		FOR BHF USE					

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0027086

Facility Name: Bethshan Association

Address: 12927 South Monitor (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

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: Steve 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 7/1/14 to 6/30/15 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) Steve 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 # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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		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 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	15,683			15,683	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,683			15,683	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.48%

D. How many bed-hold days during this year were paid by the Department?
175 (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)
non

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 7/16/1982

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 [ ] NO [ ]

Tax Year: 2015 Fiscal Year: 2015

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

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	145,975	9,601	8,158	163,734		163,734		163,734			1
2	Food Purchase		124,800		124,800		124,800		124,800			2
3	Housekeeping	62,472	18,681	4,885	86,038		86,038		86,038			3
4	Laundry	11,721	4,309		16,030		16,030		16,030			4
5	Heat and Other Utilities			45,047	45,047		45,047		45,047			5
6	Maintenance	51,111	14,959	28,494	94,564		94,564		94,564			6
7	Other (specify):* scavenger			5,253	5,253		5,253		5,253			7
8	**TOTAL General Services**	271,279	172,350	91,837	535,466		535,466		535,466			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,412,110	72,595	9,238	1,493,943	(39,218)	1,454,725		1,454,725			10
10a	Therapy	112,874	2,868	511	116,253		116,253		116,253			10a
11	Activities	65,070	9,479		74,549		74,549		74,549			11
12	Social Services	15,203		3,523	18,726		18,726		18,726			12
13	CNA Training		3,555		3,555	39,218	42,773		42,773			13
14	Program Transportation		20,606		20,606		20,606		20,606			14
15	Other (specify):* Program Director	74,220			74,220		74,220		74,220			15
16	**TOTAL Health Care and Programs**	1,679,477	109,103	21,672	1,810,252		1,810,252		1,810,252			16
	C. General Administration											
17	Administrative	96,757			96,757		96,757	(2,565)	94,192			17
18	Directors Fees											18
19	Professional Services			22,222	22,222		22,222	(15)	22,207			19
20	Dues, Fees, Subscriptions & Promotions			5,925	5,925		5,925		5,925			20
21	Clerical & General Office Expenses	45,364	5,518	10,367	61,249		61,249	(963)	60,286			21
22	Employee Benefits & Payroll Taxes			496,099	496,099		496,099	(325)	495,774			22
23	Inservice Training & Education			1,126	1,126		1,126		1,126			23
24	Travel and Seminar			3,450	3,450		3,450	(328)	3,122			24
25	Other Admin. Staff Transportation			2,742	2,742		2,742		2,742			25
26	Insurance-Prop.Liab.Malpractice			37,942	37,942		37,942		37,942			26
27	Other (specify):* Miscellaneous		1,540		1,540		1,540	(583)	957			27
28	**TOTAL General Administration**	142,121	7,058	579,873	729,052		729,052	(4,779)	724,273			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,092,877	288,511	693,382	3,074,770		3,074,770	(4,779)	3,069,991			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.

Facility Name & ID Number Bethshan Association #0027086 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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			123,931	123,931		123,931		123,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,048	4,048		4,048	421	4,469			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			127,979	127,979		127,979	421	128,400			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			163,452	163,452		163,452		163,452			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			163,452	163,452		163,452		163,452			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,092,877	288,511	984,813	3,366,201		3,366,201	(4,358)	3,361,843			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
FY2015

To:	Nurse Aid Training	Sch V, Ln 13	Training Wages	$	39,218.00
From:	Nursing & Medical Records	Sch V, Ln 10			

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	421	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	(2,565)	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	(2,214)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,358)		$	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))**	$ (4,358)		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

