

Facility Name & ID Number Bethshan Association

0027086 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		ICF/DD 16 or Less			6
7	45	TOTALS	45	16,425	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	16,093			16,093	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,093			16,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.98%

D. How many bed reserve days during this year were paid by the Department?
139 (Do not include bed reserve days in Section B.)

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

none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 7/16/1982

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: 2018 Fiscal Year: 2018

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

Facility Name & ID Number

Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	154,399	11,571	9,198	175,168		175,168		175,168		1
2	Food Purchase		139,459		139,459		139,459		139,459		2
3	Housekeeping	63,918	21,343	7,147	92,408		92,408		92,408		3
4	Laundry	9,685	4,366		14,051		14,051		14,051		4
5	Heat and Other Utilities			46,998	46,998		46,998		46,998		5
6	Maintenance	20,218	14,287	26,413	60,918		60,918		60,918		6
7	Other (specify):* scavenger			3,640	3,640		3,640		3,640		7
8	TOTAL General Services	248,220	191,026	93,396	532,642		532,642		532,642		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,547,223	104,129	11,432	1,662,784	(62,664)	1,600,120		1,600,120		10
10a	Therapy	90,881	914	611	92,406		92,406		92,406		10a
11	Activities	67,461	17,674		85,135		85,135		85,135		11
12	Social Services	14,463		3,323	17,786		17,786		17,786		12
13	CNA Training		9,875		9,875	62,664	72,539		72,539		13
14	Program Transportation		16,682		16,682		16,682		16,682		14
15	Other (specify):* Program Director	66,470			66,470		66,470		66,470		15
16	TOTAL Health Care and Programs	1,786,498	149,274	15,366	1,951,138		1,951,138		1,951,138		16
	C. General Administration										
17	Administrative	97,377			97,377		97,377	(2,888)	94,489		17
18	Directors Fees										18
19	Professional Services			21,519	21,519		21,519	(20)	21,499		19
20	Dues, Fees, Subscriptions & Promotions			6,398	6,398		6,398		6,398		20
21	Clerical & General Office Expenses	63,294	5,309	5,608	74,211		74,211	(950)	73,261		21
22	Employee Benefits & Payroll Taxes			418,315	418,315		418,315	(532)	417,783		22
23	Inservice Training & Education			408	408		408		408		23
24	Travel and Seminar			3,040	3,040		3,040	(378)	2,662		24
25	Other Admin. Staff Transportation			2,020	2,020		2,020		2,020		25
26	Insurance-Prop.Liab.Malpractice			34,399	34,399		34,399		34,399		26
27	Other (specify):* miscellaneous		1,493		1,493		1,493	(500)	993		27
28	TOTAL General Administration	160,671	6,802	491,707	659,180		659,180	(5,268)	653,912		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,195,389	347,102	600,469	3,142,960		3,142,960	(5,268)	3,137,692		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			119,690	119,690		119,690		119,690		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			3,685	3,685		3,685		3,685		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			123,375	123,375		123,375		123,375		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			163,328	163,328		163,328		163,328		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			163,328	163,328		163,328		163,328		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,195,389	347,102	887,172	3,429,663		3,429,663	(5,268)	3,424,395		45

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

Bethshan Association I
ID # 0027086
Schedule V, ISFR Reclassifications
FY2018

To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	\$	62,664
From:	Nursing & Medical Records	Sch V, Ln 10			

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				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	(2,888)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,380)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,268)		\$	30

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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (5,268)		37

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

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

		1	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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Bethshan Association

ID# 0027086

Report Period Beginning: 7/1/17

Ending: 6/30/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Fundraising payroll	\$ (20)	19	1
2	Fundraising Clerical Salaries	(950)	21	2
3	Non Direct Care Seminars	(378)	24	3
4	Miscellaneous	(500)	27	4
5	Fundraising employee payroll taxes	(532)	22	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	Total	(2,380)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
B. Health Care and Programs														
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	(2,888)	0	0	0	0	0	0	0	0	0	0	(2,888)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20)	0	0	0	0	0	0	0	0	0	0	(20)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(950)	0	0	0	0	0	0	0	0	0	0	(950)	21
22	Employee Benefits & Payroll Taxes	(532)	0	0	0	0	0	0	0	0	0	0	(532)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(378)	0	0	0	0	0	0	0	0	0	0	(378)	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):*	(500)	0	0	0	0	0	0	0	0	0	0	(500)	27
28	TOTAL General Administration	(5,268)	0	0	0	0	0	0	0	0	0	0	(5,268)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,268)	0	0	0	0	0	0	0	0	0	0	(5,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,268)	0	(5,268)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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.

