



Facility Name & ID Number Bethshan Association I & Bethshan Association II

# 7086, 0030528 Report Period Beginning: 7/1/06 Ending: 6/30/07

**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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,957			15,957	11
12	SC					12
13	DD 16 OR LESS	5,359			5,359	13
14	TOTALS	21,316			21,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.74%

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

761 (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)

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

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: 2007 Fiscal Year: 2007

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

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number Bethshan Association I & Bethshan Associati # 027086, 003052 Report Period Beginning: 7/1/06 Ending: 6/30/07**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
	<b>A. General Services</b>										
1	Dietary	161,848	14,644	18,540	195,032		195,032	195,032			1
2	Food Purchase		191,920		191,920		191,920	191,920			2
3	Housekeeping	81,418	27,319	7,291	116,028		116,028	116,028			3
4	Laundry	24,313	3,407		27,720		27,720	27,720			4
5	Heat and Other Utilities			54,015	54,015		54,015	54,015			5
6	Maintenance	64,917	18,134	20,406	103,457		103,457	103,457			6
7	Other (specify):* <u>scavenger</u>			3,423	3,423		3,423	3,423			7
8	<b>TOTAL General Services</b>	332,496	255,424	103,675	691,595		691,595	691,595			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200	7,200			9
10	Nursing and Medical Records	1,532,622	61,745	10,876	1,605,243	(32,170)	1,573,073	1,573,073			10
10a	Therapy	79,995	6,099	6,000	92,094		92,094	92,094			10a
11	Activities	150,149	13,831		163,980		163,980	163,980			11
12	Social Services	22,779			22,779		22,779	22,779			12
13	CNA Training		1,521		1,521	32,170	33,691	33,691			13
14	Program Transportation		19,520		19,520		19,520	19,520			14
15	Other (specify):* <u>Program Director</u>	120,396			120,396		120,396	120,396			15
16	<b>TOTAL Health Care and Programs</b>	1,905,941	102,716	24,076	2,032,733		2,032,733	2,032,733			16
	<b>C. General Administration</b>										
17	Administrative	101,016			101,016		101,016	101,016			17
18	Directors Fees										18
19	Professional Services			44,658	44,658		44,658	44,658			19
20	Dues, Fees, Subscriptions & Promotions			15,088	15,088		15,088	15,088			20
21	Clerical & General Office Expenses	78,034	9,261	16,533	103,828		103,828	(9,667)	94,161		21
22	Employee Benefits & Payroll Taxes			551,678	551,678	1,512	553,190	(2,675)	550,515		22
23	Inservice Training & Education			5,097	5,097	(1,320)	3,777		3,777		23
24	Travel and Seminar			2,690	2,690		2,690	(643)	2,047		24
25	Other Admin. Staff Transportation			2,218	2,218	(192)	2,026		2,026		25
26	Insurance-Prop.Liab.Malpractice			44,238	44,238		44,238		44,238		26
27	Other (specify):* <u>miscellaneous</u>		1,531		1,531		1,531	(550)	981		27
28	<b>TOTAL General Administration</b>	179,050	10,792	682,200	872,042		872,042	(13,535)	858,507		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,417,487	368,932	809,951	3,596,370		3,596,370	(13,535)	3,582,835		29

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

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

**Bethshan Association I & II**  
**ID # 0027086 & 0030528**  
**Schedule V, ISFR Reclassifications**  
**FY2007**

To:	Employee Benefits	Sch V, Ln 22	Staff employment physicals	\$ 192
From:	Other Admin. Staff Transp.	Sch V, Ln 25		
To:	Employee Benefits	Sch V, Ln 22	Tuition Reimbursement	\$ 1,320
From:	Inservice Training & Education	Sch V, Ln 23		
To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	\$ 32,170
From:	Nursing & Medical Records	Sch V, Ln 10		

