FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0027086 & 0030528

Facility Name: Bethshan Association I & Bethshan Association II

Address: 12927 South Monitor Avenue (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708) 371-0800 **Fax #** (708) 371-0833

HFS ID Number:

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

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/09 to 6/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Steven J. Goudzwaard
(Title) Director of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 0086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,697			15,697	11
12	SC					12
13	DD 16 OR LESS	5,544			5,544	13
14	TOTALS	21,241			21,241	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.40%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/16/82 / 2/7/86

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2010 Fiscal Year: 2010

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

Facility Name & ID Number Bethshan Association I & Bethshan Associatic #27086 & 00305 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,352	10,663	11,100	190,115		190,115		190,115			1
2	Food Purchase		148,193		148,193		148,193		148,193			2
3	Housekeeping	65,621	20,009	6,785	92,415		92,415		92,415			3
4	Laundry	11,619	5,763		17,382		17,382		17,382			4
5	Heat and Other Utilities			43,658	43,658		43,658		43,658			5
6	Maintenance	63,715	16,232	24,005	103,952		103,952		103,952			6
7	Other (specify):* scavenger			3,942	3,942		3,942		3,942			7
8	TOTAL General Services	309,307	200,860	89,490	599,657		599,657		599,657			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,625,222	49,093	13,918	1,688,233	(26,276)	1,661,957		1,661,957			10
10a	Therapy	113,748	1,492	7,351	122,591		122,591		122,591			10a
11	Activities	92,105	9,620		101,725		101,725		101,725			11
12	Social Services	16,357			16,357		16,357		16,357			12
13	CNA Training		2,192		2,192	26,276	28,468		28,468			13
14	Program Transportation		18,466		18,466		18,466		18,466			14
15	Other (specify):* Program Director	120,779			120,779		120,779		120,779			15
16	TOTAL Health Care and Programs	1,968,211	80,863	29,669	2,078,743		2,078,743		2,078,743			16
	C. General Administration											
17	Administrative	102,162			102,162		102,162		102,162			17
18	Directors Fees											18
19	Professional Services			20,891	20,891		20,891		20,891			19
20	Dues, Fees, Subscriptions & Promotions			9,809	9,809		9,809		9,809			20
21	Clerical & General Office Expenses	76,523	6,644	12,017	95,184		95,184	(16,125)	79,059			21
22	Employee Benefits & Payroll Taxes			570,616	570,616		570,616	(2,024)	568,592			22
23	Inservice Training & Education			2,243	2,243		2,243		2,243			23
24	Travel and Seminar			3,345	3,345		3,345	(458)	2,887			24
25	Other Admin. Staff Transportation			1,989	1,989		1,989		1,989			25
26	Insurance-Prop.Liab.Malpractice			40,294	40,294		40,294		40,294			26
27	Other (specify):* miscellaneous		2,175		2,175		2,175	(1,200)	975			27
28	TOTAL General Administration	178,685	8,819	661,204	848,708		848,708	(19,807)	828,901			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,456,203	290,542	780,363	3,527,108		3,527,108	(19,807)	3,507,301			29

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

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

Bethshan Association I & II
ID # 0027086 & 0030528
Schedule V, ISFR Reclassifications
FY2010

To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	$ 26,276
From:	Nursing & Medical Records	Sch V, Ln 10		

Facility Name & ID Number Bethshan Association I & Bethshan Association II #0027086 & 00 Report Period Beginning: 7/1/09 Ending: 6/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			112,133	112,133		112,133		112,133			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,342	9,342		9,342	(177)	9,165			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	**TOTAL Ownership**			185,435	185,435		185,435	(177)	185,258			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			193,424	193,424		193,424		193,424			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			193,424	193,424		193,424		193,424			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,456,203	290,542	1,159,222	3,905,967		3,905,967	(19,984)	3,885,983			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 & Bethshan Association II #'086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(177)	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	(16,125)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,721)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,023)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (20,023)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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