Bethshan Association

ID# 0027086

Report Period Beginning: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Fundraising payroll	$ (15)	19	1
2	Fundraising Clerical Salaries	(963)	21	2
3	Fundraising Employee Benefits	(325)	22	3
4	Non Direct Care Seminars	(328)	24	4
5	Miscellaneous	(583)	27	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**	(2,214)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethshan Association # 0027086 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	(2,565)	0	0	0	0	0	0	0	0	0	0	(2,565)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15)	0	0	0	0	0	0	0	0	0	0	(15)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(963)	0	0	0	0	0	0	0	0	0	0	(963)	21
22	Employee Benefits & Payroll Taxes	(325)	0	0	0	0	0	0	0	0	0	0	(325)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(328)	0	0	0	0	0	0	0	0	0	0	(328)	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):*	(583)	0	0	0	0	0	0	0	0	0	0	(583)	27
28	**TOTAL General Administration**	(4,779)	0	0	0	0	0	0	0	0	0	0	(4,779)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,779)	0	0	0	0	0	0	0	0	0	0	(4,779)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethshan Association **#** 0027086 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	421	0	0	0	0	0	0	0	0	0	0	421	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**	421	0	0	0	0	0	0	0	0	0	0	421	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)**	(4,358)	0	0	0	0	0	0	0	0	0	0	(4,358)	45

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 [X] 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.**

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Sally Poortenga, Vice President	BOD						2
3	Jori Brink, Treasurer	BOD						3
4	Ann Payne, Secretary	BOD						4
5	Ira Slagter	BOD						5
6	Judy Gill	BOD						6
7	Jack Hoekstra	BOD						7
8	Tom Lemmenes	BOD						8
9	James VanKampen	BOD						9
10	Clint Verhagen	BOD						10
11	Kim Lagestee-Mulder	BOD						11
12	Russ 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: 7/1/14 Ending: 6/30/15

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 7/1/14 Ending: 6/30/15

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	Square Feet	70,363	15	$ 150,829	$ 146,180	24,602	$ 52,736	1
2	17	Administration	# beds	131	15	281,588	281,588	45	96,729	2
3	19	Professional Services	# beds	131	15	46,608		45	16,010	3
4	20	Dues/Fees/Subscriptions	# beds	131	15	7,780		45	2,673	4
5	21	Clerical & General Office	# beds	131	15	149,612	132,055	45	51,393	5
6	22	Workers Comp	budgeted salaries	4,965,270	15	102,339		2,066,930	42,601	6
7	22	Other Employee Benefits	# beds	131	15	17,568		45	6,035	7
8	23	In Service Training	# beds	131	15	65		45	22	8
9	24	Seminars & Workshop	# beds	131	15	390		45	134	9
10	25	Staff Travel	# beds	131	15	7,925		45	2,722	10
11	26	Liability Insurance	# beds	131	15	46,141		45	15,850	11
12	27	Miscellaneous	# beds	131	15	3,531		45	1,213	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					$ 814,376	$ 559,823		$ 288,118	25

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	various noteholders		X	facility remodeling		various	$ 101,200	$ 101,200	on demand	0.0400	$ 4,048	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 101,200	$ 101,200			$ 4,048	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 101,200	$ 101,200			$ 4,048	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ none** **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 2015

