

Facility Name & ID Number Bement Health Care Center

0046052 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	21,960	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	21,960	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,513	5,369	892	17,774	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,513	5,369	892	17,774	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.94%

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 02/02/96

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

YES

Date 02/02/96

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 892

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	108,319	12,866		121,185		121,185	3,159	124,344		1
2	Food Purchase		112,919		112,919		112,919	(738)	112,181		2
3	Housekeeping	107,063	19,043		126,106		126,106	23	126,129		3
4	Laundry	11,391	12,285		23,676		23,676	1	23,677		4
5	Heat and Other Utilities			71,465	71,465		71,465	327	71,792		5
6	Maintenance	28,002	7,108	27,959	63,069		63,069	1,931	65,000		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							777	777		7
8	TOTAL General Services	254,775	164,221	99,424	518,420		518,420	5,480	523,900		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	549,565	36,134	104,032	689,731		689,731	4,188	693,919		10
10a	Therapy			83,151	83,151		83,151		83,151		10a
11	Activities	24,630	100	224	24,954		24,954	(788)	24,166		11
12	Social Services	15,872			15,872		15,872		15,872		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							957	957		15
16	TOTAL Health Care and Programs	590,067	36,234	196,407	822,708		822,708	4,357	827,065		16
	C. General Administration										
17	Administrative	44,073			44,073		44,073	24,594	68,667		17
18	Directors Fees										18
19	Professional Services			9,263	9,263		9,263	2,776	12,039		19
20	Dues, Fees, Subscriptions & Promotions			7,536	7,536		7,536	656	8,192		20
21	Clerical & General Office Expenses	12,216	3,287	16,402	31,905		31,905	28,576	60,481		21
22	Employee Benefits & Payroll Taxes			178,624	178,624		178,624		178,624		22
23	Inservice Training & Education			1,172	1,172		1,172	188	1,360		23
24	Travel and Seminar			300	300		300	188	488		24
25	Other Admin. Staff Transportation			9,816	9,816		9,816	2,430	12,246		25
26	Insurance-Prop.Liab.Malpractice			13,326	13,326		13,326	148	13,474		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,787	8,787		27
28	TOTAL General Administration	56,289	3,287	236,439	296,015		296,015	68,343	364,358		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	901,131	203,742	532,270	1,637,143		1,637,143	78,180	1,715,323		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 **Bement Health Care Center**

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Report Period Beginning:

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Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			38,347	38,347		38,347	4,820	43,167			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			189,413	189,413		189,413	1,808	191,221			32
33	Real Estate Taxes			39,662	39,662		39,662	451	40,113			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,931	12,931		12,931	385	13,316			35
36	Other (specify):*											36
37	TOTAL Ownership			280,353	280,353		280,353	7,464	287,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,240		25,240		25,240		25,240			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,940	32,940		32,940		32,940			42
43	Other (specify):* Non-allowable Cost	13,018	355	48,623	61,996		61,996	(61,996)				43
44	TOTAL Special Cost Centers	13,018	25,595	81,563	120,176		120,176	(61,996)	58,180			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	914,149	229,337	894,186	2,037,672		2,037,672	23,648	2,061,320			45

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

Bement Health Care Center

ID# 0046052

Report Period Beginning: 1/1/2008

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,590)	43	1
2	X-Rays-Part A	554	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,295)	10	3
4	Offset Miscellaneous Food Revenue	(790)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(2,287)	21	5
6	Nonallowable Dues	(200)	20	6
7	Farm Land Depreciation	(79)	30	7
8	Day Care Revenue	(788)	11	8
9	Resident Flowers	(597)	43	9
10	Disallowed Special Events	(1,586)	43	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	(8,658)		49

Facility Name & ID Number

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0046052

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1/1/2008

Ending:

12/31/2008

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,159	\$ 3,159	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	52	52	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	327	327	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,931	1,931	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	777	777	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,483	5,483	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	957	957	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	24,594	24,594	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,776	2,776	12	
13	V							13	
14	Total		\$			\$ 40,080	\$ *	40,080	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 and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 856	\$	856	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	30,863		30,863	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	188		188	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	188		188	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,430		2,430	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	148		148	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,787		8,787	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,362		3,362	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,365		2,365	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	451		451	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	385		385	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		\$			\$ 50,023	\$ *	50,023	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:

1/1/2008

Ending:

12/31/2008

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	Mark Petersen	President	Administrative	100.00	1,804,080	0.74	1.23	Salary	24,594	L17, C7	1
2											2
3											3
4	***Other Nursing Home Compensation and Compensation are										4
5	Attached on Schedule 7A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,594		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:

