

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0046052

Facility Name: Bement Health Care Center

Address: 601 North Morgan Street Bement 61813
Number City Zip Code

County: Piatt

Telephone Number: (217) 678-2191 Fax # (217) 678-7521

HFS ID Number:

Date of Initial License for Current Owners: 02/02/96

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☒	"Sub-S" Corp.	☐	Other
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
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 1/1/2011 to 12/31/2011 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)	Mark B. Petersen	
Paid Preparer	(Title)	Chief Executive Officer	
	(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	Bement Health Care Center
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#	0046052	Report Period Beginning:	1/1/2011	Ending:	12/31/2011
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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

N/A

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period			
1	60	Skilled (SNF)	60	21,900	1		
2		Skilled Pediatric (SNF/PED)			2		
3		Intermediate (ICF)			3		
4		Intermediate/DD			4		
5		Sheltered Care (SC)			5		
6		ICF/DD 16 or Less			6		
7	60	TOTALS	60	21,900	7		

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,641	3,995	767	14,403	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,641	3,995	767	14,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.77%

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

None (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 ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/02/1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/02/1996 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 8 and days of care provided 661

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL	☒	MODIFIED	☐	CASH*	☐
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

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

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	112,575	8,498		121,073		121,073	2,906	123,979			1
2	Food Purchase		88,907		88,907		88,907	(4,249)	84,658			2
3	Housekeeping	64,177	16,030		80,207		80,207	19	80,226			3
4	Laundry	34,015	8,029		42,044		42,044		42,044			4
5	Heat and Other Utilities			57,402	57,402		57,402	190	57,592			5
6	Maintenance	23,169	10,281	19,570	53,020		53,020	1,185	54,205			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							662	662			7
8	TOTAL General Services	233,936	131,745	76,972	442,653		442,653	713	443,366			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	724,563	56,017	16,114	796,694		796,694	29	796,723			10
10a	Therapy			62,102	62,102		62,102		62,102			10a
11	Activities	21,741	17	758	22,516		22,516	(210)	22,306			11
12	Social Services	20,945			20,945		20,945		20,945			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Off. Ben. All.</u>											15
16	TOTAL Health Care and Programs	767,249	56,034	87,974	911,257		911,257	(181)	911,076			16
	C. General Administration											
17	Administrative			63,600	63,600		63,600	(10,489)	53,111			17
18	Directors Fees											18
19	Professional Services			5,230	5,230		5,230	3,324	8,554			19
20	Dues, Fees, Subscriptions & Promotions			6,360	6,360		6,360	84	6,444			20
21	Clerical & General Office Expenses	31,218	2,175	10,146	43,539		43,539	26,948	70,487			21
22	Employee Benefits & Payroll Taxes			128,375	128,375		128,375		128,375			22
23	Inservice Training & Education							97	97			23
24	Travel and Seminar							29	29			24
25	Other Admin. Staff Transportation			5,854	5,854		5,854	2,489	8,343			25
26	Insurance-Prop.Liab.Malpractice			20,222	20,222		20,222	674	20,896			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							11,010	11,010			27
28	TOTAL General Administration	31,218	2,175	239,787	273,180		273,180	34,166	307,346			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,032,403	189,954	404,733	1,627,090		1,627,090	34,698	1,661,788			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			36,952	36,952		36,952	3,932	40,884			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			156,183	156,183		156,183	869	157,052			32
33	Real Estate Taxes			43,202	43,202		43,202	239	43,441			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,864	23,864		23,864	424	24,288			35
36	Other (specify):*											36
37	TOTAL Ownership			260,201	260,201		260,201	5,464	265,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,671		28,671		28,671		28,671			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Non-allowable Costs		576	20,339	20,915		20,915	(20,915)				43
44	TOTAL Special Cost Centers		29,247	53,189	82,436		82,436	(20,915)	61,521			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,032,403	219,201	718,123	1,969,727		1,969,727	19,247	1,988,974			45

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

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(4,262)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,006)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	40	30		9
10	Interest and Other Investment Income	(3,815)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	43		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	8,242	43		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	(22,700)	43		24
25	Fund Raising, Advertising and Promotional	(1,677)	43		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 <u>See Page 5A</u>	(4,025)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,451)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	48,698	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 48,698		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 19,247		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.		X	\$		38
39						39
40	<u>Gift and Coffee Shops</u>		X			40
41	<u>Barber and Beauty Shops</u>		X			41
42	<u>Laboratory and Radiology</u>		X			42
43	<u>Prescription Drugs</u>		X			43
44						44
45	<u>Other-Attach Schedule</u>		X			45
46	<u>Other-Attach Schedule</u>		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,085)	43	1
2	X-Rays-Part A	(1,089)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(139)	21	3
4	Offset Chamber of Commerce Dues	(150)	20	4
5	Resident Flowers	(146)	43	5
6	Disallowed Special Events	(206)	43	6
7	Offset Transportation Revenue	(210)	11	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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41				41
42				42
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44				44
45				45
46				46
47				47
48				48
49	Total	(4,025)		49