NAME	NOTE #	AMOUNT	Dates Interest was Paid	Int. Rate	Interest Paid
Donald R. Tiemens Living Trust Agreement dated July 21, 2010	483	$ 10,000.00	01-Aug-2014	4%	200.00
			01-Feb-2015	4%	200.00
John B. & Linda L. Meyer Jt Ten WROS	438	$ 10,000.00	01-Sep-2014	4%	200.00
			01-Mar-2015	4%	200.00
Cornelius and Eldene Dykstra	448	$ 10,000.00	01-Sep-2014	4%	200.00
			01-Mar-2015	4%	200.00
David & Amy Tiemersma	452	$ 2,000.00	01-Sep-2014	4%	40.00
			01-Mar-2015	4%	40.00
Robert J or Charlotte Parrish	453	$ 10,000.00	01-Sep-2014	4%	200.00
			01-Mar-2015	4%	200.00
Lois J Ooms Living Trust	455	$ 5,000.00	01-Sep-2014	4%	100.00
			01-Mar-2015	4%	100.00
Herbert &/or Estelle Ooms Living	502	$ 10,000.00	01-Sep-2014	4%	200.00
Trust dated 10/17/92			01-Mar-2015	4%	200.00
Eleanor Ouwenga or Laurie (Teggelaar)	458-459	$ 8,000.00	01-Sep-2014	4%	160.00
			01-Mar-2015	4%	160.00
Dexter and Laura Boersma	461	$ 5,000.00	01-Sep-2014	4%	100.00
			01-Mar-2015	4%	100.00
Jean DeYoung, Ttee of the William DeYoung	503	$ 10,000.00	01-Sep-2014	4%	200.00
Survivor's Trust dated 1/18/00			01-Mar-2015	4%	200.00
Beverly Joyce Renz	466	$ 4,000.00	01-Oct-2014	4%	80.00
			01-Apr-2015	4%	80.00
Edith S. Hanneman, TTEE under the	471&479	$ 10,000.00	01-Oct-2014	4%	200.00
Edith S. Hanneman declaration of			01-Apr-2015	4%	200.00
trust dated 2/4/93, %Sharon Derks, 3758 Terrace Dr. Lansing, IL 60438					
Harriette VanBeveren or Aldena VanBeveren	481	$ 7,200.00	01-Oct-2014	4%	144.00
			01-Apr-2015	4%	144.00
GRAND TOTAL ALL NOTES		$ 101,200.00			$ 4,048.00

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 7/1/14 Ending: 6/30/15

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).

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 # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 15,813	20-40	$ 15,813	$	$ 1,005,894	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling & Improvements				99,918	3,752	20 - 40	3,752		92,301	9
10	fixed equipment				5,448	203	20 - 40	203		4,564	10
11	Addition: PT, nursing, office, & maintenance			1993	385,632	9,197	40	9,197		211,522	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		115,896	15
16	water & sewer improvements				22,009	37	30	37		21,722	16
17	Woodfold accordian 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	1,196	15	1,196		23,806	20
21	Bathroom remodeling			2002	133,435	9,235	15	9,235		118,949	21
22	Rooms painted (4 pods)			2002	6,840	470	15	470		6,135	22
23	Ceramic tile - livingroom			2002	4,250	298	15	298		3,853	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	463	15	463		5,438	27
28	garage roof			2004	2,030	137	15	137		1,516	28
29	Roof - (north)			2005	7,765	528	15	528		5,476	29
30	Bathroom remodeling			2006	8,860	931	10	931		8,318	30
31	Furnace & A/C - Pod 1 & 4			2006	13,085					13,085	31
32	Fire System			2006	1,759	173	10	173		1,585	32
33	Whirlpool bath remodeling (pod 4)			2007	8,600	582	15	582		5,106	33
34	Fire Alarm CPU board			2007	1,745	178	10	178		1,508	34
35	Lennox Condensor			2007	2,165	225	10	225		1,752	35
36	Pergola			2007	2,000	211	10	211		1,789	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Landscaping	2007	$ 4,509	$ 465	10	$ 465	$	$ 4,004	37
38	Lennox Elite HVAC	2008	14,650	982	15	982		7,774	38
39	Paint Kitchen	2008	3,900	396	10	396		2,779	39
40	Kitchen Stainless Wall Panels	2008	2,040	135	15	135		957	40
41	Driveway Seal Coat	2008	3,650					3,650	41
42	Rheem Water Heater	2009	5,917	598	10	598		3,376	42
43	Water Heater	2010	778	79	10	79		355	43
44	Sealcoating and Striping Parking Lot	2010	3,504	760	5	760		3,441	44
45	Building Alarm Panel	2011	860	58	15	58		248	45
46	Exterior Wood replacement	2012	4,825	485	10	485		1,872	46
47	Exterior Eaves & Trim	2012	4,550	458	10	458		1,724	47
48	Kitchen Door & Panic Hardware	2012	1,700	171	10	171		573	48
49	Metal Hall Door	2012	1,100	111	10	111		371	49
50	Lennox Air Conditioner	2012	2,990	200	15	200		651	50
51	Drywall,tile shower,paint bathrooms (4 pods)	2013	16,430	1,101	15	1,101		2,996	51
52	closet doors / fire doors	2013	9,900	497	20	497		1,046	52
53	LED light fixtures	2014	28,234	4,033	7	4,033		5,832	53
54	Fire sprinkler system	2014	11,525	1,055	10 - 20	1,055		1,926	54
55	Generator	2014	41,900	2,793	15	2,793		4,888	55
56	generator transfer switch	2014	2,825	404	7	404		572	56
57	Bathroom wall guards/kick plates	2014	9,531	1,906	5	1,906		2,417	57
58	Furnice - Office	2014	997	100	10	100		133	58
59	Conference room Kitchen/bath cabinet sink countertop	2014	10,626	1,063	10	1,063		1,240	59
60	rewire home run	2014	2,550	128	20	128		138	60
61	sealcoating striping	2014	4,880	2,440	2	2,440		4,473	61
62	trees (10)	2014	3,850	257	15	257		449	62
63	LED light fixtures	2015	16,048	1,921	7	1,921		1,920	63
64	Plumbing - Pod 1	2015	3,398	113	20	113		113	64
65	Lennox HVAC - conf. room	2015	4,350	169	15	169		169	65
66	Paving	2015	22,694	252	15	252		252	66
67	Ornamental Iron Fence	2015	5,630	94	10	94		94	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,290,911	$ 68,445		$ 68,445	$	$ 1,774,243	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: 7/1/14 Ending: 6/30/15