1/1/2008

Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	17,774	\$ 3,159	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	17,774	52	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	17,774	23	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	17,774	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	17,774	327	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	17,774	1,931	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	17,774	777	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	17,774	5,483	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	17,774	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	17,774	957	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	17,774	24,594	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	17,774	2,776	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	17,774	856	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	17,774	30,863	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	17,774	188	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	17,774	188	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	17,774	2,430	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	17,774	148	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	17,774	8,787	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	17,774	3,362	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	17,774	2,365	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	17,774	451	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	17,774	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	17,774	385	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 90,103	25

Facility Name & ID Number

Bement Health Care Center

0046052

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	\$ 2,925,622	12/31/13	Varies	\$ 188,498	1				
2	State Bank of Toulon		X	Van	\$572.65	08/05/05	29,265	10,832	08/05/10	0.0650	915	2				
3							Interest Income Offset				(557)	3				
4							Home Office Allocation-PHC				2,365	4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$572.65		\$ 3,029,265	\$ 2,936,454			\$ 191,221	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 3,029,265	\$ 2,936,454			\$ 191,221	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.)

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 2007 report.		\$	38,500	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.)	2007	\$	38,662	2
3. Under or (over) accrual (line 2 minus line 1).		\$	162	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	39,500	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. Home Office Allocation		\$	451	
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.		\$	40,113	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	32,082	8
	2004	34,960	9
	2005	35,961	10
	2006	36,971	11
	2007	38,662	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bement Health Care Center COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0046052

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-00-07-000-609-00</u>	<u>Long-Term Care Facility</u>	\$ <u>38,662.04</u>	\$ <u>38,662.04</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,662.04</u>	\$ <u>38,662.04</u>

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 X NO

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Bement Health Care Center

0046052

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	<u>Facility</u>	<u>109,829</u>	<u>1996</u>	<u>\$ 33,600</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	109,829		\$ 33,600	3

Facility Name & ID Number Bement Health Care Center

0046052

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60	1996		\$ 780,146	\$	35	\$ 22,290	\$ 22,290	\$ 287,912	4
5										5
6										6
7	Home Office Allocation									7
8										8
	Improvement Type**									
9	Landscaping		1996	3,650		20	183	183	2,303	9
10	Parking Lot		1996	1,669		20	83	83	1,020	10
11	Driveway		1996	1,050		20	53	53	661	11
12	Painting and Remodeling		1996	3,155		20	158	158	1,974	12
13	Curtains		1996	4,928		20	246	246	3,097	13
14	Walkway		1996	361		20	18	18	228	14
15	Alarm and Fire Equipment		1996	4,437		20	222	222	2,793	15
16	Sign		1996	434		20	22	22	298	16
17	Heating and Unit Platform		1996	1,219		20	61	61	844	17
18	300 Gallon Tank		1997	1,370		20	69	69	826	18
19	Install Gas Line		1997	1,862		20	93	93	1,101	19
20	Steel Door		1997	1,170		20	59	59	696	20
21	New Gas Line		1997	1,875		20	94	94	1,057	21
22	Gas Water Heater		1997	5,008		20	250	250	2,794	22
23	Zone Line Heaters		1997	730		20	37	37	427	23
24	Zone Line Heaters		1997	754		20	38	38	429	24
25	Generator Repair		1997	6,112		20	306	306	3,390	25
26	Ase Blacktop		1998	10,062		20	503	503	5,283	26
27	Electrical Service Generator Work		1998	1,846		20	92	92	967	27
28	Zone Line Heaters		1998	716		20	36	36	377	28
29	Heater		1999	4,956		20	248	248	2,355	29
30	Kickplates, Handrails		1999	1,803		20	90	90	856	30
31	Grade Driveway and Parking Lot		1999	3,100		20	155	155	1,473	31
32	Parking Lot Sealant		1999	1,060		20	53	53	504	32
33	Garage		2000	8,892		20	445	445	3,780	33
34	Door Frame Protectors		2000	1,059		20	53	53	450	34
35	Nine Windows		2000	2,289		20	114	114	971	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:

1/1/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Zone Line Heater(Reclass from Equipment)	2000	\$ 1,312	\$	20	\$ 66	\$ 66	\$ 559	37
38	Carpet	2001	1,297		7	93	93	1,297	38
39	Fire system	2001	22,829		39	585	585	4,390	39
40	Air System	2001	9,985		39	256	256	1,920	40
41	Fire Door	2001	826		39	21	21	159	41
42	Water Heater	2002	3,975		39	102	102	714	42
43	Gutters	2004	6,783		39	174	174	783	43
44	Sidewalks	2005	1,484		20	74	74	259	44
45	4 Awnings(Reclass from Equipment)	2005	3,281		10	328	328	1,148	45
46	Concrete/Sealer	2006	8,450		20	423	423	1,057	46
47	New Rooftop unit	2007	17,449		20	872	872	1,308	47
48	Boiler	2007	16,750		15	1,117	1,117	1,675	48
49	Water Heater	2008	6,100		7	436	436	436	49
50	Concrete/Sealer	2008	5,818		20	291	291	291	50
51	Nurses Station	2008	3,100		7	221	221	221	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59	Land Improvement Booked			1,286			(1,286)		59
60	Building Booked			20,004			(20,004)		60
61	Building Improvement Booked			8,110			(8,110)		61
62									62
63									63
64									64
65									65
66	2008-Home Office Allocation-Building Improvements		9,229			221	221		66
67	2008-Home Office Allocation-Land Improvements		617			40	40		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 974,998	\$ 29,400		\$ 31,391	\$ 1,991	\$ 345,083	70

**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:

1/1/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 25,607	\$ 5,497	\$ 2,561	\$ (2,936)		\$ 5,435	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	151,780					151,780	73
74	Home Office Allocation			3,362	3,362			74
75	TOTALS	\$ 177,387	\$ 5,497	\$ 5,923	\$ 426		\$ 157,215	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	95 Dodge Truck	2001	\$ 31,500	\$	\$	\$	5	\$ 31,500	76
77	Resident Care	06 Ford	2005	29,264	3,371	5,853	2,482	5	20,486	77
78										78
79										79
80	TOTALS			\$ 60,764	\$ 3,371	\$ 5,853	\$ 2,482		\$ 51,986	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)	\$ 1,246,749	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,268	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,167	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,899	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 554,284	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	79	579	87
88	Offset on Page 5A				88
89					89
90					90
91	TOTALS	\$ 15,094	\$ 79	\$ 579	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: \$ 13,316 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			<u>N/A</u>		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 Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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

1/1/2008

Period End

12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	9,190
Dishwasher		645
Copier		3,097
Home Office Allocation		385
		<u>13,316</u>
		<u>13,316</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	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	10A(3)	hrs	\$	2,553	\$ 38,289	\$	2,553	\$ 38,289	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		39	579		39	579	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,952	44,283		2,952	44,283	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				25,240		25,240	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			\$	5,544	\$ 83,151	\$ 25,240	5,544	\$ 108,391	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 Bement Health Care Center

0046052

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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	\$ 3,295,443	\$ 3,295,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	386,266	386,266	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,855	14,855	6
7	Other Prepaid Expenses	8,893	8,893	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)	\$ 4,259,665	\$ 4,259,665	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		33,600	13
14	Buildings, at Historical Cost	780,146	789,375	14
15	Leasehold Improvements, at Historical Cost	207,966	185,623	15
16	Equipment, at Historical Cost	255,526	238,151	16
17	Accumulated Depreciation (book methods)	(541,692)	(554,284)	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 (spec <u>Farm Property</u>)	13,997	13,997	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 715,943	\$ 706,462	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,975,608	\$ 4,966,127	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 387,411	\$ 387,411	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,477	62,477	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,718	2,718	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,500	39,500	32
33	Accrued Interest Payable	17,233	17,233	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	19,127	19,127	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 528,466	\$ 528,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,832	10,832	39
40	Mortgage Payable	2,925,622	2,925,622	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)	\$ 2,936,454	\$ 2,936,454	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,464,920	\$ 3,464,920	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,510,688	\$ 1,501,207	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,975,608	\$ 4,966,127	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,409,885	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,409,885	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,803	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)	\$ 100,803	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)	\$ 1,510,688	24 *

* This must agree with page 17, line 47.