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
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,906	\$ 2,906	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	13	13	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	19	19	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	190	190	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,185	1,185	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	662	662	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	29	29	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	63,600	Petersen Health Care, Inc.	100.00%	53,111	(10,489)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,324	3,324	12
13	V								13
14	Total			\$ 63,600			\$ 61,439	\$ * (2,161)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 234	\$ 234	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	27,087	27,087	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	97	97	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	29	29	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,489	2,489	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	674	674	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,010	11,010	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,892	3,892	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,684	4,684	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	239	239	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	424	424	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 50,859	\$ * 50,859	39

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

Facility Name & ID Number

Bement Health Care Center

0046052

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Bement Health Care Center

0046052

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14								14
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16								16
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30								30

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			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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											1
2											2
3	N/A										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 Bement Health Care Center# 0046052

Report Period Beginning:

1/1/2011Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	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	1	Dietary	Resident Days	1,542,131	77	\$ 311,109	\$ 308,619	14,403	\$ 2,906	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	14,403	13	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	14,403	19	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	14,403	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	14,403	190	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	14,403	1,185	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	14,403	662	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	14,403	29	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	14,403	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	14,403	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	14,403	53,111	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	14,403	3,324	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	14,403	234	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	14,403	27,087	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	14,403	97	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	14,403	29	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	14,403	2,489	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	14,403	674	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	14,403	11,010	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	14,403	3,892	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	14,403	4,684	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	14,403	239	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	14,403	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	14,403	424	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 112,298	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,000,000	\$ 2,782,666	12/31/13	Varies	\$ 156,183	1
2												2
3								Interest Income Offset			(57)	3
4								Home Office Allocation-PHC			4,684	4
5								Farm Property Income Offset			(3,758)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,000,000	\$ 2,782,666			\$ 157,052	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,782,666			\$ 157,052	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2010 report.	\$	44,760	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.)	2010 \$	43,322	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,438)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	44,640	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.)		239	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	43,441	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	36,971	8
	2007	38,662	9
	2008	41,990	10
	2009	43,429	11
	2010	43,322	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	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.

FACILITY NAME	<u>Bement Health Care Center</u>	COUNTY	<u>Piatt</u>
---------------	----------------------------------	--------	--------------

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:

12,000

B. General Construction Type:

Exterior

Block

Frame

Wood

Number of Stories

1
- C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	109,829	1996	\$ 33,600	1
2					2
3	TOTALS	109,829		\$ 33,600	3

Facility Name & ID Number Bement Health Care Center

0046052

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	60		1996		\$ 780,146	\$	35	\$ 22,290	\$ 22,290	\$ 354,782	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping		1996		3,650		20	183	183	2,852	9
10	Parking Lot		1996		1,669		20	83	83	1,269	10
11	Driveway		1996		1,050		20	53	53	820	11
12	Painting and Remodeling		1996		3,155		20	158	158	2,448	12
13	Curtains		1996		4,928		20	246	246	3,835	13
14	Walkway		1996		361		20	18	18	282	14
15	Alarm and Fire Equipment		1996		4,437		20	222	222	3,459	15
16	Sign		1996		434		20	22	22	364	16
17	Heating and Unit Platform		1996		1,219		20	61	61	1,027	17
18	300 Gallon Tank		1997		1,370		20	69	69	1,033	18
19	Install Gas Line		1997		1,862		20	93	93	1,380	19
20	Steel Door		1997		1,170		20	59	59	873	20
21	New Gas Line		1997		1,875		20	94	94	1,339	21
22	Gas Water Heater		1997		5,008		20	250	250	3,544	22
23	Zone Line Heaters		1997		730		20	37	37	538	23
24	Zone Line Heaters		1997		754		20	38	38	543	24
25	Generator Repair		1997		6,112		20	306	306	4,308	25
26	Asf Blacktop		1998		10,062		20	503	503	6,792	26
27	Electrical Service Generator Work		1998		1,846		20	92	92	1,243	27
28	Zone Line Heaters		1998		716		20	36	36	485	28
29	Heater		1999		4,956		20	248	248	3,099	29
30	Kickplates, Handrails		1999		1,803		20	90	90	1,126	30
31	Grade Driveway and Parking Lot		1999		3,100		20	155	155	1,938	31
32	Parking Lot Sealant		1999		1,060		20	53	53	663	32
33	Garage		2000		8,892		20	445	445	5,115	33
34	Door Frame Protectors		2000		1,059		20	53	53	609	34
35	Nine Windows		2000		2,289		20	114	114	1,313	35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Bement Health Care Center