STATE OF ILLINOIS

Bethshan Association I & Bethshan Association II

ID# 0027086 & 0030528

Report Period Beginning: 7/1/09

Ending: 6/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Direct Care Seminars	$ (458)	24	1
2	Fundraising Employee Benefits	(2,024)	22	2
3	Miscellaneous	(1,200)	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	**Total**	(3,682)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethshan Association I & Bethshan Association II #27086 & 00305 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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)	
	A. General Services													
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	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	(16,125)	0	0	0	0	0	0	0	0	0	0	(16,125)	21
22	Employee Benefits & Payroll Taxes	(2,024)	0	0	0	0	0	0	0	0	0	0	(2,024)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(458)	0	0	0	0	0	0	0	0	0	0	(458)	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):*	(1,200)	0	0	0	0	0	0	0	0	0	0	(1,200)	27
28	**TOTAL General Administration**	(19,807)	0	0	0	0	0	0	0	0	0	0	(19,807)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,807)	0	0	0	0	0	0	0	0	0	0	(19,807)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethshan Association I & Bethshan Association II #27086 & 00305 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	(177)	0	0	0	0	0	0	0	0	0	0	(177)	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**	(177)	0	0	0	0	0	0	0	0	0	0	(177)	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)**	(19,984)	0	0	0	0	0	0	0	0	0	0	(19,984)	45

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 00305 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

BETHSHAN ASSOCIATION I & II
ID 0027086 & 0030528
Period 7/1/09 through 6/30/10
Schedule VII-A Attachment

Board of Trustees 2009-2010

Brian Dobben	President	819 Argyle	Flossmoor	IL	60422
Ira Slagter	Vice President	19124 Boulder Ridge Ct.	Mokena	IL	60448
Donald Poortenga	Treasurer	1135 Stommel Place	Dyer	IN	46311
Kim Lagestee Mulder	Secretary	16020 Veterans Park Drive	South Holland	IL	60473
Wayne Boss	Director	55 Village Woods Dr	Crete	IL	60417
Judy Gill	Director	3301 - 231st St.	Chicago Heights	Il	60411
John Groenboom	Director	N1525 Oak Shores Ln	Fontana	WI	53125
James Hofman	Director	12212 S 89th Ave	Palos Park	IL	60464
Ann Payne	Director	13617 Arrowhead Ct.	Orland Park	IL	60462
Gerald VanProoyen	Director	1336 Inverness Lane	Schererville	IN	46375
Howard VanDyke	Director	19 W 520 Country Lane	Lombard	IL	60148
Neil VerHagen	Director	16930 Avalon Ct.	South Holland	IL	60473

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

Facility Name & ID Number Bethshan Association I & Bethshan Associat # 0027086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	none								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Bethshan Association I & Bethshan Association II #27086 & 00305 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	# beds	130	11	$ 133,998	$ 133,998	61	$ 62,876	1
2	14	Program Transportation	# beds	130	11	23,606		61	11,077	2
3	17	Administration	# beds	130	11	217,450	217,450	61	102,034	3
4	19	Professional Services	# beds	130	11	43,725		61	20,517	4
5	20	Dues/Fees/Subscriptions	# beds	130	11	16,676		61	7,825	5
6	21	Clerical & General Office	# beds	130	11	179,838	163,080	61	84,386	6
7	22	Workers Comp	budgeted salaries	4,445,971	11	107,498		2,423,597	58,600	7
8	22	Other Employee Benefits	# beds	130	11	10,623		61	4,985	8
9	23	In Service Training	# beds	130	11	401		61	188	9
10	24	Seminars & Workshop	# beds	130	11	741		61	348	10
11	25	Staff Travel	# beds	130	11	4,238		61	1,989	11
12	26	Liability Insurance	# beds	130	11	82,150		61	38,547	12
13	27	Miscellaneous	# beds	130	11	4,397		61	2,063	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					$ 825,341	$ 514,528		$ 395,435	25