Facility Name & ID Number

Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Brian Dobben, President	BOD						1
2	Bob Payne, Vice President	BOD						2
3	Kim Lagestee-Mulder, Secretary	BOD						3
4	Timothy Eriks, Treasurer	BOD						4
5	Judy Gill	BOD						5
6	Tom Lemmenes	BOD						6
7	Ira Slagter	BOD						7
8	Allen Jongsma	BOD						8
9	Jack Hoekstra	BOD						9
10	Clint Verhagen	BOD						10
11	Don Poortenga	BOD						11
12	Erin VanDyke	BOD						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

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

0027086

Report Period Beginning:

7/1/17

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	work orders	945	16	\$ 107,333	\$ 104,614	179	\$ 20,331	1
2	17	Administration	# beds	138	16	298,615	298,615	45	97,374	2
3	19	Professional Services	# beds	138	16	52,620		45	17,159	3
4	20	Dues/Fees/Subscriptions	# beds	138	16	10,749		45	3,505	4
5	21	Clerical & General Office	# beds	138	16	210,618	191,052	45	68,680	5
6	22	Workers Comp	budgeted salaries	6,591,876	16	94,289		2,099,944	30,037	6
7	22	Other Employee Benefits	# beds	138	16	26,852		45	8,756	7
8	23	In Service Training	# beds	138	16	31		45	10	8
9	24	Seminars & Workshop	# beds	138	16	1,183		45	386	9
10	25	Staff Travel	# beds	138	16	6,192		45	2,019	10
11	26	Liability Insurance	# beds	138	16	47,424		45	15,464	11
12	27	Miscellaneous	# beds	138	16	2,362		45	770	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	TOTALS					\$ 858,268	\$ 594,281		\$ 264,491	25

Facility Name & ID Number

Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	various noteholders		X	facility remodeling		various	\$ 97,200	\$ 87,200	on demand	0.0400	\$ 3,818	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 97,200	\$ 87,200			\$ 3,818	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 97,200	\$ 87,200			\$ 3,818	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 2018

NAME	NOTE #	AMOUNT
John B. & Linda L. Meyer Jt Ten WROS	438	\$ 10,000.00
Cornelius Dykstra 1996 Trust Cornelius Dykstra, Trustee	448	\$ 10,000.00
Donald R. Tiemens Living Trust Agreement dated July 21, 2010	483	\$ 10,000.00
David & Amy Tiemersma	452	\$ 2,000.00
Robert J or Charlotte Parrish	453	\$ 10,000.00
Lois J Ooms Living Trust	455	\$ 5,000.00
Eleanor Ouwenga or Laurie (Teggelaar)	458-459	\$ 8,000.00
Dexter and Laura Boersma	461	\$ 5,000.00
Jean DeYoung, Ttee of the William DeYoung Survivor's Trust dated 1/18/00	503	\$ 10,000.00
Edith S. Hanneman, TTEE under the Edith S. Hanneman declaration of trust dated 2/4/93	471&479	\$ 10,000.00
Harriette VanBeveren or Aldena VanBeveren	481	\$ 7,200.00
		<u>\$ 87,200.00</u>

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 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 2018 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	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:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethshan Association 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 2017 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 2017.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

0027086 Report Period Beginning:

7/1/17 Ending:

6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,602 B. General Construction Type: Exterior brick Frame metal Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (c) Rent equipment from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Empty lines for listing other business entities.

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: none, Row 2: empty, Row 3: TOTALS.

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	45		1982	1982	\$ 1,098,235	\$ 15,349	20-40	\$ 15,349	\$	\$ 1,036,839	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		remodeling & improvements			99,918	174	20-40	174		98,159	9
10		fixed equipment			5,448	70	20-40	70		4,642	10
11		Addition: PT, nursing, office, & maintenance	1993		385,632	9,197	40	9,197		239,245	11
12		landscaping			18,201					18,201	12
13		automated door	1999		12,958					12,958	13
14		garage			7,000					7,000	14
15		site improvements			121,999	1,592	10 - 20	1,592		120,672	15
16		water & sewer improvements			22,009	37	30	37		21,833	16
17		woodfold accordion folding partition	2000		2,720					2,720	17
18		gas heater - Paul supply	2001		2,593					2,593	18
19		ceramic tile - diningroom	2001		3,187					3,187	19
20		flat roofs (4)	2002		26,100					26,100	20
21		bathroom remodeling	2002		133,435					133,435	21
22		rooms painted (4 pods)	2002		6,840					6,840	22
23		ceramic tile - livingroom	2002		4,250					4,250	23
24		Briggs generator	2002		2,995					2,995	24
25		smoking shelter	2002		3,972					3,972	25
26		fire alarm upgrade	2003		9,969					9,969	26
27		whirlpool room remodeling	2003		6,750	386	15	386		6,750	27
28		garage roof	2004		2,030	137	15	137		1,927	28
29		roof (north)	2005		7,765	528	15	528		7,060	29
30		bathroom remodeling	2006		8,860					8,860	30
31		Furnace & A/C - pod 1 & 4	2006		13,085					13,085	31
32		fire system	2006		1,759					1,759	32
33		whirlpool bath remodeling (pod 4)	2007		8,600	583	15	583		6,853	33
34		fire alarm CPU board	2007		1,745					1,745	34
35		Lennox condensor	2007		2,165					2,165	35
36		pergola	2007		2,000					2,000	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

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	landscaping	2007	\$ 4,509	\$		\$	\$	\$ 4,509	37
38	Lennox Elite HVAC	2008	14,650	982	15	982		10,720	38
39	paint kitchen	2008	3,900	329	10	329		3,900	39
40	kitchen stainless wall panels	2008	2,040	135	15	135		1,362	40
41	Rheem water heater	2009	5,917	598	10	598		5,170	41
42	water heater	2010	778	80	10	80		593	42
43	building alarm panel	2011	860	58	15	58		422	43
44	exterior wood replacement	2012	4,825	486	10	486		3,328	44
45	exterior eaves & trim	2012	4,550	458	10	458		3,098	45
46	kitchen door & panic hardware	2012	1,700	172	10	172		1,087	46
47	metal hall door	2012	1,100	111	10	111		704	47
48	Lennox air conditioner	2012	2,990	201	15	201		1,252	48
49	drywall,tile shower,paint bathrooms (4 pods)	2013	16,430	1,102	15	1,102		6,300	49
50	closet doors / fire doors	2013	9,900	497	20	497		2,535	50
51	LED light fixtures	2014	28,234	4,033	7	4,033		17,931	51
52	fire sprinkler system	2014	11,525	1,055	10 - 20	1,055		5,091	52
53	generator	2014	41,900	2,794	15	2,794		13,268	53
54	generator transfer switch	2014	2,825	404	7	404		1,784	54
55	bathroom wall guards/kick plates	2014	9,531	1,906	5	1,906		8,135	55
56	furnace - office	2014	997	100	10	100		433	56
57	conference room Kitchen/bath cabinet sink countertop	2014	10,626	1,062	10	1,062		4,428	57
58	rewire home run	2014	2,550	127	20	127		521	58
59	trees (10)	2014	3,850	257	15	257		1,220	59
60	LED light fixtures	2015	16,048	2,293	7	2,293		8,799	60
61	plumbing - Pod 1	2015	3,398	170	20	170		623	61
62	Lennox HVAC - conf. room	2015	4,350	290	15	290		1,039	62
63	paving-parking lot	2015	22,694	1,513	15	1,513		4,791	63
64	ornamental Iron fence	2015	5,630	563	10	563		1,783	64
65	entry doors, office & garage	2016	4,549	303	15	303		783	65
66	garage HVAC	2016	4,470	298	15	298		671	66
67	furnace - office	2016	1,980	132	15	132		297	67
68	AC - office	2016	6,280	418	15	418		942	68
69	door - SW courtyard	2016	8,326	555	15	555		1,203	69
70	TOTAL (lines 4 thru 69)		\$ 2,286,132	\$ 51,535		\$ 51,535	\$	\$ 1,926,536	70

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

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,286,132	\$ 51,535		\$ 51,535	\$	\$ 1,926,536	1
2	sealcoating & striping	2016	4,867	2,230	2	2,230		4,867	2
3	fencing dumpster area	2017	1,500	150	10	150		288	3
4	furnace w/air purifier pod 3	2017	2,960	197	15	197		345	4
5	garden patio landscaping, dirt/stone/brick	2017	5,830	583	10	583		972	5
6	landscaping bushes	2017	4,525	452	10	452		754	6
7	overhead door, maintenance garage	2017	2,000	133	15	133		211	7
8	roof shingles, office & garage w/skylights	2017	9,690	484	20	484		767	8
9	windows replaced, east side	2017	21,048	1,052	20	1,052		1,140	9
10	tuckpoint brick exterior of building	2017	3,300	220	15	220		238	10
11	whirlpool room (pod 3) tile & drywall	2018	2,975	165	15	165		165	11
12	doors, storage room & front lounge	2018	4,200	175	20	175		175	12
13	smoke barrier, ceiling (pods 2&4)	2018	2,800	117	20	117		117	13
14	nursing office expanded; walls, doors, closet, paint	2018	11,600	483	20	483		483	14
15	showers (2) repair (pod 3); plumbing fixtures, floor tile, walls	2018	19,600	1,034	15	1,034		1,034	15
16	P-trap, cleanout	2018	3,192	160	15	160		160	16
17	lift station pump	2018	24,960	2,912	5	2,912		2,912	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	TOTAL (lines 1 thru 33)		\$ 2,411,179	\$ 62,082		\$ 62,082	\$	\$ 1,941,164	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 332,868	\$ 39,074	\$ 39,074	\$		\$ 160,761	71
72	Current Year Purchases	44,247	2,141	2,141			2,141	72
73	Fully Depreciated Assets	386,542	4,637	4,637			386,542	73
74								74
75	TOTALS	\$ 763,657	\$ 45,852	\$ 45,852	\$		\$ 549,444	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	Ford Vans 2003-2016 / Honda Odyssey 2018		\$ 172,550	\$ 7,061	\$ 7,061	\$	5	\$ 123,631	76
77	Exec Dir./Finance Dir.	Toyota Rav4 2015/Honda CRV 2014		15,263	3,053	3,053		5	11,691	77
78	Maintenance	Ford superduty 2011 / Ford F150 2018		15,439	318	318		5	9,399	78
79	Maintenance	Ford F150 pickup	2013	disposed	1,324	1,324			disposed	79
80	TOTALS			\$ 203,252	\$ 11,756	\$ 11,756	\$		\$ 144,721	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)	\$ 3,378,088	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,690	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)	\$ 2,635,329	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.

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning: 7/1/17

Ending: 6/30/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		9,875		9,875
3	Classroom Wages (a)		14,306		14,306
4	Clinical Wages (b)		31,217		31,217
5	In-House Trainer Wages (c)		7,266		7,266
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 62,664	\$	\$ 62,664
10	SUM OF line 9, col. 1 and 2 (e)	\$	62,664		

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	28
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	28

- (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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Bethshan Association**
XV. BALANCE SHEET - Unrestricted Operating Fund.

0027086
 As of **6/30/18**

Report Period Beginning: **7/1/17**
 (last day of reporting year)

Ending: **6/30/18**

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (2,030,042)	\$ 291,467	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	268,441	398,175	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,037	31,250	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,749,564)	\$ 720,892	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,044,175	13
14	Buildings, at Historical Cost	2,411,179	7,982,060	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	966,909	2,151,402	16
17	Accumulated Depreciation (book methods)	(2,635,329)	(5,489,421)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 742,759	\$ 5,688,216	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,006,805)	\$ 6,409,108	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 62,555	\$ 115,027	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	87,200	620,565	29
30	Accrued Salaries Payable	149,366	410,102	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,830	14,200	31
32	Accrued Real Estate Taxes(Sch.IX-B)		888	32
33	Accrued Interest Payable	1,139	12,088	33
34	Deferred Compensation	1,806	4,539	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 307,896	\$ 1,177,409	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,028,508	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,028,508	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 307,896	\$ 2,205,917	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,314,701)	\$ 4,203,191	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,006,805)	\$ 6,409,108	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,266,046)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,266,046)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(185,060)	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)	\$ (185,060)	17
	B. Transfers (Itemize):		
18	Building improvements and repairs	41,175	18
19	Sewer repairs	24,960	19
20	Furnishings	38,846	20
21	Vehicle-2018 Honda Odyssey	31,424	21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 136,405	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,314,701)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning: 7/1/17