0046052

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Zone Line Heater(Reclass from Equipment)	2000	\$ 1,312	\$	20	\$ 66	\$ 66	\$ 757	37
38 Carpet	2001	1,297		7	93	93	1,576	38
39 Fire system	2001	22,829		39	585	585	6,145	39
40 Air System	2001	9,985		39	256	256	2,688	40
41 Fire Door	2001	826		39	21	21	222	41
42 Water Heater	2002	3,975		39	102	102	1,020	42
43 Gutters	2004	6,783		39	174	174	1,305	43
44 Sidewalks	2005	1,484		20	74	74	481	44
45 4 Awnings(Reclass from Equipment)	2005	3,281		10	328	328	2,132	45
46 Concrete/Sealer	2006	8,450		20	423	423	2,326	46
47 New Rooftop unit	2007	17,449		20	872	872	3,924	47
48 Boiler	2007	16,750		15	1,117	1,117	5,026	48
49 Water Heater	2008	6,100		7	872	872	3,052	49
50 Concrete/Sealer	2008	5,818		20	291	291	1,164	50
51 Nurses Station	2008	3,100		7	442	442	1,547	51
52 Nurses Station	2009	3,100		7	442	442	1,105	52
53 Air Handler	2010	4,844		15	322	322	483	53
54 Roof Repairs	2010	6,820		7	974	974	1,461	54
55 Water Heater	2011	3,637		7	260	260	260	55
56								56
57								57
58								58
59								59
60 Land Improvements Booked			1,097			(1,097)		60
61 Building Booked			20,004			(20,004)		61
62 Building Improvement Booked			10,616			(10,616)		62
63								63
64 2011-Home Office Allocation-Building Improvements		6,855			164	164		64
65 2011-Home Office Allocation-Land Improvements		640			41	41		65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 991,048	\$ 31,717		\$ 33,990	\$ 2,273	\$ 443,753	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$30,014	\$5,196	\$3,002	\$(2,194)	5-10 yrs.	\$14,220	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	151,780					151,780	73
74	Home Office Allocation			3,892	3,892			74
75	TOTALS	\$181,794	\$5,196	\$6,894	\$1,698		\$166,000	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	Facility	95 Dodge Truck	2001	\$31,500	\$	\$	\$		\$31,500	76
77	Resident Care	06 Ford	2005	29,264					29,264	77
78										78
79										79
80	TOTALS			\$60,764	\$	\$	\$		\$60,764	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,267,206	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$36,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$40,884	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,932	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$670,517	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	Inherited basis in Land(Farm)	\$13,800	\$	\$	86
87	Record 1/4 of basis of Farmland	1,294	39	1,293	87
88	Offset on Page 5A				88
89					89
90					90
91	TOTALS	\$15,094	\$39	\$1,293	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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: *

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: \$ 24,288 Description: See Attached Schedule 14A
(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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.

Bement Health Care Center
0046052

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	19,121
Dishwasher		708
Laundry Equipment		-
Copier		4,035
Home Office Allocation		424
		24,288

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? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	☐ YES ☒ NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER CNA	3. CLINICAL PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY HOURS PER CNA
--	--	---	--

B. EXPENSES

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,883	\$ 28,248	\$	1,883	\$	28,248
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		569	8,537		569		8,537
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	10A(2)	hrs		1,653	24,799		1,653		24,799
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	39(2)	# of prescripts				28,671			28,671
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify): Respiratory Therapist	10A(3)			26	395		26		395
13	Other (specify): Consultant	10A(3)			8	123		8		123
14	TOTAL			\$	4,139	\$ 62,102	\$ 28,671	4,139	\$	90,773

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.

This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,983,403	\$ 2,983,403	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	322,498	322,498	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,927	16,927	6
7	Other Prepaid Expenses	8,889	8,889	7
8	Accounts Receivable (owners or related parties)	554,208	554,208	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,885,925	\$ 3,885,925	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,063	33,600	13
14	Buildings, at Historical Cost	780,146	787,001	14
15	Leasehold Improvements, at Historical Cost	172,304	204,047	15
16	Equipment, at Historical Cost	259,933	242,558	16
17	Accumulated Depreciation (book methods)	(655,096)	(670,517)	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 Farm Property)	13,800	13,800	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 625,150	\$ 610,489	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,511,075	\$ 4,496,414	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 320,385	\$ 320,385	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,100	57,100	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,687	3,687	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,640	44,640	32
33	Accrued Interest Payable	13,984	13,984	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	31,803	31,803	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 471,599	\$ 471,599	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,782,666	2,782,666	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)	\$ 2,782,666	\$ 2,782,666	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,254,265	\$ 3,254,265	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,256,810	\$ 1,242,149	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,511,075	\$ 4,496,414	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,414,465	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,414,466	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(157,656)	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)	\$ (157,656)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,256,810	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bement Health Care Center

