



Facility Name & ID Number Bethshan Association I & II# 0027086 Report Period Beginning: 7/1/07 Ending: 6/30/08

## 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	<u>45</u>	Intermediate/DD	<u>45</u>	<u>16,470</u>	4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>61</u>	TOTALS	<u>61</u>	<u>22,326</u>	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	<u>15,898</u>			<u>15,898</u>
12	SC				12
13	DD 16 OR LESS	<u>5,589</u>			<u>5,589</u>
14	TOTALS	<u>21,487</u>			<u>21,487</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.24%

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

777 (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: 2008 Fiscal Year: 2008

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

Facility Name & ID Number Bethshan Association I & II # 0027086 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	166,800	16,741	15,150	198,691		198,691		198,691			1
2	Food Purchase		174,834		174,834		174,834		174,834			2
3	Housekeeping	80,865	25,408	6,544	112,817		112,817		112,817			3
4	Laundry	24,859	3,571		28,430		28,430		28,430			4
5	Heat and Other Utilities			52,692	52,692		52,692		52,692			5
6	Maintenance	64,325	17,364	14,485	96,174		96,174		96,174			6
7	Other (specify):* scavenger			3,632	3,632		3,632		3,632			7
8	<b>TOTAL General Services</b>	<b>336,849</b>	<b>237,918</b>	<b>92,503</b>	<b>667,270</b>		<b>667,270</b>		<b>667,270</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	1,610,753	54,854	14,045	1,679,652	(43,687)	1,635,965		1,635,965			10
10a	Therapy	84,788	2,107	6,307	93,202		93,202		93,202			10a
11	Activities	124,179	15,577		139,756		139,756		139,756			11
12	Social Services	22,865			22,865		22,865		22,865			12
13	CNA Training		3,037		3,037	43,687	46,724		46,724			13
14	Program Transportation		24,156		24,156		24,156		24,156			14
15	Other (specify):* Program Director	121,433			121,433		121,433		121,433			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,964,018</b>	<b>99,731</b>	<b>27,552</b>	<b>2,091,301</b>		<b>2,091,301</b>		<b>2,091,301</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	102,478			102,478		102,478		102,478			17
18	Directors Fees											18
19	Professional Services			20,675	20,675		20,675		20,675			19
20	Dues, Fees, Subscriptions & Promotions			14,221	14,221		14,221		14,221			20
21	Clerical & General Office Expenses	74,940	7,643	15,793	98,376	(60)	98,316	(20,029)	78,287			21
22	Employee Benefits & Payroll Taxes			591,964	591,964	409	592,373	(2,195)	590,178			22
23	Inservice Training & Education			2,303	2,303		2,303		2,303			23
24	Travel and Seminar			3,032	3,032		3,032	(1,630)	1,402			24
25	Other Admin. Staff Transportation			3,389	3,389	(349)	3,040		3,040			25
26	Insurance-Prop.Liab.Malpractice			43,185	43,185		43,185		43,185			26
27	Other (specify):* miscellaneous		1,852		1,852		1,852	(900)	952			27
28	<b>TOTAL General Administration</b>	<b>177,418</b>	<b>9,495</b>	<b>694,562</b>	<b>881,475</b>		<b>881,475</b>	<b>(24,754)</b>	<b>856,721</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,478,285</b>	<b>347,144</b>	<b>814,617</b>	<b>3,640,046</b>		<b>3,640,046</b>	<b>(24,754)</b>	<b>3,615,292</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**  
**FY2008**

To:	Employee Benefits	Sch V, Ln 22	Staff employment physicals	\$ 349
From:	Other Admin. Staff Transp.	Sch V, Ln 25		
To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	\$ 43,687
From:	Nursing & Medical Records	Sch V, Ln 10		
To:	Employee Benefits	Sch V, Ln 22	misc. salaries	\$ 60
From:	Miscellaneous Salaries	Sch V, Ln 21		

Facility Name & ID Number Bethshan Association I & II #0027086 Report Period Beginning: 7/1/07 Ending: 6/30/08

## 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			121,430	121,430	121,430		121,430			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			9,892	9,892	9,892	(5,759)	4,133			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>			195,282	195,282	195,282	(5,759)	189,523			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			196,441	196,441	196,441		196,441			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			196,441	196,441	196,441		196,441			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,478,285	347,144	1,206,340	4,031,769	4,031,769	(30,513)	4,001,256			45

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

Facility Name & ID Number Bethshan Association I & II

# 0027086

Report Period Beginning: 7/1/07

Ending: 6/30/08

**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	(5,759)	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	(20,029)	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	(4,725)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (30,513)</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>\$ (30,513)</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.