Ending: 6/30/18

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,827,499	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,827,499	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	62,051	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 62,051	23
D. Non-Operating Revenue			
24	Contributions	350,000	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 350,000	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>miscellaneous</u>	53	28
28a	<u>gain on disposition of assets</u>	5,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,053	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,244,603	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	532,642	31
32	Health Care	1,951,138	32
33	General Administration	659,180	33
B. Capital Expense			
34	Ownership	123,375	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	163,328	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,429,663	40
41	Income before Income Taxes (line 30 minus line 40)**	(185,060)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (185,060)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,827,499	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,827,499	49

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

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

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

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

Facility Name & ID Number Bethshan Association

0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18

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	1,815	2,119	\$ 89,202	\$ 42.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,101	9,775	271,965	27.82	3
4	Licensed Practical Nurses	3,277	3,655	90,447	24.75	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	2,052	2,371	90,881	38.33	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,783	2,081	41,723	20.05	9
10	Activity Assistants	1,309	1,572	25,738	16.37	10
11	Social Service Workers	322	365	14,463	39.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,961	2,313	45,786	19.80	14
15	Cook Helpers/Assistants	8,379	9,072	108,613	11.97	15
16	Dishwashers					16
17	Maintenance Workers	787	865	20,218	23.37	17
18	Housekeepers	3,750	4,173	63,918	15.32	18
19	Laundry	940	1,021	9,685	9.49	19
20	Administrator	561	678	50,436	74.39	20
21	Assistant Administrator					21
22	Other Administrative	1,044	1,134	46,941	41.39	22
23	Office Manager					23
24	Clerical	2,481	2,846	63,294	22.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,215	8,138	160,754	19.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	61,778	67,139	934,855	13.92	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Program Director</u>	1,967	2,118	66,470	31.38	33
34	TOTAL (lines 1 - 33)	110,522	121,435	\$ 2,195,389 *	\$ 18.08	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	142	\$ 9,198	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	8,497	10-3	39
40	Physical Therapy Consultant	6	476	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	135	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	52	3,323	12-3	45
46	Other(specify) <u>Psychiatrist</u>	6	1,915	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	294	\$ 23,544		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9	\$ 468	10-3	50
51	Licensed Practical Nurses	16	552	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 1,020		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Joe Lanenga	Executive Director	0	\$ 50,436	Workers' Compensation Insurance	\$ 31,208	IDPH License Fee	\$			
Steve Goudzwaard	Finance Director	0	32,502	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	1,272			
Julie Sather	Executive Assistant	0	14,439	FICA Taxes	160,506	Health Care Worker Background Check	1,518			
				Employee Health Insurance	165,567	(Indicate # of checks performed <u>19</u>)				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Inst on Public Policy	2,217			
				Pension	44,545	Employee Professional Fees/Dues	1,321			
				Employee Benefits	15,957	Sams Club/filing fees/Visa	70			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,377	TOTAL (agree to Schedule V, line 22, col.8)			\$ 417,783	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,398
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 (Executive Director)		\$ 2,386	Out-of-State Travel	\$		
				personal use of auto (Maintenance)		1,962				
				personal use of auto (Director of Finance)		2,125	In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$ 6,473	Seminar Expense	2,662	
C. Professional Services										
Vendor/Payee	Type		Amount							
Dreyer Ooms & VanDrunen	audit & accounting		\$ 9,862							
Paycor	payroll service provider		879							
Paycom	payroll service provider		7,302							
US Telepunch	payroll attendance		1,058							
Open Systems	accounting software maint.		343							
Informability	IT system contractor		908							
Don Moss	Information Srv Provider		783							
CSP	IT consulting		140							
Ahead	subscription		163							
Holtrop	Promotional Srvs		49							
Dropbox	online storage		32							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 21,519				Entertainment Expense (agree to Sch. V, line 24, col. 8)		\$ 2,662	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bethshan Association# 0027086

Report Period Beginning:

7/1/17

Ending:

6/30/18**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? yes
If YES, give association name and amount. Institute on Public Policy - \$2,217
- (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? 15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,567 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. \$ 163,328
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? no 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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. n/a
Attach invoices and a summary of services for all architect and appraisal fees