0046052

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

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

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,688,038	1
2	Discounts and Allowances for all Levels	(66,012)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,622,026	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,939	6
7	Oxygen	1,457	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 116,396	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,250	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,644	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,769	20
21	Other Medical Services	11,810	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,473	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	57	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	361	28
28a	Farm Property Revenue	3,758	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,119	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,812,071	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	442,653	31
32	Health Care	911,257	32
33	General Administration	273,180	33
	B. Capital Expense		
34	Ownership	260,201	34
	C. Ancillary Expense		
35	Special Cost Centers	49,586	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,969,727	40
41	Income before Income Taxes (line 30 minus line 40)**	(157,656)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (157,656)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** 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 **Bement Health Care Center**# **0046052**

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,044	2,044	\$ 60,922	\$ 29.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,375	4,679	111,878	23.91	3
4	Licensed Practical Nurses	6,391	6,614	120,881	18.28	4
5	CNAs & Orderlies	29,681	30,265	381,247	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,758	1,927	19,248	9.99	9
10	Activity Assistants					10
11	Social Service Workers	1,605	1,885	20,945	11.11	11
12	Dietician					12
13	Food Service Supervisor	1,993	1,993	26,365	13.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,246	10,054	86,210	8.57	15
16	Dishwashers					16
17	Maintenance Workers	1,883	1,883	23,169	12.30	17
18	Housekeepers	7,289	7,536	64,177	8.52	18
19	Laundry	3,987	4,086	34,015	8.32	19
20	Administrator	2,080	2,080	53,111	25.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,312	2,312	31,218	13.50	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	2,403	2,403	52,128	21.69	33
34	TOTAL (lines 1 - 33)	77,047	79,761	\$ 1,085,514 *	\$ 13.61	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,585	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3	123	L10, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3	\$ 11,708		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	115	\$ 5,283	L10, C3	50
51	Licensed Practical Nurses	17	662	L10, C3	51
52	Certified Nurse Assistants/Aides	353	7,939	L10, C3	52
53	TOTAL (lines 50 - 52)	485	\$ 13,885		53

Bement Health Care Center

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,109	2,109	49,635	23.53
Transportation	294	294	2,493	8.48
TOTAL	2,403	2,403	52,128	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
April Utley	Administrator	0	\$ 32,388
Adam Pullen	Administrator	0	20,723
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,111
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 63,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 63,600
C. Professional Services			
Vendor/Payee	Type		Amount
Mediacom LLC	Computer Services		\$ 879
E-Health Data Solutions	Computer Services		3,485
Honkamp Krueger & Co.	Accounting Services		228
Allscripts	Computer Services		638
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,230
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 28,113
Unemployment Compensation Insurance			23,287
FICA Taxes			78,605
Employee Health Insurance			(4,530)
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			932
Employee Retirement			1,968
TOTAL (agree to Schedule V, line 22, col.8)			\$ 128,375
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			2,786
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks	98		984
Miscellaneous Licenses & Permits			450
Miscellaneous Dues & Subscriptions			150
Home Office Allocation			234
Less: Public Relations Expense			(150)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,444
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			29
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 29

*** Attach copy of IMRF notifications**

****See instructions.**

Bement Health Care Center
0046052
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,230
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	3
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	462
Miscellaneous Vendors	Computer Services	37
Advanced Answers on Demand	Computer Services	1,928
Access 2 Go	Computer Services	190
Kemper Technology	Computer Services	88
MediFax	Computer Services	30
VisionShare/Ability Network	Computer Services	136
Advanced System Design	Computer Services	178
Simple LTC	Computer Services	223
Optimizer Systems	Other Prof Fees	23
Clifton Gunderson	Other Prof Fees	8
Mike Miller	Other Prof Fees	11
OIC Group	Other Prof Fees	3
AllScripts	Other Prof Fees	6
Rounding		(2)
Total (agree to Schedule V, line 19, column 8)		8,554

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	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?
If YES, give association name and amount.

No

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 21,918 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 32,850

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

N/A

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 210

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 210

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

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?

N/A

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

N/A
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli & Company

(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?
Attach invoices and a summary of services for all architect and appraisal fees

N/A