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

BHF USE ONLY					
48		49		50	
				51	
					52

Bethshan Association I & II

ID# 0027086

Report Period Beginning: 7/1/07

Ending: 6/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Direct Care Seminars	\$ (1,630)	24	1
2	Fundraising Employee Benefits	(2,195)	22	2
3	Miscellaneous gifts & dinners	(900)	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>	(4,725)		49

## STATE OF ILLINOIS

Summary A

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

# 0027086

Report Period Beginning:

7/1/07

Ending:

6/30/08

## 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	(20,029)	0	0	0	0	0	0	0	0	0	0	(20,029)	21
22	Employee Benefits & Payroll Taxes	(2,195)	0	0	0	0	0	0	0	0	0	0	(2,195)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,630)	0	0	0	0	0	0	0	0	0	0	(1,630)	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):*	(900)	0	0	0	0	0	0	0	0	0	0	(900)	27
28	<b>TOTAL General Administration</b>	(24,754)	0	0	0	0	0	0	0	0	0	0	(24,754)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(24,754)	0	0	0	0	0	0	0	0	0	0	(24,754)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethshan Association I & II

# 0027086

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	(5,759)	0	0	0	0	0	0	0	0	0	0	(5,759)	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>(5,759)</b>	<b>0</b>	<b>(5,759)</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>(30,513)</b>	<b>0</b>	<b>(30,513)</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**

ID 0027086 & 0030528

Period 7/1/07 through 6/30/08

Schedule VII-A Attachment

Board of Trustees 2007-2008

Brian Dobben	President	819 Argyle	Flossmoor	IL	60422
Bob Payne	Vice President	13617 Arrowhead Ct	Orland Park	IL	60462
Donald Poortenga	Treasurer	1135 Stommel Place	Dyer	IN	46311
Kim Lagestee Mulder	Secretary	18765 Forestview Lane	Lansing	IL	60438
Judy Gill	Director	3301 - 231st St.	Chicago Heights	IL	60411
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
Howard VanDyke	Director	19 W country Lane	Lombard	IL	60148
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

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 &amp; ID Number

Bethshan Association I &amp; II

#

0027086

Report Period Beginning:

7/1/07

Ending:

6/30/08

## 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 & II

# 0027086 Report Period Beginning: 7/1/07

Ending: 6/30/08

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	\$ 136,234	\$ 132,030	61	\$ 64,421	1
2	14	Program Transportation	# beds 129	11	36,541		61	17,279	2
3	19	Professional Services	# beds 129	11	36,177		61	17,107	3
4	20	Dues/Fees/Subscriptions	# beds 129	11	21,699		61	10,261	4
5	21	Clerical & General Office	# beds 129	11	178,005	157,575	61	84,173	5
6	22	Workers Comp	budgeted salaries 4,366,500	11	79,712		2,407,794	43,955	6
7	22	Other Employee Benefits	# beds 129	11	18,781		61	8,881	7
8	23	In Service Training	# beds 129	11	2,090		61	988	8
9	24	Seminars & Workshop	# beds 129	11	3,268		61	1,545	9
10	25	Staff Travel	# beds 129	11	5,645		61	2,669	10
11	26	Liability Insurance	# beds 129	11	90,473		61	42,782	11
12	27	Miscellaneous	# beds 129	11	3,325		61	1,572	12
13	17	Administration	# beds 129	11	213,106	213,106	61	100,771	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				\$ 825,056	\$ 502,711		\$ 396,404	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<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	148,200	148,200	on demand	0.0600	8,892	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			\$ 9,892	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			\$ 9,892	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 2008

