126	625	625			1,250	79
80	TOTALS			\$ 92,321	\$ 9,139	\$ 9,139	\$		\$ 66,222	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)	\$ 975,879	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,134	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,134	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)	\$ 726,865	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	Bathroom remodelling	\$ 19,179	92
93			93
94			94
95		\$ 19,179	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.

YESNO

		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:

YESNO

Terms:

*

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

15. Is Movable equipment rental included in building rental?

YESNO
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	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	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.)

	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	\$ 52,738	\$ 3,731,051	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,243	1,121,814	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	834	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)	\$ 149,815	\$ 4,887,730	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		9,976,953	12
13	Land	25,000	1,134,175	13
14	Buildings, at Historical Cost	731,991	9,603,041	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	218,888	2,542,104	16
17	Accumulated Depreciation (book methods)	(726,865)	(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>	19,179	42,559	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 268,193	\$ 16,404,581	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 418,008	\$ 21,292,311	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,150	\$ 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	66,676	576,602	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,798	18,441	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	462	4,844	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Day Program fees payable</u>	27,798	99,333	36
37	<u>SSI/VA recoupment payable</u>	150	210	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 98,034	\$ 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)	\$ 98,034	\$ 720,256	46
47	TOTAL EQUITY(page 18, line 24)	\$ 319,974	\$ 20,572,055	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 418,008	\$ 21,292,311	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 481,519	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 481,519	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(161,545)	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)	\$ (161,545)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 319,974	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Tibstra House

0035196

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	\$ 1,243,083	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,243,083	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,243,083	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	212,405	31
32	Health Care	750,597	32
33	General Administration	326,971	33
	B. Capital Expense		
34	Ownership	42,134	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	72,056	36
	D. Other Expenses (specify):		
37	<u>Uncollectable Fees for Services</u>	465	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,404,628	40
41	Income before Income Taxes (line 30 minus line 40)**	(161,545)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (161,545)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,067,399.42	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>	172,834.00	50
51	Other-(specify) <u>VA benefit - patient credits</u>	2,850.00	51
52	Other-(specify)		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)	\$ 1,243,083	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	138	159	\$ 8,574	\$ 53.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	984	1,260	53,810	42.71	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	104	120	5,888	49.07	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,103	2,275	57,823	25.42	9
10	Activity Assistants					10
11	Social Service Workers	52	58	2,902	50.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,813	1,955	44,358	22.69	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	488	537	16,783	31.25	17
18	Housekeepers	1,754	2,030	51,893	25.56	18
19	Laundry					19
20	Administrator	218	246	20,148	81.90	20
21	Assistant Administrator					21
22	Other Administrative	242	264	20,882	79.10	22
23	Office Manager					23
24	Clerical	1,291	1,433	42,968	29.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	2,114	2,368	81,666	34.49	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	15,830	17,492	427,087	24.42	30
31	Medical Records					31
32	Other Health C: Admin/Dir of Prgr	1,680	1,915	92,804	48.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	28,811	32,112	\$ 927,586 *	\$ 28.89	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	26	\$ 1,571	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	0	35	10a-3	40
41	Occupational Therapy Consultant	0	83	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	240	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) psychiatrist	3	516	10-3	46
47	Medicine Administration		1,020	10-3	47
48					48
49	TOTAL (lines 35 - 48)	31	\$ 3,465		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Tibstra House

0035196Report Period Beginning: 7/1/2024Ending: 6/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Julie Sather

Executive Director

0

\$ 20,148

Steve Goudzwaard

Finance Director

0

19,316

Joe Lanenga

Exec Director Emeritus

0

1,566

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 41,030

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

CapinCrouse

Audit and Accounting

\$ 6,321

Paycom

Payroll Services

5,665

Don Moss/Ahead of our Time

Information Svs Provider

486

Informability

IT System Services

1,013

Mane Ideas

Website Design

89

Open Systems, Sumac license

Accounting Software Maint

1,029

Constant Contact

email Service Subscription

26

Jackson Lewis PC

403b Legal Services

1,355

Yearli

1099 filing service

21

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 16,005

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 10,467

Unemployment Compensation Insurance

FICA Taxes

67,342

Employee Health Insurance

92,712

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

403b contributions - employer

19,014

Employee t-shirts

586

Employee physicals and vaccines

1,905

Employee awards, meals, events, inservice gifts, etc

3,619

Staff wellness challenge

557

TOTAL (agree to Schedule V, line 22, col.8)

\$ 196,202

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

Description

Line #

Amount

Personal Use of Auto (Program Dir

14 & 30

\$ 1,011

Personal Use of Auto (Maintenance)

14 & 30

1,390

Personal Use of Auto (Dir of Finance

25 & 30

966

TOTAL

\$ 3,367

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

600

Health Care Worker Background Check

481

(Indicate # of checks performed 5)

Patient Background Checks

Association Dues (total from pg 22, #4)

Employee profesional fees, notary fees

229

Business License - South Holland

412

CLIA fees, CPI membership

53

Alarm Fees - South Holland

625

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 2,400

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

212

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 212

* Attach copy of IMRF notifications

**See instructions.

Tibstra House
ID # 0035196
Schedule XIX - C, Professional Services
Legal Fee Disclosure
FY2025

\$ 1,355		Jackson Lewis PC	ID# 655371	
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.	\$ 343	\$	-
5/6/2025	Finalize resolutions, reviewing documents, respond to emails, questions regarding various 403b plan issues and amendments.	\$ 305	\$	-
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	\$ 707	\$	-
Total costs of legal fees - Jackson Lewis PC (as allocated to Bethshan I)		\$ 1,355	see note	

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. \$ _____ Line _____
- (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. \$ 72,056
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? yes 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. \$ _____ Has any meal income been offset against related costs? n/a 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? yes
Firm Name: CapinCrouse
- (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.

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ID # 0035196
Schedule XX - General Information
LN. 8 - Explanation of Salary Allocation
FY2025

Frea Mars	(Sch V.- Ln 15-1)	Program Director Salary	\$	73,421	80%
	(Sch V. - Ln 10-1)	QIDP Salary	\$	18,100	20%
			\$	91,521	100%

* Frea is the Program Director but also case manager for 4 individuals

* note: Sch V - Ln 15-1 also includes Director of Programs' wages