STATE OF ILLINOIS

Facility Name & ID Number Bethshan Association I & Bethshan Association II #0027086, 0030 Report Period Beginning: 7/1/06 Ending: 6/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			130,928	130,928		130,928		130,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,979	10,979		10,979	(1,463)	9,516			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>			205,867	205,867		205,867	(1,463)	204,404			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			203,683	203,683		203,683		203,683			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			203,683	203,683		203,683		203,683			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,417,487	368,932	1,219,501	4,005,920		4,005,920	(14,998)	3,990,922			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,463)	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	(9,667)	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	(3,868)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (14,998)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<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>\$ (14,998)</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>

Bethshan Association I & Bethshan Association II

ID# 0027086, 0030528

Report Period Beginning: 7/1/06

Ending: 6/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non Direct Care Seminars	\$ (643)	24	1
2	Fundraising Employee Benefits	(2,675)	22	2
3	Miscellaneous gifts & dinners	(550)	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>	(3,868)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethshan Association I & Bethshan Association II

# 127086, 00305; Report Period Beginning:

7/1/06

Ending:

6/30/07

**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	(9,667)	0	0	0	0	0	0	0	0	0	0	(9,667)	21
22	Employee Benefits & Payroll Taxes	(2,675)	0	0	0	0	0	0	0	0	0	0	(2,675)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(643)	0	0	0	0	0	0	0	0	0	0	(643)	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):*	(550)	0	0	0	0	0	0	0	0	0	0	(550)	27
28	<b>TOTAL General Administration</b>	(13,535)	0	0	0	0	0	0	0	0	0	0	(13,535)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(13,535)	0	0	0	0	0	0	0	0	0	0	(13,535)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethshan Association I & Bethshan Association II

#127086, 00305 Report Period Beginning:

7/1/06 Ending:

6/30/07

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

	Capital Expense	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>D. Ownership</b>												
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	(1,463)	0	0	0	0	0	0	0	0	0	0	(1,463) 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>(1,463)</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>(1,463) 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 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(14,998)</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>(14,998) 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:	
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.

**BETHSHAN ASSOCIATION I & II**

ID 0027086 & 0030528

Period 7/1/06 through 6/30/07

Schedule VII-A Attachment

Board of Trustees 2006-2007

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
Ira Slagter	Director	19124 Boulder Ridge Ct.	Mokena	IL	60448
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
Kim Lagestee Mulder	Director	18765 Forestview Lane	Lansing	IL	60438

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.

Facility Name & ID Number      Bethshan Association I & Bethshan Associat      # 0027086, 0030528      Report Period Beginning:      7/1/06      Ending:      6/30/07

## 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	NONE								\$	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 I & Bethshan Association II #127086, 00305 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	129	11	\$ 130,765	\$ 129,379	61	\$ 61,835	1
2	14	Program Transportation	# beds	129	11	33,531	0	61	15,856	2
3	19	Professional Services	# beds	129	11	37,346	0	61	17,660	3
4	20	Dues/Fees/Subscriptions	# beds	129	11	21,221	0	61	10,035	4
5	21	Clerical & General Office	# beds	129	11	164,887	164,887	61	77,970	5
6	22	Workers Comp	budgeted salaries	4,366,500	11	65,700	0	2,407,794	36,229	6
7	22	Other Employee Benefits	# beds	129	11	8,224	0	61	3,889	7
8	23	In Service Training	# beds	129	11	705	0	61	333	8
9	24	Seminars & Workshop	# beds	129	11	636	0	61	301	9
10	25	Staff Travel	# beds	129	11	3,834	0	61	1,813	10
11	26	Liability Insurance	# beds	129	11	22,737	0	61	10,752	11
12	27	Miscellaneous	# beds	129	11	2,529	0	61	1,196	12
13	17	Administration	# beds	129	11	212,407	212,407	61	100,441	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					\$ 704,522	\$ 506,673		\$ 338,310	25

Facility Name & ID Number **Bethshan Association I & Bethshan Associati** # **7086, 0030528** Report Period Beginning: **7/1/06** Ending: **6/30/07**

**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	
						Original	Balance					
	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									
	<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 noteolders		X	start-up capital		various	148,200	148,200	on demand	0.0600	10,604	2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 158,200	\$ 158,200			\$ 11,604	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>						\$ 158,200	\$ 158,200			\$ 11,604	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 2007

last name	NAME	NOTE #	AMOUNT	Dates Interest		Interest
				was Paid	Int. Rate	
Tiemens	Donald R or Carolyn A Tiemens	483	\$ 10,000.00	01-Aug-2006	6%	300.00
Tiemens				01-Feb-2007	6%	300.00
Ipema	Henry P. Ipema Revocable Living Trust Dated June 2, 2004	484	\$ 2,000.00	01-Aug-2006	6%	60.00
Ipema				01-Feb-2007	6%	60.00
Rehling	Alfrieda D. Rehling Living Trust, date 2/22/02	485	\$ 5,000.00	01-Aug-2006	6%	150.00
Rehling	Alfrieda D. Rehling, Trustee			01-Feb-2007	6%	150.00
	(note redeemed 4/17/07)		\$ (5,000.00)	17-Apr-2007	6%	62.47
Kooi	Grace Kooi or Carol J. DeYong	486	\$ 10,000.00	01-Aug-2006	6%	300.00
Kooi	or Garry L. Kooi			01-Feb-2007	6%	300.00
Chilton	Winnie Chilton	487	\$ 10,000.00	01-Aug-2006	6%	300.00
Chilton			-	01-Feb-2007	6%	300.00
			<u>\$ 32,000.00</u>			<u>\$ 2,282.47</u>
Post	Peter M Post, Sr. &/or Jeanette	435	\$ 10,000.00	01-Sep-2006	6%	300.00
Post	&/or Peter M Post, Jr.			01-Mar-2007	6%	300.00
Van Kley	Violet J Van Kley	436	\$ 10,000.00	01-Sep-2006	6%	300.00
Van Kley	(note redeemed 3/1/07)		\$ (10,000.00)	01-Mar-2007	6%	300.00
Meyer	John B. & Linda L. Meyer Jt Ten WROS	438	\$ 10,000.00	01-Sep-2006	6%	300.00
Meyer				01-Mar-2007	6%	300.00
DykstraC	Cornelius and Eldene Dykstra	448	\$ 10,000.00	01-Sep-2006	6%	300.00
DykstraC				01-Mar-2007	6%	300.00
TiemersmaD	David & Amy Tiemersma	452	\$ 2,000.00	01-Sep-2006	6%	60.00
TiemersmaD				01-Mar-2007	6%	60.00
Parrish	Robert J or Charlotte Parrish	453	\$ 10,000.00	01-Sep-2006	6%	300.00
Parrish				01-Mar-2007	6%	300.00
OomsL	Lois J Ooms Living Trust	455	\$ 5,000.00	01-Sep-2006	6%	150.00
OomsL				01-Mar-2007	6%	150.00
ClousingC	Cornelius Clousing (Change address 2006)	456	\$ 10,000.00	31-Aug-2006	6%	300.00
ClousingC	James C. Clousing & Marsha Ryskamp, Ben.	rdmd 8/31/06	\$ (10,000.00)		6%	0.00
OomsH	Herbert &/or Estelle Ooms Living	502	\$ 10,000.00	01-Sep-2006	6%	300.00
OomsH	Trust dated 10/17/92			01-Mar-2007	6%	300.00
Ouwenga	Clarence or Eleanor or Laurie	458-459	\$ 8,000.00	01-Sep-2006	6%	240.00
Ouwenga		Ouwenga		01-Mar-2007	6%	240.00
Boersma	Dexter and Laura Boersma	461	\$ 5,000.00	01-Sep-2006	6%	150.00
Boersma				01-Mar-2007	6%	150.00
DeYoung	Jean DeYoung, Ttee of the William DeYoung	503	\$ 10,000.00	01-Sep-2006	6%	300.00
DeYoung	Survivor's Trust dated 1/18/00			01-Mar-2007	6%	300.00
Stalman	Helen M Stalman	463	\$ 10,000.00	01-Sep-2006	6%	300.00
Stalman				01-Mar-2007	6%	300.00
Ipema	Henry P. Ipema Revocable Living Trust Dated June 2, 2004	490	\$ 5,000.00	01-Sep-2006	6%	150.00
Ipema			-	01-Mar-2007	6%	150.00
			<u>\$ 95,000.00</u>			<u>\$ 6,600.00</u>
Renz	Beverly Joyce Renz	466	\$ 4,000.00	01-Oct-2006	6%	120.00
Renz				01-Apr-2007	6%	120.00
Hanneman	Edith S. Hanneman, TTEE under the	471&479	\$ 10,000.00	01-Oct-2006	6%	300.00
Hanneman	Edith S. Hanneman declaration of			01-Apr-2007	6%	300.00
Hanneman	trust dated 2/4/93					
VanBeveren	Harriette VanBeveren or Aldena VanBeveren	481	\$ 7,200.00	01-Oct-2006	6%	216.00
VanBeveren			-	01-Apr-2007	6%	216.00
			<u>\$ 21,200.00</u>			<u>\$ 1,272.00</u>
Olthoff	Ralph or Jean Olthoff	482	\$ 10,000.00	01-Nov-2006	6%	300.00
Olthoff	(note redeemed 1/31/07, Jean Olthoff ssn345-20-4234)		(10,000.00)	29-Jan-2007	6%	150.00
			<u>\$ -</u>			<u>\$ 450.00</u>
Tolsma	Bess Tolsma or Betty Schurman	251	\$ 10,000.00	01-Dec-2006	10%	500.00
Tolsma	or Mary Boerema		-	01-Jun-2007	10%	500.00
			<u>\$ 10,000.00</u>			<u>\$ 1,000.00</u>
GRAND TOTAL ALL NOTES			<u>\$ 158,200.00</u>			<u>\$11,604.47</u>