NAME	NOTE #	AMOUNT	Dates Interest was Paid	Int. Rate	Interest		Months Accrued
					Interest Paid	Accrued as of 6/30	
Donald R or Carolyn A Tiemens	483	\$ 10,000.00	01-Aug-2007	6%	300.00		
			01-Feb-2008	6%	300.00	250.00	5.0
Henry P. Iperma Revocable Living Tr	484	\$ 2,000.00	01-Aug-2007	6%	60.00		
			01-Feb-2008	6%	60.00	50.00	5.0
Grace Kooi or Carol J. DeYoung or Garry L. Kooi	486	\$ 10,000.00	01-Aug-2007	6%	300.00	250.00	5.0
Winnie Chilton	487	\$ 10,000.00	01-Aug-2007	6%	300.00		
		-	01-Feb-2008	6%	300.00	250.00	5.0
		<u>\$ 32,000.00</u>			<u>\$ 1,920.00</u>	<u>\$ 800.00</u>	
Peter M Post, Sr. &/or Jeanette &/or Peter M Post, Jr.	435	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
John B. & Linda L. Meyer Jt Ten WR	438	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
Cornelius and Eldene Dykstra	448	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
David & Amy Tiemersma	452	\$ 2,000.00	01-Sep-2007	6%	60.00		
			01-Mar-2008	6%	60.00	40.00	4.0
Robert J or Charlotte Parrish	453	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
Lois J Ooms Living Trust	455	\$ 5,000.00	01-Sep-2007	6%	150.00		
			01-Mar-2008	6%	150.00	100.00	4.0
Herbert &/or Estelle Ooms Living Trust dated 10/17/92	502	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
Clarence or Eleanor or Laurie Ouwenga	458-459	\$ 8,000.00	01-Sep-2007	6%	240.00		
			01-Mar-2008	6%	240.00	160.00	4.0
Dexter and Laura Boersma	461	\$ 5,000.00	01-Sep-2007	6%	150.00		
			01-Mar-2008	6%	150.00	100.00	4.0
Jean DeYoung, Ttee of the William C Survivor's Trust dated 1/18/00	503	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
Helen M Stalman	463	\$ 10,000.00	01-Sep-2007	6%	300.00		
			01-Mar-2008	6%	300.00	200.00	4.0
Henry P. Iperma Revocable Living Tr	490	\$ 5,000.00	01-Sep-2007	6%	150.00		
		-	01-Mar-2008	6%	150.00	100.00	4.0
		<u>\$ 95,000.00</u>			<u>\$ 5,700.00</u>	<u>\$ 1,900.00</u>	
Beverly Joyce Renz	466	\$ 4,000.00	01-Oct-2007	6%	120.00		
			01-Apr-2008	6%	120.00	60.00	3.0
Edith S. Hanneman, TTEE under the Edith S. Hanneman declaration of trust dated 2/4/93	471&479	\$ 10,000.00	01-Oct-2007	6%	300.00		
			01-Apr-2008	6%	300.00	150.00	3.0
Harriette VanBeveren or Aldena Van	481	\$ 7,200.00	01-Oct-2007	6%	216.00		
		-	01-Apr-2008	6%	216.00	108.00	3.0
		<u>\$ 21,200.00</u>			<u>\$ 1,272.00</u>	<u>\$ 318.00</u>	
Bess Tolsma or Betty Schurman or Mary Boerema	251	\$ 10,000.00	01-Dec-2007	10%	500.00		
		-	01-Jun-2008	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>\$ 158,200.00</u>			<u>\$ 9,892.00</u>	<u>\$ 3,101.33</u>	



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bethshan Association I & II COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027086

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

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

Facility Name & ID Number Bethshan Association I & II

# 0027086 Report Period Beginning:

7/1/07 Ending:

6/30/08

**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 &amp; ID Number Bethshan Association I &amp; II

# 0027086

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	\$ 16,039	20 - 40	\$ 16,039	\$	\$ 896,278	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Remodeling & Improvements BI & BII			147,377	4,320	20 - 40	4,320		107,303	9
10		fixed equipment			46,021	2,088	10 - 40	2,088		32,975	10
11		Addition: PT, nursing, office, & maintenance		1993	385,632	9,641	40	9,641		144,612	11
12		Landscaping			18,201	694	20	694		14,512	12
13		Automated door		1999	12,958	1,296	10	1,296		11,957	13
14		Garage			7,000	73	15 - 20	73		6,564	14
15		site improvements BI & BII			124,623	7,100	10 - 20	7,100		99,876	15
16		water & sewer improvements			22,009	734	30	734		18,614	16
17		Woodfold accordian folding partition		2000	2,720	272	10	272		2,183	17
18		Gas heater - Paul Supply BI		2001	2,593	259	10	259		1,973	18
19		Ceramic Tile - diningroom BI		2001	3,187	319	10	319		2,314	19
20		Besam automated entrance BII		2001	1,702	170	10	170		1,277	20
21		Bathroom remodeling BII		2001	8,455	846	10	846		6,041	21
22		Flat roofs (4) BI		2002	26,100	1,740	15	1,740		12,170	22
23		Bathroom remodeling BI		2002	133,435	8,896	15	8,896		56,340	23
24		Rooms painted (4 pods) BI		2002	6,840	456	15	456		2,929	24
25		Ceramic tile - livingroom BI		2002	4,250	283	15	283		1,855	25
26		Briggs generator BI		2002	2,995	374	8	374		2,293	26
27		Smoking shelter BI		2002	3,972	397	10	397		2,601	27
28		Fire alarm upgrade BI		2003	9,969	997	10	997		5,864	28
29		Whirlpool room remodeling BI		2003	6,750	450	15	450		2,275	29
30		Roof - (BI garage)		2004	2,030	135	15	135		567	30
31		Roof - (BI-north)		2005	7,765	518	15	518		1,842	31
32		Bathroom remodeling BI		2006	8,860	886	10	886		2,071	32
33		Furnace & A/C - Pod 1 & 4		2006	13,085	1,636	8	1,636		3,692	33
34		Fire System BI		2006	1,759	176	10	176		357	34
35		Fire Doors (5) BII		2006	2,354	235	10	235		557	35
36		Ceramic Tile Hallways BII		2006	4,250	425	10	425		993	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 & II