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	\$ 1,863,857	1
2	Discounts and Allowances for all Levels	87,045	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,950,902	3
	B. Ancillary Revenue		
4	Day Care	788	4
5	Other Care for Outpatients		5
6	Therapy	138,762	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 139,550	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	790	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	39,158	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,055	20
21	Other Medical Services	1,881	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,884	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	557	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 557	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	3,582	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,582	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,138,475	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	518,420	31
32	Health Care	822,708	32
33	General Administration	296,015	33
	B. Capital Expense		
34	Ownership	280,353	34
	C. Ancillary Expense		
35	Special Cost Centers	87,236	35
36	Provider Participation Fee	32,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,037,672	40
41	Income before Income Taxes (line 30 minus line 40)**	100,803	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 100,803	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:

1/1/2008

Ending:

12/31/2008

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	2,080	2,160	\$ 53,019	\$ 24.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,818	6,166	133,805	21.70	3
4	Licensed Practical Nurses	3,715	3,768	65,559	17.40	4
5	CNAs & Orderlies	25,837	26,677	265,121	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	20,744	9.97	9
10	Activity Assistants	385	385	3,886	10.09	10
11	Social Service Workers	1,253	1,373	15,872	11.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,524	13,604	108,319	7.96	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,136	28,002	13.11	17
18	Housekeepers	11,489	11,529	107,063	9.29	18
19	Laundry	1,489	1,542	11,391	7.39	19
20	Administrator	1,993	1,993	44,073	22.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	821	830	12,216	14.72	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 C: CPC	1,544	1,544	32,061	20.76	32
33	Other(specify) <u>Marketing</u>	724	724	13,018	17.98	33
34	TOTAL (lines 1 - 33)	74,832	76,511	\$ 914,149 *	\$ 11.95	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	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 600	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			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)	\$ 9,600		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	362 \$ 17,065	10(3)	50
51	Licensed Practical Nurses	1,112 44,421	10(3)	51
52	Certified Nurse Assistants/Aides	1,850 43,275	10(3)	52
53	TOTAL (lines 50 - 52)	3,324 \$ 104,761		53

Bement Health Care Center
 0046052
 Period Beginning 1/1/2008
 Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing	2,080	2,160	53,019	24.54
Assistant Director of Nsg.				
Registered Nurses	5,818	6,166	133,805	21.70
Licensed Practical Nurses	3,715	3,768	65,559	17.40
Nurse Aides & Orderlies	25,837	26,677	265,121	9.94
Nurse Aide Trainees				
Licensed Therapist				
Activity Director	2,080	2,080	20,744	9.97
Activity Assistants	385	385	3,886	10.09
Social Service Workers	1,253	1,373	15,872	11.56
Dietician				
Food Service Supervisor				
Head Cook				
Cook Helpers/Assistants	13,524	13,604	108,319	7.96
Dishwashers				
Maintenance Workers	2,080	2,136	28,002	13.11
Housekeepers	11,489	11,529	107,063	9.29
Laundry	1,489	1,542	11,391	7.39
Administrator	1,993	1,993	44,073	22.11
Assistant Administrator				
Other Administrative				
Office Manager	821	830	12,216	14.72
Clerical				
Vocational Instruction				
Academic Instruction				
Medical Director				
Qualified Mental Retard.Prof.				
Resident Services Coordinator				
Habilitation Aides				
Medical Records				
Housekeeping Supr				
Care Plan Coordinator	1,544	1,544	32,061	20.76
Marketing	724	724	13,018	17.98
TOTAL (lines 1 - 35)	74,832	76,512	914,149	

Bement Health Care Center

0046052

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,263

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	101
GoffWilson, P.A.	Legal	337
Ginoli & Company	Accountants	819
RSM McGladrey	Accountants	8
Emdeon Business Services	Computer Services	39
Advanced Answers on Demand	Computer Services	54
Access 2 Go	Computer Services	638
Ivans	Computer Services	188
Kemper Technology	Computer Services	98
VisionShare	Computer Services	345
Logmein	Computer Services	37
Comm Net Communiations	Computer Services	27
Charter Communications	Computer Services	10
Advanced System Designs	Computer Services	8
Consolidated Communications	Computer Services	12
Miscellaneous Vendors	Computer Services	7
Miscellaneous Vendors	Miscellaneous	48

Total (agree to Schedule V, line 19, column 8)	<u>12,039</u>
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Bement

Period Beginning **1/1/2008**
Period End **12/31/2008**

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Deddo	Administrator	0	20,625
Adam Pullen	Administrator	0	23,448
	Total		<u>44,073</u>

Facility Name & ID Number Bement Health Care Center# 0046052

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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. 2,320 -IHCA
- (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? No
- (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? N/A
- (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? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,229 Line 10
- (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? N/A
If YES, give effective date of lease. 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)? 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,940
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? Yes Indicate the amount. \$ 790
- (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. \$ No
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? N/A
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees