

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0027086 & 0030528

**Facility Name:** Bethshan Association & Bethshan Association II

**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:** 363038592001 / 363038592002

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

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501 (c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Goudzwaard **Telephone Number:** (708) 371-0800

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven J. Goudzwaard</u>	
	(Title) <u>Director of Finance</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

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

Facility Name & ID Number Bethshan Association & Bethshan Association II# '086 & 0030528 Report Period Beginning: 7/1/05 Ending: 6/30/06

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	45	Intermediate/DD	45	16,425	4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	16,042			16,042
12	SC				12
13	DD 16 OR LESS	5,470			5,470
14	TOTALS	21,512			21,512

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.62%

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

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

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

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

NONEF. Does the facility maintain a daily midnight census? YES

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

YES  NO 

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

YES  NO 

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

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

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

YES  Date \_\_\_\_\_ NO 

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 2006 Fiscal Year: 2006

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

Facility Name & ID Number Bethshan Association & Bethshan Association # 27086 & 00305 Report Period Beginning: 7/1/05 Ending: 6/30/06

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	154,853	11,572	18,300	184,725		184,725		184,725			1
2	Food Purchase		191,380		191,380		191,380		191,380			2
3	Housekeeping	72,171	27,113	5,138	104,422		104,422		104,422			3
4	Laundry	26,884	3,302		30,186		30,186		30,186			4
5	Heat and Other Utilities			57,388	57,388		57,388		57,388			5
6	Maintenance	57,637	14,580	17,507	89,724		89,724		89,724			6
7	Other (specify):* Scavenger			3,551	3,551		3,551		3,551			7
8	<b>TOTAL General Services</b>	<b>311,545</b>	<b>247,947</b>	<b>101,884</b>	<b>661,376</b>		<b>661,376</b>		<b>661,376</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,491,563	71,046	11,234	1,573,843	(36,547)	1,537,296		1,537,296			10
10a	Therapy	67,313	4,649	9,130	81,092		81,092		81,092			10a
11	Activities	136,636	13,246		149,882		149,882		149,882			11
12	Social Services	16,240			16,240		16,240		16,240			12
13	CNA Training					37,437	37,437		37,437			13
14	Program Transportation		24,496		24,496		24,496		24,496			14
15	Other (specify):* Program Director	113,267			113,267		113,267		113,267			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,825,019</b>	<b>113,437</b>	<b>27,564</b>	<b>1,966,020</b>	<b>890</b>	<b>1,966,910</b>		<b>1,966,910</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	100,821			100,821		100,821		100,821			17
18	Directors Fees											18
19	Professional Services			19,910	19,910		19,910		19,910			19
20	Dues, Fees, Subscriptions & Promotions			16,848	16,848		16,848		16,848			20
21	Clerical & General Office Expenses	80,426	8,775	16,408	105,609		105,609	(9,173)	96,436			21
22	Employee Benefits & Payroll Taxes			480,618	480,618	8,907	489,525	(2,486)	487,039			22
23	Inservice Training & Education			7,822	7,822	(3,539)	4,283		4,283			23
24	Travel and Seminar			3,412	3,412		3,412	(791)	2,621			24
25	Other Admin. Staff Transportation			4,007	4,007	(515)	3,492		3,492			25
26	Insurance-Prop.Liab.Malpractice			43,837	43,837		43,837		43,837			26
27	Other (specify):* Miscellaneous		8,840		8,840	(5,743)	3,097	(2,100)	997			27
28	<b>TOTAL General Administration</b>	<b>181,247</b>	<b>17,615</b>	<b>592,862</b>	<b>791,724</b>	<b>(890)</b>	<b>790,834</b>	<b>(14,550)</b>	<b>776,284</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,317,811</b>	<b>378,999</b>	<b>722,310</b>	<b>3,419,120</b>		<b>3,419,120</b>	<b>(14,550)</b>	<b>3,404,570</b>			<b>29</b>

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

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

**Bethshan Association I & II**  
**ID # 0027086 & 0030528**  
**Schedule V, ISFR Reclassifications**  
**FY2006**

To:	Employee Benefits	Sch V, Ln 22	Staff employment physicals	\$	515
From:	Other Admin. Staff Transp.	Sch V, Ln 25			
To:	Employee Benefits	Sch V, Ln 22	Staff gifts, parties, dinners, etc.	\$	5,743
From:	Miscellaneous	Sch V, Ln 27			
To:	Employee Benefits	Sch V, Ln 22	Tuition Reimbursement	\$	2,649
From:	Inservice Training & Education	Sch V, Ln 23			
To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	\$	36,547
From:	Nursing & Medical Records	Sch V, Ln 10			
To:	Nurse Aid Training	Sch V, Ln 13	Training Material Costs	\$	890
From:	In Service Training & Education	Sch V, Ln 23			

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Bethshan Association & Bethshan Association II #0027086 & 00 Report Period Beginning: 7/1/05 Ending: 6/30/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			156,395	156,395		156,395		156,395			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,147	12,147		12,147	(1,579)	10,568			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			63,960	63,960		63,960		63,960			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			232,502	232,502		232,502	(1,579)	230,923			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			203,084	203,084		203,084		203,084			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			203,084	203,084		203,084		203,084			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,317,811	378,999	1,157,896	3,854,706		3,854,706	(16,129)	3,838,577			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(1,579)	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	(9,173)	21		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	(5,377)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (16,129)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (16,129)</b>		<b>37</b>

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Bethshan Association & Bethshan Association II

ID# 0027086 & 0030528

Report Period Beginning: 7/1/05

Ending: 6/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Direct Care Seminars	\$ (791)	24	1
2	Fundraising Employee Benefits	(2,486)	22	2
3	Miscellaneous gifts & dinners	(2,100)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,377)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Bethshan Association &amp; Bethshan Association II

#27086 &amp; 0030: Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(9,173)	0	0	0	0	0	0	0	0	0	0	(9,173)	21
22	Employee Benefits & Payroll Taxes	(2,486)	0	0	0	0	0	0	0	0	0	0	(2,486)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(791)	0	0	0	0	0	0	0	0	0	0	(791)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,100)	0	0	0	0	0	0	0	0	0	0	(2,100)	27
28	<b>TOTAL General Administration</b>	(14,550)	0	0	0	0	0	0	0	0	0	0	(14,550)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(14,550)	0	0	0	0	0	0	0	0	0	0	(14,550)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethshan Association & Bethshan Association II

#27086 & 0030: Report Period Beginning:

7/1/05 Ending:

6/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,579)	0	0	0	0	0	0	0	0	0	0	(1,579)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,579)</b>	<b>0</b>	<b>(1,579)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(16,129)</b>	<b>0</b>	<b>(16,129)</b>	<b>45</b>									

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethshan Association	100	Tibstra House	South Holland	Bethshan Foundation	Palos Heights	Charitable Corp

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

## BETHSHAN ASSOCIATION I & II

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ID 0027086 & 0030528

Period 7/1/05 through 6/30/06

Schedule VII-A Attachment

### Board of Trustees 2005-2006

Brian Dobben	President	819 Argyle	Flossmoor	IL	60422
Donald Poortenga	Secretary	1135 Stommel Place	Dyer	IN	46311
Timothy Eriks	Treasurer	1208 Ballybunion Ct.	Dyer	IN	46311
Bob Payne	Vice President	13617 Arrowhead Ct	Orland Park	IL	60462
Marge Boerman	Director	2258 W 111th Place	Chicago	IL	60643
John Groenboom	Director	N1525 Oak Shores Ln	Fontana	WI	53125
Jim Hofman	Director	12212 S 89th Ave	Palos Park	IL	60464
James Van Dyke	Director	11 N 215 Capullet Cr	Elgin	IL	60123
James VanKampen	Director	1 S 437 Lewis	Lombard	IL	60148
Neil VerHagen	Director	16930 Avalon Ct.	South Holland	IL	60473
Gerald VanProoyen	Director	1336 Inverness Lane	Schererville	IN	46375
Burdette Zandstra	Director	2705 Parkway Drive	Highland	IN	46322

None of the above Board Members directly provided services to Bethshan Association other than their voluntary, non-compensated duties as members of the Board of Directors. Nor has any Board member ownership in any entity that conducted business transactions with Bethshan during this reporting period.

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Bethshan Association & Bethshan Association II #27086 & 0030 Report Period Beginning: 7/1/05 Ending: 6/30/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	# beds 128	11	\$ 123,604	\$ 120,412	61	\$ 58,905	1
2	12	Social Services	# clients 70	11	27,613	27,613	42	16,568	2
3	14	Program Transportation	# beds 128	11	38,055		61	18,136	3
4	17	Administrator	# beds 128	11	206,392	206,392	61	98,359	4
5	19	Professional Services	# beds 128	11	26,311		61	12,539	5
6	20	dues/Fees/Subscriptions	# beds 128	11	28,235		61	13,456	6
7	21	Clerical & General Office	# beds 128	11	189,976	168,825	61	90,535	7
8	22	Workers Comp	budgeted salaries 4,271,152	11	53,454		2,362,998	29,573	8
9	22	Pension	# beds 128	11	10,416		61	4,964	9
10	23	In Service Training	# beds 128	11	3,611		61	1,721	10
11	24	Seminars & Workshop	# beds 128	11	1,136		61	541	11
12	25	Staff Travel	# beds 128	11	6,715		61	3,200	12
13	26	Liability Insurance	# beds 128	11	22,787		61	10,859	13
14	27	Miscellaneous	# beds 128	11	12,349		61	5,885	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 750,654	\$ 523,242		\$ 365,241	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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Bess Tolsema		X	start-up capital		6/26/81	\$ 10,000	\$ 10,000	on demand	0.1000	\$ 1,000	1					
2	various noteholders		X	start-up capital		various	183,200	183,200	on demand	0.0600	11,277	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 193,200	\$ 193,200			\$ 12,277	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 193,200	\$ 193,200			\$ 12,277	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.)

BETHSHAN ASSOCIATION  
 PROMISSORY NOTE SCHEDULE  
 FOR FY 2006

vendor ID	last name	NAME	NOTE #	AMOUNT	Dates Interest was Paid	Int. Rate	Interest	Interest Paid	Interest Accrued as of 6/30	Months Accrued
TIEMEN	Tiemens	Donald R or Carolyn A Tiemens	483	\$ 10,000.00	01-Aug-2005	6%	300.00			
	Tiemens				01-Feb-2006	6%	300.00	250.00	5.0	
IPEMA	Ipema	Henry P. Ipema Revocable Living Trust Dated June 2,	484	\$ 2,000.00	01-Aug-2005	6%	60.00			
	Ipema				01-Feb-2006	6%	60.00	50.00	5.0	
REHLIN	Rehling	Alfrieda D. Rehling Living Trust, date 2/22/02	485	\$ 5,000.00	01-Aug-2005	6%	150.00			
	Rehling	Alfrieda D. Rehling, Trustee			01-Feb-2006	6%	150.00	125.00	5.0	
KOOI	Kooi	Grace Kooi or Carol J. DeYong	486	\$ 10,000.00	01-Aug-2005	6%	300.00			
	Kooi	or Garry L. Kooi			01-Feb-2006	6%	300.00	250.00	5.0	
CHILTO	Chilton	Winnie Chilton	487	\$ 10,000.00	01-Aug-2005	6%	300.00			
	Chilton				01-Feb-2006	6%	300.00	250.00	5.0	
				<u>\$ 37,000.00</u>			<u>\$ 2,220.00</u>	<u>\$ 925.00</u>		
POST	Post	Peter M Post, Sr. &/or Jeanette	435	\$ 10,000.00	01-Sep-2005	6%	300.00			
	Post	&/or Peter M Post, Jr.			01-Mar-2006	6%	300.00	200.00	4.0	
VANKLE	Van Kley	Violet J Van Kley	436	\$ 10,000.00	01-Sep-2005	6%	300.00			
	Van Kley				01-Mar-2006	6%	300.00	200.00	4.0	
MEYER	Meyer	John B. & Linda L. Meyer Jt Ten WROS	438	\$ 10,000.00	01-Sep-2005	6%	300.00			
	Meyer				01-Mar-2006	6%	300.00	200.00	4.0	
SWIGRT	Swigart	Thomas Jr. or Lois G Swigart	447	\$ 5,000.00	01-Sep-2005	6%	150.00			
	Swigart	(redeemed 11-30-2005)		\$ (5,000.00)	30-Nov-2005	6%	74.79	0.00	0.0	
CORDYK	DykstraC	Cornelius and Eldene Dykstra	448	\$ 10,000.00	01-Sep-2005	6%	300.00			
	DykstraC				01-Mar-2006	6%	300.00	200.00	4.0	
TIEMER	TiemersmaD	David & Amy Tiemersma	452	\$ 2,000.00	01-Sep-2005	6%	60.00			
	TiemersmaD				01-Mar-2006	6%	60.00	40.00	4.0	
PARISH	Parrish	Robert J or Charlotte Parrish	453	\$ 10,000.00	01-Sep-2005	6%	300.00			
	Parrish				01-Mar-2006	6%	300.00	200.00	4.0	
L_OOMS	OomsL	Lois J Ooms Living Trust	455	\$ 5,000.00	01-Sep-2005	6%	150.00			
	OomsL				01-Mar-2006	6%	150.00	100.00	4.0	
CORNEL	ClousingC	Cornelius Clousing (Change address 2006)	456	\$ 10,000.00	01-Sep-2005	6%	300.00			
	ClousingC	James C. Clousing & Marsha Ryskamp, Ben.			01-Mar-2006	6%	300.00	200.00	4.0	
HEROOM	OomsH	Herbert &/or Estelle Ooms Living	502	\$ 10,000.00	01-Sep-2005	6%	300.00			
	OomsH	Trust dated 10/17/82			01-Mar-2006	6%	300.00	200.00	4.0	
CLAROU	Ouwenga	Clarence or Eleanor or Laurie	458-459	\$ 8,000.00	01-Sep-2005	6%	240.00			
	Ouwenga				01-Mar-2006	6%	240.00	160.00	4.0	
DEXTER	Boersma	Dexter and Laura Boersma	461	\$ 5,000.00	01-Sep-2005	6%	150.00			
	Boersma				01-Mar-2006	6%	150.00	100.00	4.0	
WM.DY2	DeYoung	Jean DeYoung, Ttee of the William DeYoung	503	\$ 10,000.00	01-Sep-2005	6%	300.00			
	DeYoung	Survivor's Trust dated 1/18/00			01-Mar-2006	6%	300.00	200.00	4.0	
STALMN	Stalman	Helen M Stalman	463	\$ 10,000.00	01-Sep-2005	6%	300.00			
	Stalman				01-Mar-2006	6%	300.00	200.00	4.0	
IPEMA	Ipema	Henry P. Ipema Revocable Living Trust Dated June 2,	490	\$ 5,000.00	01-Sep-2005	6%	150.00			
	Ipema				01-Mar-2006	6%	150.00	100.00	4.0	
				<u>\$ 115,000.00</u>			<u>\$ 7,124.79</u>	<u>\$ 2,300.00</u>		
RENZ	Renz	Beverly Joyce Renz	466	\$ 4,000.00	01-Oct-2005	6%	120.00			
	Renz				01-Apr-2006	6%	120.00	60.00	3.0	
HANNEM	Hanneman	Edith S. Hanneman, TTEE under the	471&479	\$ 10,000.00	01-Oct-2005	6%	300.00			
	Hanneman	Edith S. Hanneman declaration of			01-Apr-2006	6%	300.00	150.00	3.0	
	Hanneman	trust dated 2/4/93								
RAATJE	Raatjes	Margaret Raatjes, Trustee for	476	\$ 2,000.00	01-Oct-2005	6%	60.00			
	Raatjes	Robert & Dennis E Raatjes (redeemed 10/01/05)		\$ (2,000.00)	01-Oct-2005	6%	0.00	0.00	0.0	
VANBEV	VanBeveren	Harriette VanBeveren or Aldena VanBeveren	481	\$ 7,200.00	01-Oct-2005	6%	216.00			
	VanBeveren				01-Apr-2006	6%	216.00	108.00	3.0	
				<u>\$ 21,200.00</u>			<u>\$ 1,332.00</u>	<u>\$ 318.00</u>		
RALPH	Olthoff	Ralph or Jean Olthoff	482	\$ 10,000.00	01-Nov-2005	6%	300.00			
	Olthoff				01-May-2006	6%	300.00	100.00	2.0	
				<u>\$ 10,000.00</u>			<u>\$ 600.00</u>	<u>\$ 100.00</u>		
TOLSMA	Tolsma	Bess Tolsma or Betty Schurman	251	\$ 10,000.00	01-Dec-2005	10%	500.00			
	Tolsma	or Mary Boerema			01-Jun-2006	10%	500.00	83.33	1.0	
				<u>\$ 10,000.00</u>			<u>\$ 1,000.00</u>	<u>\$ 83.33</u>		
GRAND TOTAL ALL NOTES				<u>\$ 193,200.00</u>			<u>\$ 12,276.79</u>	<u>\$ 3,726.33</u>		



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bethshan Association & Bethshan Association II COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027086 & 0030528

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 2005 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 2005.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24602 & 8693 B. General Construction Type: Exterior brick Frame metal Number of Stories 1

C. Does the Operating Entity?  (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).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 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	<u>none</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

Facility Name & ID Number **Bethshan Association & Bethshan Association II**# **7086 & 003052** Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	45		1982	1982	\$ 1,116,585	\$ 20,057		\$ 20,057	\$	\$ 860,182	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Remodeling & Improvements BI & BII			147,377	5,793	20 - 40	5,793		97,703	9
10		fixed equipment			46,021	2,088	10 to 40	2,088		28,800	10
11		Addition: PT, nursing, office, & maintenance		1993	385,632	9,641	40	9,641		125,331	11
12		Landscaping			18,201	769	20	769		13,124	12
13		Automated door		1999	12,958	1,296	10	1,296		9,365	13
14		Garage			7,000	73	15 - 20	73		6,418	14
15		site improvements BI & BII			124,623	7,100	10 to 20	7,100		85,677	15
16		water & sewer improvements			22,009	734	30	734		17,147	16
17		Woodfold accordian folding partition		2000	2,720	272	10	272		1,639	17
18		Gas heater - Paul Supply		2001	2,593	259	10	259		1,454	18
19		Ceramic Tile - diningroom BI		2001	3,187	319	10	319		1,676	19
20		Besam Automated Entrance BII		2001	1,702	170	10	170		937	20
21		Bathroom remodeling BII		2001	8,455	846	10	846		4,350	21
22		Flat roofs (4) BI		2002	26,100	1,740	15	1,740		8,690	22
23		Bathroom remodeling BI		2002	133,435	8,896	15	8,896		38,548	23
24		Rooms painted (4 pods) BI		2002	6,840	456	15	456		2,017	24
25		Ceramic tile - livingroom BI		2002	4,250	283	15	283		1,289	25
26		Briggs generator BI		2002	2,995	374	8	374		1,545	26
27		Smoking shelter BI		2002	3,972	397	10	397		1,806	27
28		Fire alarm upgrade		2003	9,969	997	10	997		3,870	28
29		Whirlpool room remodeling		2003	6,750	450	15	450		1,375	29
30		Roof - (BI garage)		2004	2,030	135	15	135		297	30
31		Roof (BI - north)		2005	7,765	518	15	518		807	31
32		Bathroom remodeling		2006	8,860	299	10	299		299	32
33		Furnace & A/C - Pod 1 & 4		2006	13,085	421	8	421		421	33
34		Fire System		2006	1,759	5	10	5		5	34
35		Fire Doors (5)		2006	2,354	86	10	86		86	35
36		Ceramic Tile Hallways		2006	4,250	143	10	143		143	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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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)	\$ 2,133,477	\$ 64,617		\$ 64,617	\$	\$ 1,315,001	70

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

Facility Name & ID Number Bethshan Association & Bethshan Association II # 27086 & 0030528 Report Period Beginning: 7/1/05 Ending: 6/30/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 207,593	\$ 40,256	\$ 40,256	\$	5 to 10	\$ 166,301	71
72	Current Year Purchases	62,630	5,532	5,532		3 to 10	5,532	72
73	Fully Depreciated Assets	475,964	11,660	11,660		5 to 10	475,964	73
74								74
75	TOTALS	\$ 746,187	\$ 57,448	\$ 57,448	\$		\$ 647,797	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	vans	1996-2003	\$ 260,583	\$ 28,935	\$ 28,935	\$		\$ 236,364	76
77	Executive Director	Mazda Tribute	2003	11,269	2,254	2,254			7,533	77
78	Maintenance	Ford F250 Pickup w/plow	2000	15,593	693	693			15,593	78
79	Maintenance	Chevy Silverado 4x4 w/plow	2005	12,248	2,450	2,450			3,530	79
80	TOTALS			\$ 299,693	\$ 34,332	\$ 34,332	\$		\$ 263,020	80

E. Summary of Care-Related Assets

	1 Description	2 Reference	3 Amount	4 Line
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,179,357	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 156,397	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 156,397	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)	\$ 2,225,818	85

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

	1 Description & Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	5 Line
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Elim Christian Services

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1976</u>	<u>16</u>	<u>7/01/01</u>	\$ <u>63,960</u>	<u>3</u>	<u>3</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>63,960</u>			7

10. Effective dates of current rental agreement:

Beginning 7/01/04

Ending 6/30/07

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

Fiscal Year Ending                      Annual Rent

12.	<u>6/30/07</u>	\$ <u>63,960</u>
13.	<u>6/30/08</u>	\$ <u>63,960</u>
14.	<u>6/30/09</u>	\$ <u>63,960</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

\* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		890		890
3	Classroom Wages (a)		10,751		10,751
4	Clinical Wages (b)		20,476		20,476
5	In-House Trainer Wages (c)		5,320		5,320
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 37,437	\$	\$ 37,437
10	SUM OF line 9, col. 1 and 2 (e)	\$	37,437		

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	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>29</b>

- (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.)**

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	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 prescripts														9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Exceptional Care Program																12
13	Other (specify):																13
14	<b>TOTAL</b>			\$				\$		\$				\$			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.

Facility Name & ID Number Bethshan Association & Bethshan Association II# '086 & 0030528Report Period Beginning: 7/1/05

Ending:

6/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (1,056,500)	\$ 337,782	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	612,229	771,148	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,085	87,319	6
7	Other Prepaid Expenses	2,170	2,170	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (393,016)	\$ 1,198,419	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		459,750	13
14	Buildings, at Historical Cost	2,133,477	5,046,650	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,045,880	1,788,632	16
17	Accumulated Depreciation (book methods)	(2,225,818)	(3,530,889)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 953,539	\$ 3,764,143	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 560,523	\$ 4,962,562	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 132,651	\$ 178,463	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,280	291,264	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,838	10,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,726	7,174	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>403(B) Contributions Payable</u>	1,401	2,483	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 313,896	\$ 490,007	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	193,200	193,200	39
40	Mortgage Payable		519,479	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 193,200	\$ 712,679	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 507,096	\$ 1,202,686	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 53,427	\$ 3,759,876	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 560,523	\$ 4,962,562	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>387,057</b>	<b>1</b>
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>387,057</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(385,363)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (385,363)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
18	<b>HVAC</b>	13,085	18
19	<b>Bathroom remodeling</b>	8,860	19
20	<b>Ceramic Tile Floor</b>	4,250	20
21	<b>Copy Machine</b>	15,293	21
22	<b>Computer File Server &amp; Software</b>	10,245	22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 51,733	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 53,427	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Bethshan Association & Bethshan Association II #086 & 0030528 Report Period Beginning: 7/1/05Ending: 6/30/06**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,394,708	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,394,708	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	44,029	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	10,780	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 54,809	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	690	24
25	Interest and Other Investment Income***	1,579	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,269	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>DT Transportation</b>	17,556	28
28a	<b>Miscellaneous</b>	1	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 17,557	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,469,343	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	661,376	31
32	Health Care	1,966,020	32
33	General Administration	791,724	33
<b>B. Capital Expense</b>			
34	Ownership	232,502	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	203,084	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,854,706	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(385,363)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (385,363)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Bethshan Association & Bethshan Association II

# 086 & 0030528

Report Period Beginning: 7/1/05

Ending: 6/30/06

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,995	2,188	\$ 66,744	\$ 30.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,629	4,068	91,277	22.44	3
4	Licensed Practical Nurses	7,282	7,912	162,809	20.58	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	2,347	2,645	67,313	25.45	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,974	2,175	34,296	15.77	9
10	Activity Assistants	6,410	7,112	102,340	14.39	10
11	Social Service Workers	398	454	16,240	35.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,322	2,594	38,727	14.93	14
15	Cook Helpers/Assistants	9,541	10,524	116,126	11.03	15
16	Dishwashers					16
17	Maintenance Workers	2,757	2,991	57,637	19.27	17
18	Housekeepers	5,020	5,654	72,171	12.76	18
19	Laundry	2,655	3,003	26,884	8.95	19
20	Administrator	837	991	72,048	72.70	20
21	Assistant Administrator					21
22	Other Administrative	741	741	28,773	38.83	22
23	Office Manager					23
24	Clerical	3,849	4,348	80,426	18.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,981	9,013	180,817	20.06	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	75,246	84,220	989,916	11.75	30
31	Medical Records					31
32	Other Health C: Program Director	2,907	3,378	113,267	33.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,891	154,011	\$ 2,317,811 *	\$ 15.05	34

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

\*\* See instructions.

**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	305	\$ 18,300	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant	16	590	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10-3	39
40	Physical Therapy Consultant	14	692	10a-3	40
41	Occupational Therapy Consultant	45	2,607	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	71	2,831	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant		3,000	10a-3	45
46	Other(specify) <u>Podiatrist</u>	24	2,880	10-3	46
47	<u>Psychiatrist</u>	39	7,012	10-3	47
48					48
49	TOTAL (lines 35 - 48)	514	\$ 45,712		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4	\$ 152	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4	\$ 152		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joseph Lanenga	Executive Director	0	\$ 72,048	Workers' Compensation Insurance	\$ 29,455	IDPH License Fee	\$ 70	
Steve Goudzwaard	Director of Finance	0	28,773	Unemployment Compensation Insurance	4,395	Advertising: Employee Recruitment	1,983	
				FICA Taxes	166,959	Health Care Worker Background Check		
				Employee Health Insurance	233,120	(Indicate # of checks performed <u>45</u> )	510	
				Employee Meals		Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		AAMR, IARF, CARF	13,039	
				Pension	44,203	DDNA	113	
				Employee Physicals	515	Inspection/Bank/Filing Fees	2	
				Misc (flowers, gifts, party)	5,743	Employee Professional Fees/Dues	1,002	
				tuition	2,649	Sams Membership	129	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 100,821	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,848
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$	Personal use of auto		\$ 3,286	Out-of-State Travel	\$
							In-State Travel	609
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	2,012
C. Professional Services				TOTAL			Entertainment Expense ( )	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Dreyer Ooms & VanDrunen	audit & accounting		\$ 8,983				TOTAL	
ADP	payroll preparation		6,447				\$ 2,621	
Points North Consulting	payroll technical support		71					
Hoogendoorn & Talbot	legal services		143					
Informability	computer consulting		1,911					
Pennelope Kneisler	QMRP Consultant		834					
Open Systems	payroll consulting		1,485					
IARF	survey		36					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$ 3,286		
			\$ 19,910					

\* Attach copy of IMRF notifications

\*\*See instructions.