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	$ 259,917	$ 29,627	$ 29,627	$		$ 113,857	71
72	Current Year Purchases	28,652	3,143	3,143			3,143	72
73	Fully Depreciated Assets	479,516					479,516	73
74								74
75	TOTALS	$ 768,085	$ 32,770	$ 32,770	$		$ 596,516	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	FordVans 2003-2011 / Honda Odyssey 2007		$ 161,161	$ 11,076	$ 11,076	$	5	$ 154,962	76
77	Exec Dir./Prog.Dir/Fin.Dir.	ToyotaRAV4-2015 / HondaCRV-2012&2014		39,146	6,588	6,588		5	16,696	77
78	Maintenance	Ford superduty 2011 / Ford F150 2013		19,395	3,781	3,781		5	11,452	78
79	Exec Dir	Toyota Camry 2012	2012	disposed	1,271	1,271		5	disposed	79
80	TOTALS			$ 219,702	$ 22,716	$ 22,716	$		$ 183,110	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)	$ 3,278,698	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,931	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,931	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)	$ 2,553,869	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: 7/1/14 Ending: 6/30/15

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

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 _____
    Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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 # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		3,555		3,555
3	Classroom Wages (a)		10,932		10,932
4	Clinical Wages (b)		20,008		20,008
5	In-House Trainer Wages (c)		8,278		8,278
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 42,773	$	$ 42,773
10	SUM OF line 9, col. 1 and 2 (e)	$ 42,773			

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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

(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.

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15 (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	$ (2,082,803)	$ 317,272	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	548,543	680,366	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,204	30,614	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)**	$ (1,522,056)	$ 1,028,252	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		924,175	13
14	Buildings, at Historical Cost	2,290,911	7,250,913	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	987,787	2,049,165	16
17	Accumulated Depreciation (book methods)	(2,553,869)	(4,939,221)	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): construction in process	2,275	4,856	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 727,104	$ 5,289,888	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (794,952)	$ 6,318,140	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 152,916	$ 235,296	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	101,200	621,531	29
30	Accrued Salaries Payable	137,022	348,633	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,170	10,403	31
32	Accrued Real Estate Taxes(Sch.IX-B)		614	32
33	Accrued Interest Payable	1,312	11,805	33
34	Deferred Compensation	777	2,333	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)**	$ 397,397	$ 1,230,615	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		813,732	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)**	$	$ 813,732	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 397,397	$ 2,044,347	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,192,349)	$ 4,273,793	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (794,952)	$ 6,318,140	48