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2006 report.		\$	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2006 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2002	8																										
2003	9																										
2004	10																										
2005	11																										
2006	12																										
<b>FOR BHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2006 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bethshan Association I & Bethshan Association I COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027086, 0030528

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2006 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 2006

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

**B. Real Estate Tax Cost Allocation:**

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

**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 ground (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	none			\$	1
2					2
3	<b>TOTALS</b>			\$	3

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

# 27086, 0030528 Report Period Beginning:

7/1/06

Ending:

6/30/07

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	45	1982	1982	\$ 1,116,585	\$ 20,057		\$ 20,057		\$ 880,238	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Remodeling & Improvements BI & BII			147,377	5,280	20 - 40	5,280		102,983	9
10	fixed equipment			46,021	2,088	10 - 40	2,088		30,887	10
11	Addition: PT, nursing, office, & maintenance	1993		385,632	9,641	40	9,641		134,971	11
12	Landscaping			18,201	694	20	694		13,818	12
13	Automated door	1999		12,958	1,296	10	1,296		10,661	13
14	Garage			7,000	73	15 - 20	73		6,491	14
15	site improvements BI & BII			124,623	7,100	10 - 20	7,100		92,776	15
16	water & sewer improvements			22,009	734	30	734		17,881	16
17	Woodfold accordian folding partition	2000		2,720	272	10	272		1,911	17
18	Gas heater - Paul Supply BI	2001		2,593	259	10	259		1,713	18
19	Ceramic Tile - diningroom BI	2001		3,187	319	10	319		1,995	19
20	Besam automated entrance BII	2001		1,702	170	10	170		1,107	20
21	Bathroom remodeling BII	2001		8,455	846	10	846		5,196	21
22	Flat roofs (4) BI	2002		26,100	1,740	15	1,740		10,430	22
23	Bathroom remodeling BI	2002		133,435	8,896	15	8,896		47,444	23
24	Rooms painted (4 pods) BI	2002		6,840	456	15	456		2,473	24
25	Ceramic tile - livingroom BI	2002		4,250	283	15	283		1,572	25
26	Briggs generator BI	2002		2,995	374	8	374		1,919	26
27	Smoking shelter BI	2002		3,972	397	10	397		2,204	27
28	Fire alarm upgrade BI	2003		9,969	997	10	997		4,867	28
29	Whirlpool room remodeling BI	2003		6,750	450	15	450		1,825	29
30	Roof - (BI garage)	2004		2,030	135	15	135		432	30
31	Roof - (BI-north)	2005		7,765	518	15	518		1,325	31
32	Bathroom remodeling BI	2006		8,860	886	10	886		1,185	32
33	Furnace & A/C - Pod 1 & 4	2006		13,085	1,636	8	1,636		2,057	33
34	Fire System BI	2006		1,759	176	10	176		181	34
35	Fire Doors (5) BII	2006		2,354	235	10	235		321	35
36	Ceramic Tile hallways BII	2006		4,250	425	10	425		568	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bethshan Association I & Bethshan Association II

# 27086, 0030528 Report Period Beginning:

7/1/06

Ending:

6/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Whirlpool bath remodeling (Pod 4)	2007	\$ 8,600	\$ 511	15	\$ 511	\$	\$ 511	37
38	Fire alarm CPU board BI	2007	1,745	109	10	109		109	38
39	Lennox Condensor BI	2007	2,165	11	10	11		11	39
40	Pergola	2007	2,000	178	10	178		178	40
41	Landscaping	2007	4,509	383	10	383		383	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
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56									56
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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)		\$ 2,152,496	\$ 67,625		\$ 67,625	\$	\$ 1,382,623	70

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

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	\$ 126,136	\$ 25,442	\$ 25,442	\$	3 - 10	\$ 62,495	71
72	Current Year Purchases	40,361	4,170	4,170		5 - 10	4,170	72
73	Fully Depreciated Assets	618,430	9,309	9,309		5 - 10	618,430	73
74								74
75	TOTALS	\$ 784,927	\$ 38,921	\$ 38,921	\$		\$ 685,095	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	\$ 19,784	\$ 19,784	\$	5	\$ 256,148	76
77	Executive Director	Toyota Camry	2006	10,696	2,045	2,045		5	2,045	77
78	Maintenance	Ford E250 Pickup/Chevy Silverad	2000/2005	27,841	2,450	2,450		5	21,573	78
79	Executive Director	Mazda Tribute	2003	disposed	105	105		5	disposed	79
80	TOTALS			\$ 299,120	\$ 24,384	\$ 24,384	\$		\$ 279,766	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,236,543	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	130,930	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	130,930	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)	\$	2,347,484	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		\$	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?  YES  NO  
If NO, see instructions.

	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	<u>1976</u>	<u>16</u>	<u>7/01/01</u>	<u>\$ 63,960</u>	<u>3</u>	<u>3</u>	3
4							4
5							5
6							6
7	<b>TOTAL</b>	<b>16</b>		<b>\$ 63,960</b>			7

10. Effective dates of current rental agreement:  
Beginning 7/1/05  
Ending 6/30/08

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2008</u>	<u>\$ 63,960</u>
13.	<u>6/30/2009</u>	<u>\$ 63,960</u>
14.	<u>6/30/2010</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	<b>TOTAL</b>		\$	\$	21

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

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

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

<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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,521		1,521
3	Classroom Wages (a)		12,301		12,301
4	Clinical Wages (b)		17,151		17,151
5	In-House Trainer Wages (c)		2,718		2,718
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 33,691	\$	\$ 33,691
10	SUM OF line 9, col. 1 and 2 (e)	\$	33,691		

- (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.

**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	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>26</b>

- (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	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 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.

STATE OF ILLINOIS

Facility Name & ID Number **Bethshan Association I & Bethshan Association II** # **7086, 0030528** Report Period Beginning: **7/1/06** Ending: **6/30/07**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **6/30/07** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (1,461,503)	\$ 239,795	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	847,455	1,023,010	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,357	100,107	6
7	Other Prepaid Expenses			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>	\$ (557,691)	\$ 1,362,912	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	2,152,496	5,126,435	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,084,047	1,807,979	16
17	Accumulated Depreciation (book methods)	(2,347,484)	(3,725,625)	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): <b>Construction in Process</b>	25,190	31,905	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 914,249	\$ 3,700,444	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 356,558	\$ 5,063,356	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 217,612	\$ 294,170	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	158,200	189,472	29
30	Accrued Salaries Payable	192,196	325,189	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,590	11,992	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,101	6,344	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>403(B) Contribution Payable</b>	1,590	2,758	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 579,289	\$ 829,925	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		459,484	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>	\$	\$ 459,484	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 579,289	\$ 1,289,409	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (222,731)	\$ 3,773,947	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 356,558	\$ 5,063,356	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 53,427	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 53,427	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(317,328)	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)	\$ (317,328)	17
<b>B. Transfers (Itemize):</b>			
18	Bathroom Remodeling	8,600	18
19	HVAC	2,165	19
20	Landscaping	6,509	20
21	Equipment	17,857	21
22	Software/Computers	6,039	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 41,170	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (222,731)	24 *