# 0027086

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	\$ 573	15	\$ 573	\$	\$ 1,084	37
38	Fire alarm CPU board BI	2007	1,745	175	10	175		283	38
39	Lennox Condensor BI	2007	2,165	217	10	217		228	39
40	Pergola	2007	2,000	200	10	200		378	40
41	Landscaping	2007	4,509	451	10	451		834	41
42	Lennox Elite HVAC BI	2008	14,650	931	15	931		931	42
43	Paint Kitchen BI	2008	3,900	44	10	44		44	43
44	Kitchen Stainless Wall Panels BI	2008	2,040	5	15	5		5	44
45	Bathroom remodeling & design (3) (BII)	2008	37,530	2,331	15	2,331		2,331	45
46	Automatic Door (BII)	2008	1,995	17	5	17		17	46
47	Driveway Seal Coat BI	2008	3,650	1,262	2	1,262		1,262	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)		\$ 2,216,261	\$ 67,661		\$ 67,661	\$	\$ 1,450,282	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	\$ 140,990	\$ 28,343	\$ 28,343	\$		\$ 72,347	71
72	Current Year Purchases	28,048	2,455	2,455			2,455	72
73	Fully Depreciated Assets	585,175	2,755	2,755			585,175	73
74								74
75	TOTALS	\$ 754,213	\$ 33,553	\$ 33,553	\$		\$ 659,977	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	1996-2007	\$ 275,355	\$ 15,628	\$ 15,628	\$	5	\$ 214,284	76
77	Executive Director	Toyota Camry	2006	10,696	2,139	2,139		5	4,185	77
78	Maintenance	Ford E250 Pickup/Chevy Silverac	2000/2005	27,841	2,450	2,450		5	24,022	78
79	client transportation	99 Ford van/01 Chevy Venture	1999/2001	disposed				5	disposed	79
80	TOTALS			\$ 313,892	\$ 20,217	\$ 20,217	\$		\$ 242,491	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)		\$ 3,284,366	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 121,431	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 121,431	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)		\$ 2,352,750	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?

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	<b>TOTAL</b>		<b>16</b>		\$ <b>63,960</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 7/1/08

Ending 6/30/11

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

Fiscal Year Ending                      Annual Rent

12.	<u>6/30/2009</u>	\$ <u>63,960</u>
13.	<u>6/30/2010</u>	\$ <u>63,960</u>
14.	<u>6/30/2011</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>		\$ _____	\$ _____	<b>21</b>

\* 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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		3,037		3,037
3	Classroom Wages (a)		14,373		14,373
4	Clinical Wages (b)		22,257		22,257
5	In-House Trainer Wages (c)		7,057		7,057
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 46,724	\$	\$ 46,724
10	SUM OF line 9, col. 1 and 2 (e)	\$	46,724		

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	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>25</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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<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 I & II # 0027086 Report Period Beginning: 7/1/07 Ending: 6/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/08 (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	\$ (1,581,260)	\$ 151,421	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	888,768	1,098,864	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,523	75,299	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>	\$ (649,969)	\$ 1,325,584	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	2,216,261	5,300,564	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,068,105	1,804,634	16
17	Accumulated Depreciation (book methods)	(2,352,750)	(3,878,888)	17
18	Deferred Charges	18,247	26,372	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>	\$ 949,863	\$ 3,712,432	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 299,894	\$ 5,038,016	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 150,615	\$ 207,906	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	158,200	190,610	29
30	Accrued Salaries Payable	210,000	359,862	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,466	13,838	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,101	6,121	33
34	Deferred Compensation	1,797	3,086	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36		49	49	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 531,228	\$ 781,472	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		427,074	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>	\$	\$ 427,074	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 531,228	\$ 1,208,546	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (231,334)	\$ 3,829,470	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 299,894	\$ 5,038,016	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (222,731)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (222,731)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(162,683)	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)	\$ (162,683)	17
<b>B. Transfers (Itemize):</b>			
18	Building Remodeling & Improvements	60,115	18
19	Parking lot seal-coating	3,650	19
20	Furnishings and Equipment	14,258	20
21	Office Equipment	3,793	21
22	Vehicles	72,264	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 154,080	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (231,334)	24 *