***(See instructions.)**

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,055,337)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,055,337)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(192,375)	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)**	$ (192,375)	17	
	B. Transfers (Itemize):			
18	**Building Improvements**	7,748	18	
19	**Site Improvements**	28,324	19	
20	**Furnishings**	5,000	20	
21	**Equipment**	7,068	21	
22	**Vehicles**	7,223	22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 55,363	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,192,349)	24	*

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

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,640,386	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,640,386	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	50,051	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)**	$ 50,051	23
	D. Non-Operating Revenue		
24	Contributions	479,930	24
25	Interest and Other Investment Income***	(421)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 479,509	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	miscellaneous	3,880	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,880	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,173,826	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	535,466	31
32	Health Care	1,810,252	32
33	General Administration	729,052	33
	B. Capital Expense		
34	Ownership	127,979	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	163,452	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,366,201	40
41	**Income before Income Taxes (line 30 minus line 40)****	(192,375)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (192,375)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	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)	$	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: 7/1/14 Ending: 6/30/15

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	1,911	2,080	$ 80,306	$ 38.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,103	9,995	269,356	26.95	3
4	Licensed Practical Nurses	3,687	4,112	96,003	23.35	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	3,017	3,480	112,874	32.44	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,794	1,601	40,030	25.00	9
10	Activity Assistants	1,361	2,087	25,040	12.00	10
11	Social Service Workers	346	393	15,203	38.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,957	2,313	44,263	19.14	14
15	Cook Helpers/Assistants	7,954	8,591	101,712	11.84	15
16	Dishwashers					16
17	Maintenance Workers	1,974	2,184	51,111	23.40	17
18	Housekeepers	3,444	3,960	62,472	15.78	18
19	Laundry	1,225	1,337	11,721	8.77	19
20	Administrator	595	713	53,128	74.51	20
21	Assistant Administrator					21
22	Other Administrative	826	899	43,629	48.53	22
23	Office Manager					23
24	Clerical	1,804	2,165	45,364	20.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,724	6,370	133,556	20.97	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	59,271	66,450	832,889	12.53	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Program Director	2,401	2,615	74,220	28.38	33
34	TOTAL (lines 1 - 33)	108,394	121,345	$ 2,092,877 *	$ 17.25	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	125	$ 8,158	1-3	35
36	Medical Director	52	8,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	5,535	10-3	39
40	Physical Therapy Consultant	5	398	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	113	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	52	3,523	12-3	45
46	Other(specify) Psychiatrist	10	2,732	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	331	$ 28,859		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	971	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	25	$ 971		53

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph Lanenga	Executive Director	0	$ 53,128
Steve Goudzwaard	Finance Director	0	33,749
Julie Sather	Executive Assistant	0	9,880
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,757

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
Informability	computer consultants	$ 2,079
Don Moss	Information Srv Provider	825
M. Holtrop	website design	850
Dreyer Ooms & VanDrunen	audit & accounting	10,292
Open Systems	computer software consulting	308
Paycor	payroll preparation	7,868
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 22,222

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,533
Unemployment Compensation Insurance	0
FICA Taxes	150,390
Employee Health Insurance	263,092
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	26,188
Other Employee Benefits	13,571
TOTAL (agree to Schedule V, line 22, col.8)	$ 495,774

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

Description	Line #	Amount
personal use of auto (Exec.Dir)		$ 2,620
personal use of auto (Prog.Dir.)		2,327
personal use of auto (Maint.)		961
personal use of auto (Fin.Dir)		2,379
TOTAL		$ 8,287

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 35
Advertising: Employee Recruitment	791
Health Care Worker Background Check	
(Indicate # of checks performed 25)	1,167
Patient Background Checks	
Inst on Public Policy	2,336
Employee Professional Fees/Dues	823
Sams Club/filing fees/Visa	773
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,925

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,122
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,122

**See instructions.

Facility Name & ID Number Bethshan Association # 0027086 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 **#** 0027086 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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 - $2,336**

(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? **6 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,863** 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. $ **163,452**
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 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 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.