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

## STATE OF ILLINOIS

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

# 7086, 0030528

Report Period Beginning: 7/1/06

Ending: 6/30/07

Page 19

6/30/07

**VII. 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	\$ 3,416,345	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,416,345	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	33,169	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	10,692	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 43,861	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	226,830	24
25	Interest and Other Investment Income***	1,463	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 228,293	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous</u>	93	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 93	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,688,592	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	691,595	31
32	Health Care	2,032,733	32
33	General Administration	872,042	33
<b>B. Capital Expense</b>			
34	Ownership	205,867	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	203,683	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,005,920	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(317,328)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (317,328)	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 &amp; ID Number Bethshan Association I &amp; Bethshan Association II

# 7086, 0030528

Report Period Beginning:

7/1/06

Ending:

6/30/07

## 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	1,868	2,080	\$ 66,426	\$ 31.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,755	4,092	95,464	23.33	3
4	Licensed Practical Nurses	7,406	8,124	172,813	21.27	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	2,044	2,233	79,995	35.82	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,122	2,226	35,939	16.15	9
10	Activity Assistants	7,299	7,982	114,210	14.31	10
11	Social Service Workers	596	625	22,779	36.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,281	2,526	39,367	15.58	14
15	Cook Helpers/Assistants	9,635	10,630	122,481	11.52	15
16	Dishwashers					16
17	Maintenance Workers	2,875	3,159	64,917	20.55	17
18	Housekeepers	5,646	6,327	81,418	12.87	18
19	Laundry	2,320	2,640	24,313	9.21	19
20	Administrator	733	832	60,263	72.43	20
21	Assistant Administrator					21
22	Other Administrative	881	978	40,753	41.67	22
23	Office Manager					23
24	Clerical	3,695	4,143	78,034	18.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,389	8,684	181,447	20.89	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	77,041	85,024	1,016,472	11.96	30
31	Medical Records					31
32	Other Health Care Program Director	3,071	3,510	120,396	34.30	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,657	155,815	\$ 2,417,487 *	\$ 15.52	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	309	\$ 18,540	1-3	35
36	Medical Director	53	7,200	9-3	36
37	Medical Records Consultant	8	585	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	500	10-3	39
40	Physical Therapy Consultant	7	360	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	66	2,640	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	46	3,000	10a-3	45
46	Other(specify) Psychiatrist	39	6,911	10-3	46
47	Podiatrist	24	2,880	10-3	47
48					48
49	TOTAL (lines 35 - 48)	564	\$ 42,616		49

## C. CONTRACT NURSES

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

Facility Name & ID Number Bethshan Association I & Bethshan Association II

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	
Joe Lanenga	Executive Director	0	\$ 60,263	Workers' Compensation Insurance	\$ 35,903	IDPH License Fee	\$ 70	
Steve Goudzwaard	Director of Finance	0	40,753	Unemployment Compensation Insurance	7,944	Advertising: Employee Recruitment	2,509	
				FICA Taxes	172,294	Health Care Worker Background Check (Indicate # of checks performed <u>63</u> )	621	
				Employee Health Insurance	287,410	Patient Background Checks <u>61</u>	610	
				Employee Meals		AAMR, IARF, CARF	9,757	
				Illinois Municipal Retirement Fund (IMRF)*		Sams Club/Advocates Un/Am.Red Cross	827	
				Pension	40,665	filing fees	60	
				Employee Physicals	192	Employee Professional Fees/Dues	634	
				Tuition	1,320			
				Other Employee Benefits	4,787			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,016	TOTAL (agree to Schedule V, line 22, col.8)	\$ 550,515	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,088	
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 (Exec.Dir)		\$ 7,278	Out-of-State Travel	\$
				Personal use of auto (Maint.)		1,718		
							In-State Travel	629
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	1,418
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	( )
Dreyer Ooms & VanDrunen	audit & accounting		\$ 9,647				(agree to Sch. V, line 24, col. 8)	\$ 2,047
ADP/Voicenet Technologies	payroll preparation		7,031					
Open Systems	payroll consulting		1,996					
Informability	computer consulting		1,363					
Michigan Peer Review	IDR		5,665					
Pennelope Kneisler	QMRP Consultant		316					
Martin Whalen Office Solutions	copier contract		404					
Duane Morris	legal services		18,236					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 44,658	TOTAL		\$ 8,996		

\* Attach copy of IMRF notifications

\*\*See instructions.

BETHSHAN I & I  
SCHEDULE OF STAFF TRAVEL  
FY 2007

		TRAVEL EXPENSE	SEMINARS COST	
Staff intra-agency travel for meetings at central office, etc				
<b>11-600-675 Allocation</b>				
8/2-4/07	CPI Conference Bill Dearth, QMRP St. Louis, MO	528.52		
8/14/2006	American Red Cross Fundamentals of Instructor Training Christina Cucci, DSP Chicago, IL		50.00	
9/6/2006	American Red Cross Lay Responder First Aid and CPR/AED Instructor Christina Cucci, DSP Arlington Heights, IL		300.00	
9/16/2006	American Red Cross Lay Responder First Aid and CPR/AED Instructor Christina Cucci, DSP Arlington Heights, IL		150.00	
10/10-11/2006	NIDDNA 6th Annual Educational Conference Laura Kirchoff, Program Director Val Lynch, DON Utica, IL	58.80	100.00	100.00
2/15/2007	Division of Developmental Disabilities Human Rights Committee Chairperson Training Amy Timmerma, LCSW Ola Sweiss, Intern Frea Mars, Program Director Tinley Park	8.94		
2/17/2007	Quality Therapy of IL, Inc. Therapeutic Approaches to Dementia Ann Marie Olson, QMRP Norridge, IL		110.00	
3/6/2007	The Alzheimer's Assoc. Best Friends Approach: Building a Culture of Care in Dementia Program Frea Mars, Program Director Oak Lawn, IL		35.00	
4/10-13/07	CPI conference Chad Colyer, Training Coordinator Skokie, IL	12.03		
4/12/2007	Shapiro Developmental Center Supervisory - Site safety Training Janet Herrmann, Program Director Megan McShane, QMRP Terri Murdock, QMRP Trisha Stingel, QMRP Kankakee, IL	20.78		
4/12/2007	MED 2000, Inc Managing & Preventing Chronic Pain Nancy Swiatlaski, RN Oak Lawn, IL		98.00	
4/20/2007	INR The Aging Brain MaryKay Mastman, OTPT Teresa Walus, OTPT Munster, IN		79.00	79.00
5/8/2007	ICAN "Working it Out" - Successfully dealing with conflict Carla Weidnaer, QMRP Michelle Gabrielse, QMRP Megan McShane, QMRP Trisha Stingel, QMRP Adam Toeset, QMRP Terri Murdock, QMRP Tinley Park, IL		129	
6/27/2007	Medical Update Making Diversity Work Laura Kirchoff, Program Director Palos Heights, IL		188.00	
TOTAL AFTER ADJUSTMENTS		<u>629.07</u>	<u>1,418.00</u>	<u>2,047.07</u>



Facility Name & ID Number Bethshan Association I & Bethshan Association II# 027086, 0030528

Report Period Beginning:

7/1/06

Ending:

6/30/07**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 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. \$ 18,691 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (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. \$ 203,683  
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 benefit: on Schedule V. \$ 0 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? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**Bethshan Association I & II**  
**ID # 0027086 & 0030528**  
**Schedule XX (12) Explanation of Salary Allocation**  
**FY2007**

Freya Mars	(Ln 15-5)	Program Director Salary	\$	41,260
	(Ln 10-1)	QMRP Salary	\$	12,458