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

Facility Name & ID Number Bethshan Association I & II# 0027086Report Period Beginning: 7/1/07Ending: 6/30/08**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	\$ 3,477,664	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,477,664	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	47,078	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	10,736	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 57,814	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	327,087	24
25	Interest and Other Investment Income***	5,759	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 332,846	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	762	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 762	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,869,086	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	667,270	31
32	Health Care	2,091,301	32
33	General Administration	881,475	33
<b>B. Capital Expense</b>			
34	Ownership	195,282	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	196,441	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,031,769	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(162,683)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (162,683)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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 I & II

# 0027086

Report Period Beginning: 7/1/07

Ending: 6/30/08

**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	1,804	2,072	\$ 68,885	\$ 33.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,867	6,541	153,663	23.49	3
4	Licensed Practical Nurses	5,579	6,227	132,502	21.28	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	1,995	2,314	84,788	36.64	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,036	2,204	37,420	16.98	9
10	Activity Assistants	4,923	5,664	86,759	15.32	10
11	Social Service Workers	540	621	22,865	36.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,111	2,432	42,414	17.44	14
15	Cook Helpers/Assistants	10,244	11,086	124,386	11.22	15
16	Dishwashers					16
17	Maintenance Workers	2,754	3,046	64,325	21.12	17
18	Housekeepers	5,394	6,264	80,865	12.91	18
19	Laundry	2,454	2,664	24,859	9.33	19
20	Administrator	732	835	61,163	73.25	20
21	Assistant Administrator					21
22	Other Administrative	887	991	41,315	41.69	22
23	Office Manager					23
24	Clerical	3,479	3,912	74,940	19.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,894	10,953	201,580	18.40	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	78,096	86,395	1,054,123	12.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Program Director</u>	3,098	3,557	121,433	34.14	33
34	TOTAL (lines 1 - 33)	141,887	157,778	\$ 2,478,285 *	\$ 15.71	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	252	\$ 15,150	1-3	35
36	Medical Director	53	7,200	9-3	36
37	Medical Records Consultant	8	590	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10-3	39
40	Physical Therapy Consultant	5	267	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	76	3,040	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	46	3,000	10a-3	45
46	Other(specify) <u>Psychiatrist</u>	47	8,463	10-3	46
47	<u>Podiatrist</u>	24	2,880	10-3	47
48					48
49	TOTAL (lines 35 - 48)	523	\$ 41,190		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





**BETHSHAN I & II**  
**SCHEDULE OF STAFF TRAVEL**  
**FY 2008**

		<u>TRAVEL</u> <u>EXPENSE</u>	<u>SEMINARS</u> <u>COST</u>
<b>11-600-675 Allocation</b>			
6/26/2007	IARF Assoc Meeting Springfield, IL Janet Herrmann, Program Director	100.69	
10/10/2007	ICAN Aging and Dementia in the DD population Arlington Heights, IL Laura Kirchhoff, Program Director Katherina Konrath, QMRP	7.68 7.68	
10/25-26/07	The Institute on Public Policy Best Practices Conference Lisle, IL Laura Kirchhoff, Program Director	48.00	225.00
11/12-13/07	ILRTA Focus on the Future Alsip, IL Marie Inczauskis, Activity Director		195.00
1/22/2008	ARC of Illinois QMRP Leadership Conference Judy Mrgan, QMRP Katherina Konrath, QMRP Carla Weidenaar, QMRP		121.50 121.50 121.50
3/11/2008	ARC of Illinois From School to an Integrated Adult Life in the Community Tinley Park, IL Laura Kirchhoff, Program Director		125.00
3/26/2008	ICAN Creating meaningful activities for persons with DD Arlington Heights, IL Marie Inczauskis, Activity Director	12.19	
4/22/2008	ICAN End of Life Decision Laura Kirchhoff, Program Director	106.97	149.00
6/30/2008	Alzheimer's Assoc Alzheimer Support Group Training Chicago, IL Freya Mars, Program Director		60.00
		<b><u>283.21</u></b>	<b><u>1,118.50</u></b>
			<b>1,401.71</b>

**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. \$ 21,579 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. \$ 196,441  
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. \$ 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**  
**FY2008**

Freya Mars	(Ln 15-5)	Program Director Salary	\$	41,288
	(Ln 10-1)	QMRP Salary	\$	12,468