**BETHSHAN I & II  
SCHEDULE OF STAFF TRAVEL  
FY 2006**

	<u>TRAVEL EXPENSE</u>	<u>SEMINARS COST</u>	
Staff intra-agency travel for meetings at central office, etc.			
<b>675 Allocation</b>			
8/18/2005	Cross Country Education Exercise Physiology & Weight Management Strategies Tina Hill, RN Chicago, IL		179.00
8/24/2006	Cross Country Education Pressure Ulcer Management Pam VanderMeer, OTPT Tina Hill, RN Naperville, IL	103.25	159.00 159.00
9/16/2005	Abilities Expo Chuckie Hofstra, OTPT Pam VanderMeer, OTPT	56.36	
11/9/2005	ARC of IL Sexuality and People with DD Rev C. DeBoer, Chaplain Judy Gill, Chaplain Tinley Park, IL		50.00 50.00
1/24/2006	ARC of IL Annual QMRP Leadership Conference Amy Tiemersma, LSCW Michelle Gabrielse, QMRP Peggy Mollena, QMRP Alsip, IL		52.42
3/2/2006	IL Healthcare Assoc Therapeutic Activities Ehren Cantu, Activities Marie Inczauskis, Activities Ulica, IL		200.00
3/3/2006	Crisis Prevention Institute International Instructors Conference 8/3-4/06 William Dearth, QMRP St. Louis, MO		149.00
3/13/2006	Professional Training Co Food Safety & Sanitation Frea Mars, Program Director Middletown, IL		125.00
3/16/2006	OIG Training Rule 50 Val Lynch, DON Frea Mars, Program Director Dave Tiemersma, Program Director Oak Lawn, IL		
4/23-25/06	DDNA Focus on Developmental Disabilities Nursing Val Lynch, DON Daytona Beach, FL	345.00	344.00
4/5-6/06	ARC of IL Annual Convention Frea Mars, Program Director Lisle, IL		225.00
4/26-27/06	OIG Training Basic Investigative Skills Frea Mars, Program Director Dave Tiemersma Oak Lawn, IL	23.54	
4/26/2006	National Association for Down Syndrome Aging Issues in Adults with Down Syndrome Laura Kirchoff, Program Direct Bill Dearth, QMRP Ann Marie Olson, QMRP Tishia Stangel, QMRP Adam Toessel, QMRP Itasca, IL	36.00 34.40	
6/6/2006	OIG Refresher Training Laura Kirchoff, Program Direct Janet Herrmann, Program Director Tishia Stangel, QMRP Alsip, IL	10.50	
6/13/2006	Debie Fuess Water Safety Course Ehren Cantu, Activity Director Valerie Poulos, DSP Kevin Gruzewski, Activity Director Marie Inczauskis, Activity Director Tina Cucci, DSP		80.00 80.00 80.00 80.00
<b>TOTAL AFTER ADJUSTMENTS</b>		<b>609.05</b>	<b>2,012.42</b>
			<b>2,621.47</b>



**Bethshan Association I & II**  
**ID # 0027086 & 0030528**  
**Schedule XX (12) Explanation of Salary Allocation**  
**FY2006**

Freya Mars	(Ln 15-5)	Program Director Salary	\$	40,527
	(Ln 10-1)	QMRP Salary	\$	12,214

Facility Name &amp; ID Number Bethshan Association &amp; Bethshan Association II

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 203,084  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,332 Has any meal income been offset against related costs? n/a Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- 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? yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 17,556**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Dreyer, Ooms, & VanDrunen Ltd The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.