Facility Name & ID Number Bethshan Association I & Bethshan Associatic #7086 & 003052 Report Period Beginning: 7/1/09 Ending: 6/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	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	138,200	138,200	on demand	0.0600	8,342	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 148,200	$ 148,200			$ 9,342	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 148,200	$ 148,200			$ 9,342	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 2010

NAME	NOTE #	AMOUNT	Dates Interest was Paid	Int. Rate	Interest Paid
Donald R or Carolyn A Tiemens	483	$ 10,000.00	01-Aug-2009	6%	300.00
			01-Feb-2010	6%	300.00
Henry P. Ipema Revocable Living Trust Dated June 2	484	$ 2,000.00	01-Aug-2009	6%	60.00
			01-Feb-2010	6%	60.00
Grace Kooi or Carol J. DeYoung or Garry L. Kooi	486	$ 10,000.00	01-Aug-2009	6%	300.00
(redeemed 11/1/09)		$ (10,000.00)		6%	0.00
Winnie Chilton	487	$ 10,000.00	01-Aug-2009	6%	300.00
		-	01-Feb-2010	6%	300.00
		$ 22,000.00			$ 1,620.00
Peter M Post, Sr. &/or Jeanette	435	$ 10,000.00	01-Sep-2009	6%	300.00
&/or Peter M Post, Jr.			01-Mar-2010	6%	300.00
John B. & Linda L. Meyer Jt Ten WROS	438	$ 10,000.00	01-Sep-2009	6%	300.00
			01-Mar-2010	6%	300.00
Cornelius and Eldene Dykstra	448	$ 10,000.00	01-Sep-2009	6%	300.00
			01-Mar-2010	6%	300.00
David & Amy Tiemersma	452	$ 2,000.00	01-Sep-2009	6%	60.00
			01-Mar-2010	6%	60.00
Robert J or Charlotte Parrish	453	$ 10,000.00	01-Sep-2009	6%	300.00
			01-Mar-2010	6%	300.00
Lois J Ooms Living Trust	455	$ 5,000.00	01-Sep-2009	6%	150.00
			01-Mar-2010	6%	150.00
Herbert &/or Estelle Ooms Living	502	$ 10,000.00	01-Sep-2009	6%	300.00
Trust dated 10/17/92			01-Mar-2010	6%	300.00
Clarence or Eleanor or Laurie	458-459	$ 8,000.00	01-Sep-2009	6%	240.00
Ouwenga			01-Mar-2010	6%	240.00
Dexter and Laura Boersma	461	$ 5,000.00	01-Sep-2009	6%	150.00
			01-Mar-2010	6%	150.00
Jean DeYoung, Ttee of the William DeYoung	503	$ 10,000.00	01-Sep-2009	6%	300.00
Survivor's Trust dated 1/18/00			01-Mar-2010	6%	300.00
Helen M Stalman	463	$ 10,000.00	01-Sep-2009	6%	300.00
			01-Mar-2010	6%	300.00
Henry P. Ipema Revocable Living Trust Dated June 2	490	$ 5,000.00	01-Sep-2009	6%	150.00
		-	01-Mar-2010	6%	150.00
		$ 95,000.00			$ 5,700.00
Beverly Joyce Renz	466	$ 4,000.00	01-Oct-2009	6%	120.00
			01-Apr-2010	6%	120.00
Edith S. Hanneman, TTEE under the	471&479	$ 10,000.00	01-Oct-2009	6%	300.00
Edith S. Hanneman declaration of			01-Apr-2010	6%	300.00
trust dated 2/4/93					
Harriette VanBeveren or Aldena VanBeveren	481	$ 7,200.00	01-Oct-2009	6%	216.00
		-	01-Apr-2010	6%	216.00
		$ 21,200.00			$ 1,272.00
Bess Tolsma or Betty Schurman	251	$ 10,000.00	01-Dec-2009	10%	500.00
or Mary Boerema		-	01-Jun-2010	10%	500.00
		$ 10,000.00			$ 1,000.00
GRAND TOTAL ALL NOTES		$ 148,200.00			$ 9,592.00

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086 & 0030 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethshan Association I & Bethshan Association II COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027086 & 0030528

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 & Bethshan Association II #27086 & 00305 Report Period Beginning: 7/1/09 Ending: 6/30/10

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? [BI] (a) Own the Facility [ ] (b) Rent from a Related Organization. [BII] (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).

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	none			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086 & 003052 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	$ 15,634	20 - 40	$ 15,634	$	$ 927,545	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling & Improvements BI & BII				147,377	4,273	20 - 40	4,273		115,848	9
10	fixed equipment				46,021	1,984	10 - 40	1,984		36,958	10
11	Addition: PT, nursing, office, & maintenance			1993	385,632	9,641	40	9,641		163,894	11
12	Landscaping				18,201	694	20	694		15,901	12
13	Automated door			1999	12,958		10			12,958	13
14	Garage				7,000	73	15 - 20	73		6,710	14
15	site improvements BI & BII				124,623	3,045	10 - 20	3,045		108,375	15
16	water & sewer improvements				22,009	734	30	734		20,082	16
17	Woodfold accordian folding partitiion			2000	2,720	265	10	265		2,720	17
18	Gas heater - Paul Supply BI			2001	2,593	259	10	259		2,491	18
19	Ceramic Tile - diningroom BI			2001	3,187	319	10	319		2,951	19
20	Besam automated entrance BII			2001	1,702	170	10	170		1,618	20
21	Bathroom remodeling BII			2001	8,455	846	10	846		7,732	21
22	Flat roofs (4) BI			2002	26,100	1,740	15	1,740		15,650	22
23	Bathroom remodeling BI			2002	133,435	8,896	15	8,896		74,131	23
24	Rooms painted (4 pods) BI			2002	6,840	456	15	456		3,841	24
25	Ceramic tile - livingroom BI			2002	4,250	283	15	283		2,422	25
26	Briggs generator BI			2002	2,995	327	8	327		2,995	26
27	Smoking shelter BI			2002	3,972	397	10	397		3,395	27
28	Fire alarm upgrade BI			2003	9,969	997	10	997		7,858	28
29	Whirlpool room remodeling BI			2003	6,750	450	15	450		3,175	29
30	Roof - (BI garage)			2004	2,030	135	15	135		838	30
31	Roof - (BI-north)			2005	7,765	518	15	518		2,878	31
32	Bathroom remodeling BI			2006	8,860	886	10	886		3,843	32
33	Furnace & A/C - Pod 1 & 4			2006	13,085	1,636	8	1,636		6,964	33
34	Fire System BI			2006	1,759	176	10	176		708	34
35	Fire Doors (5) BII			2006	2,354	235	10	235		1,028	35
36	Ceramic Tile Hallways BII			2006	4,250	425	10	425		1,843	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086 & 003052 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Whirlpool bath remodeling (Pod 4)	2007	$ 8,600	$ 573	15	$ 573	$	$ 2,230	37
38	Fire alarm CPU board BI	2007	1,745	175	10	175		632	38
39	Lennox Condensor BI	2007	2,165	217	10	217		661	39
40	Pergola	2007	2,000	200	10	200		778	40
41	Landscaping	2007	4,509	451	10	451		1,736	41
42	Lennox Elite HVAC BI	2008	14,650	977	15	977		2,885	42
43	Paint Kitchen BI	2008	3,900	390	10	390		824	43
44	Kitchen Stainless Wall Panels BI	2008	2,040	136	15	136		277	44
45	Bathroom remodeling & design (3) (BII)	2008	37,530	2,502	15	2,502		7,335	45
46	Automatic Door (BII)	2008	1,995	399	5	399		815	46
47	Driveway Seal Coat BI	2008	3,650	563	2	563		3,650	47
48	Rheem Water Heater	2009	5,918	412	10	412		412	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)		$ 2,222,179	$ 62,489		$ 62,489	$	$ 1,579,587	70

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

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	$ 180,260	$ 26,830	$ 26,830	$		$ 86,785	71
72	Current Year Purchases	22,100	819	819			819	72
73	Fully Depreciated Assets	588,884	579	579			588,884	73
74								74
75	TOTALS	$ 791,244	$ 28,228	$ 28,228	$		$ 676,488	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	1996-2009	$ 260,434	$ 15,337	$ 15,337	$	5	$ 200,348	76
77	Executive Director	Toyota Prius	2010	10,079	701	701		5	701	77
78	Maintenance	Chevy Silverado/Ford F150	2005/2009	26,157	3,983	3,983		5	15,233	78
79	Ex.Dir/client transp.	Camry/Ford Van	2006/2001	disposed	1,395	1,395			disposed	79
80	TOTALS			$ 296,670	$ 21,416	$ 21,416	$		$ 216,282	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)	$ 3,310,093	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 112,133	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,133	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)	$ 2,472,357	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 I & Bethshan Association II # 7086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

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:	1976	16	7/1/01	$ 63,960	3	3	3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 63,960 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

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.	6/30/2011	$ 63,960
13.	6/30/2012	$ 63,960
14.	6/30/2013	$ 63,960

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.

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 003052 Report Period Beginning: 7/1/09 Ending: 6/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		2,192		2,192
3	Classroom Wages (a)		8,862		8,862
4	Clinical Wages (b)		11,810		11,810
5	In-House Trainer Wages (c)		5,604		5,604
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 28,468	$	$ 28,468
10	SUM OF line 9, col. 1 and 2 (e)	$ 28,468			

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	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number Bethshan Association I & Bethshan Association II # '086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (1,564,654)	$ 32,396	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,227,898	2,021,379	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,839	29,396	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)**	$ (320,917)	$ 2,083,171	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,175	13
14	Buildings, at Historical Cost	2,222,179	5,540,733	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,087,914	1,812,171	16
17	Accumulated Depreciation (book methods)	(2,472,357)	(4,202,015)	17
18	Deferred Charges		8,485	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)**	$ 837,736	$ 3,844,549	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 516,819	$ 5,927,720	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,037	$ 505,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	148,200	174,846	29
30	Accrued Salaries Payable	226,878	380,831	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,316	15,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)		6,179	32
33	Accrued Interest Payable	2,851	5,466	33
34	Deferred Compensation	2,247	4,082	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)**	$ 776,529	$ 1,091,817	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		375,969	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)**	$	$ 375,969	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 776,529	$ 1,467,786	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (259,710)	$ 4,459,934	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 516,819	$ 5,927,720	48

***(See instructions.)**

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 027086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (169,835)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (169,835)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(152,876)	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)**	$ (152,876)	17
	B. Transfers (Itemize):		
18	**Computers**	1,296	18
19	**Vehicles**	40,901	19
20	**Whirlpool Bath**	15,524	20
21	**Carendo Shower Chair**	5,280	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 63,001	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (259,710)	24 *

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

Facility Name & ID Number Bethshan Association I & Bethshan Association II #7086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,481,575	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,481,575	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	10,490	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	10,824	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 21,314	23
	D. Non-Operating Revenue		
24	Contributions	250,000	24
25	Interest and Other Investment Income***	177	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 250,177	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	miscellaneous	25	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,753,091	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	599,657	31
32	Health Care	2,078,743	32
33	General Administration	848,708	33
	B. Capital Expense		
34	Ownership	185,435	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	193,424	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,905,967	40
41	**Income before Income Taxes (line 30 minus line 40)****	(152,876)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (152,876)	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 & Bethshan Association II # 086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,812	2,080	$ 71,421	$ 34.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,715	8,301	208,747	25.15	3
4	Licensed Practical Nurses	4,284	4,700	103,191	21.96	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	3,264	3,731	113,748	30.49	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,928	2,128	38,861	18.26	9
10	Activity Assistants	3,087	3,584	53,244	14.86	10
11	Social Service Workers	381	411	16,357	39.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,916	2,209	38,665	17.50	14
15	Cook Helpers/Assistants	9,882	11,269	129,687	11.51	15
16	Dishwashers					16
17	Maintenance Workers	2,453	2,813	63,715	22.65	17
18	Housekeepers	4,027	4,550	65,621	14.42	18
19	Laundry	1,334	1,408	11,619	8.25	19
20	Administrator	838	977	67,520	69.11	20
21	Assistant Administrator					21
22	Other Administrative	851	976	34,642	35.49	22
23	Office Manager					23
24	Clerical	3,231	3,720	76,523	20.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,936	8,971	185,512	20.68	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	75,395	85,413	1,056,351	12.37	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Program Director	3,016	3,469	120,779	34.82	33
34	TOTAL (lines 1 - 33)	133,350	150,710	$ 2,456,203 *	$ 16.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	185	$ 11,100	1-3	35
36	Medical Director	54	8,400	9-3	36
37	Medical Records Consultant	4	295	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	550	10-3	39
40	Physical Therapy Consultant	13	986	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	61	2,440	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	52	3,925	10a-3	45
46	Other(specify) Psychiatrist	53	11,695	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	432	$ 39,391		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	25	1,378	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	25	$ 1,378		53

Facility Name & ID Number Bethshan Association I & Bethshan Association II #'086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joe Lanenga	Executive Director	0	$ 67,520
Steve Goudzwaard	Director of Finance	0	34,642
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,162

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wessels & Pautsch	legal services	$ 340
Informability	computer consulting	620
Open Systems	payroll consulting	717
Dreyer Ooms & VanDrunen	audit & accounting	10,738
ADP Voicenet Technologies	payroll preparation	8,476
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 20,891

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,336
Unemployment Compensation Insurance	10,010
FICA Taxes	175,134
Employee Health Insurance	271,323
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	46,445
Employee Physicals	1,508
Other Employee Benefits	5,836
TOTAL (agree to Schedule V, line 22, col.8)	$ 568,592

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

Description	Line #	Amount
personal use of auto (Exec.Dir)		$ 7,912
personal use of auto (Maint.)		3,678
TOTAL		$ 11,590

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 35
Advertising: Employee Recruitment	547
Health Care Worker Background Check	
(Indicate # of checks performed 19)	410
Patient Background Checks	
filing fees	7
Sams Club/bank fees	649
Employee Frofessional Fees/Dues	8,161
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,809

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	273
Seminar Expense	2,614
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,887

**See instructions.

BETHSHAN I & II
SCHEDULE OF STAFF TRAVEL
FY 2010

		TRAVEL EXPENSE	SEMINARS COST	
	Staff intra-agency travel for meetings at central office, etc.			
5/5/2009	Northern IL Affiliate Chapter, WOCN			
	Evidence Based Nursing Practice: Keep it Simple and Safe			
	Willowbrook, IL			
	Bev Ouwinga, LPN	9.60		
10/8/2009	Institute for Brain Potential			
	Why We Worry			
	Matteson, IL			
	Nancy Switalski, RN		75.00	
	Sandy Espinosa, LPN		70.00	
10/9/2009	Institute for Brain Potential			
	Why We Worry			
	Oak Brook, IL			
	Laura Kirchhoff, Program Director	28.86	70.00	
	MaryKay Maatman, OT/PT	9.73	70.00	
	Teresa Walus, OT/PT	9.72	70.00	
11/12/2009	Central IL DDNN			
	Abilities Amidst Change			
	East Peoria, IL			
	Val Lynch, DON	91.84	125.00	
	JoFrances Jones, LPN	91.84	125.00	
11/19/2009	CE International			
	Osteoporosis			
	Oak Lawn, IL			
	Dawn VanGroningen, RN		169.00	
1/26/2010	The ARC of Illinois			
	QMRP Leadership			
	Alsip, IL			
	Frea Mars, Program Director		130.50	
	William Dearth, QSP		130.50	
	Carla Weidenaar, QSP		130.50	
3/9/2010	The ARC of Illinois			
	Positive Strategies for Changing Behavior			
	Tinley Park, IL			
	Laura Kirchhoff, Program Director		140.00	
	Frea Mars, Program Director		140.00	
	Amy Tiemersma, LCSW		140.00	
3/11/2010	Institute for National Resources			
	Food Addictions			
	Oak Brook, IL			
	Angela Klarin, RN		86.00	
3/24/2010	Institute for Brain Potential			
	Memory			
	Homewood, IL			
	Nancy Switalski, RN		75.00	
4/16/2010	Health Ed			
	How to Recognize & Treat Depression in Older Adults			
	Downers Grove, IL			
	Kathy Konrath, QSP	31.65	179.00	
4/28/2010	The ARC of Illinois			
	The New Reality: Energize and Reboot			
	Lisle, IL			
	Maria Quiroga, DSP		100.00	
4/23/2010	Career Track			
	Dealing with Difficult People			
	Joliet, IL			
	JoFrances Jones, RN		149.00	
5/21/2010	Medical Update			
	Making Diversity work for activity professional			
	Palos Heights, IL			
	Kevin Gruzewski, Activity Director		128.50	
6/4/2010	Institute for Natural Resources			
	Aging body; Aging mind			
	Lisle, IL			
	Angela Klarin, RN		86.00	
6/11/2010	Institute for Brain Potential			
	Understanding Personality Disorders			
	Matteson, IL			
	Nancy Switalski, RN		75.00	
	Dawn VanGroningen, RN		75.00	
	Frea Mars, Program Director		75.00	
		273.24	**2,614.00**	**2,887.24**

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 0027086 & 0030528 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 0030528 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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. $ **11,827** 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. $ **193,424**
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**

(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
FY2010

Frea Mars	(Ln 15-5)	Program Director Salary	$	40,059
	(Ln 10-1)	QMRP Salary	$	12,717

Bethshan I & Bethshan II
SCH. V. Line 25 - Admin Transportation
FY 2010

TransDate	Desc	Reference		
7/24/09	Administrative Travel	company vehicle fuel	Joe Lanenga	123.36
8/24/09	Administrative Travel	company vehicle fuel	Joe Lanenga	129.33
9/1/09	Administrative Travel	42mi LSN Trust Mtng	Steve Goudzwaard	7.88
9/23/09	Administrative Travel	company vehicle fuel	Joe Lanenga	65.14
9/23/09	Administrative Travel	company vehicle battery	Joe Lanenga	31.88
10/23/09	Administrative Travel	company vehicle fuel	Joe Lanenga	67.42
10/28/09	Administrative Travel	103 miles	Jean Voss	20.30
11/23/09	Administrative Travel	company vehicle fuel	Joe Lanenga	109.46
12/23/09	Administrative Travel	company vehicle fuel	Joe Lanenga	50.98
1/21/10	Administrative Travel	company vehicle license renewal	Joe Lanenga	46.45
1/25/10	Administrative Travel	company vehicle fuel	Joe Lanenga	486.72
2/21/10	Administrative Travel	123 miles	Jean Voss	23.09
2/22/10	Administrative Travel	company vehicle ignition coil	Joe Lanenga	39.79
2/22/10	Administrative Travel	company vehicle fuel	Joe Lanenga	38.42
2/22/10	Administrative Travel	company vehicle fuel	Joe Lanenga	11.73
3/24/10	Administrative Travel	company vehicle fuel	Joe Lanenga	73.82
4/20/10	Administrative Travel	Administrator Retreat	Administrator's Meeting	47.57
4/23/10	Administrative Travel	Administrator Retreat	Administrator's Meeting	14.36
4/23/10	Administrative Travel	company vehicle fuel	Joe Lanenga	469.90
5/8/10	Administrative Travel	Administrator Retreat	Administrator's Meeting	11.30
5/25/10	Administrative Travel	company vehicle fuel	Joe Lanenga	59.42
6/23/10	Administrative Travel	company vehicle fuel	Joe Lanenga	60.23
				1988.55