

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0053173</u></p> <p>Facility Name: <u>Bement Health Care Center</u></p> <p>Address: <u>601 North Morgan Street</u> <u>Bement</u> <u>61813</u> <small>Number City Zip Code</small></p> <p>County: <u>Piatt</u></p> <p>Telephone Number: <u>(217) 678-2191</u> Fax # <u>(217) 678-7521</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/02/96</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Bement Health Care Center

0053173 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 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	10,035	3,395	754	14,184	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,035	3,395	754	14,184	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.77%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/2/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/2/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 60 and days of care provided 590

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Bement Health Care Center # 0053173 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	124,815	9,222	562	134,599		134,599	3,184	137,783		1
2	Food Purchase		97,622		97,622		97,622	(1,858)	95,764		2
3	Housekeeping	50,084	14,187		64,271		64,271	48	64,319		3
4	Laundry	22,715	8,353		31,068		31,068		31,068		4
5	Heat and Other Utilities			49,528	49,528		49,528	167	49,695		5
6	Maintenance	29,424	4,540	15,093	49,057		49,057	1,505	50,562		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	227,038	133,924	65,183	426,145		426,145	3,046	429,191		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	785,546	104,936	15,658	906,140		906,140	(988)	905,152		10
10a	Therapy			151,942	151,942		151,942		151,942		10a
11	Activities	26,154	135	58	26,347		26,347	(1,409)	24,938		11
12	Social Services	15,741			15,741		15,741		15,741		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	827,441	105,071	176,658	1,109,170		1,109,170	(2,397)	1,106,773		16
	C. General Administration										
17	Administrative			198,400	198,400		198,400	(134,545)	63,855		17
18	Directors Fees										18
19	Professional Services			7,233	7,233		7,233	31,977	39,210		19
20	Dues, Fees, Subscriptions & Promotions			6,246	6,246		6,246	(86)	6,160		20
21	Clerical & General Office Expenses	27,624	1,680	33,774	63,078		63,078	33,745	96,823		21
22	Employee Benefits & Payroll Taxes			126,752	126,752		126,752	15,415	142,167		22
23	Inservice Training & Education							95	95		23
24	Travel and Seminar							47	47		24
25	Other Admin. Staff Transportation			4,197	4,197		4,197	2,282	6,479		25
26	Insurance-Prop.Liab.Malpractice			19,776	19,776		19,776	605	20,381		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	27,624	1,680	396,378	425,682		425,682	(50,465)	375,217		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,082,103	240,675	638,219	1,960,997		1,960,997	(49,816)	1,911,181		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

#0053173

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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			39,188	39,188		39,188	11,248	50,436			30
31	Amortization of Pre-Op. & Org.							74	74			31
32	Interest							5,648	5,648			32
33	Real Estate Taxes			33,389	33,389		33,389	183	33,572			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,375	22,375		22,375	968	23,343			35
36	Other (specify):*											36
37	TOTAL Ownership			94,952	94,952		94,952	18,121	113,073			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,401		18,401		18,401		18,401			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,776	114,776		114,776		114,776			42
43	Other (specify):*	11,083	380	54,718	66,181		66,181	(66,181)				43
44	TOTAL Special Cost Centers	11,083	18,781	169,494	199,358		199,358	(66,181)	133,177			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,093,186	259,456	902,665	2,255,307		2,255,307	(97,876)	2,157,431			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,872)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,056)	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	3,087	30		9
10	Interest and Other Investment Income	(505)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	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	(15,146)	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	(30,000)	43		24
25	Fund Raising, Advertising and Promotional	(11,866)	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	(6,142)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,598)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(29,278)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (29,278)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (97,876)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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Bement Health Care CenterID# 0053173Report Period Beginning: 1/1/2017Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,917)	43	1
2	X-Rays-Part A	(975)	43	2
3	Offset Transportation Revenue	(1,409)	21	3
4	Disallowed Special Events	(123)	43	4
5	Offset Miscellaneous Nursing Supplies Revenue	(1,032)	10	5
6	Offset Miscellaneous Office Supplies Revenue	(526)	21	6
7	Disallowed Chamber of Commerce Dues	(160)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(6,142)		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: 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 Management, Inc.	100.00%	\$ 3,184	\$ 3,184	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	14	14	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	48	48	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	167	167	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,505	1,505	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	44	44	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	198,400	Petersen Health Care Management, Inc.	100.00%	63,855	(134,545)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	9,972	9,972	12
13	V							13
14	Total		\$ 198,400			\$ 78,789	\$ * (119,611)	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 Management, Inc.	100.00%	\$ 74	\$	74	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	34,271		34,271	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	15,415		15,415	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	95		95	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	47		47	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,282		2,282	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	605		605	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	8,161		8,161	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	74		74	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	265		265	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	183		183	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	968		968	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		\$			\$ 62,440	\$ *	62,440	39

* 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	1 Dietary	\$	Petersen Health Quality, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Quality, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Quality, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Quality, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Quality, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Quality, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Quality, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Quality, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Quality, LLC	100.00%	22,005	22,005	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Quality, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Quality, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Quality, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Quality, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Quality, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Quality, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Quality, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Quality, LLC	100.00%	5,888	5,888	35	
36	V	33 Real Estate Taxes		Petersen Health Quality, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Quality, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Quality, LLC	100.00%	0		38	
39	Total		\$			\$ 27,893	\$ *	27,893	39

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

Facility Name & ID Number

Bement Health Care Center

0053173

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

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	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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

0053173

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Bement Health Care Center

0053173

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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											3
4	N/A										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

0053173

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 Management, 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	1,451,714	75	\$ 325,901	\$ 376,129	14,184	\$ 3,184	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	14,184	14	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	14,184	48	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	14,184	167	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	14,184	1,505	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	14,184	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	14,184	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	14,184	44	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	14,184	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	14,184	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	14,184	63,855	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	14,184	9,972	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	14,184	74	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	14,184	34,271	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	14,184	15,415	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	14,184	95	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	14,184	47	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	14,184	2,282	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	14,184	605	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	14,184	8,161	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	14,184	74	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	14,184	265	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	14,184	183	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	14,184	968	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 141,229	25

Facility Name & ID Number Bement Health Care Center

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Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 Quality, LLC

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	83,607	13	\$	\$	14,184	\$	1
2	2	Food	Resident Days	83,607	13			14,184		2
3	3	Housekeeping	Resident Days	83,607	13			14,184		3
4	4	Laundry	Resident Days	83,607	13			14,184		4
5	5	Utilities	Resident Days	83,607	13			14,184		5
6	6	Maintenance	Resident Days	83,607	13			14,184		6
7	7	Mgmt. Allocation of Benefits	Resident Days	83,607	13			14,184		7
8	10	Nursing and Medical Records	Resident Days	83,607	13			14,184		8
9	15	Mgmt. Allocation of Benefits	Resident Days	83,607	13			14,184		9
10	17	Administrative	Resident Days	83,607	13			14,184		10
11	19	Professional Services	Resident Days	83,607	13	129,710		14,184	22,005	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	83,607	13			14,184		12
13	21	Clerical and General Office	Resident Days	83,607	13			14,184		13
14	22	Employee Benefits & Payroll	Resident Days	83,607	13			14,184		14
15	23	Inservice Training & Education	Resident Days	83,607	13			14,184		15
16	24	Travel and Seminar	Resident Days	83,607	13			14,184		16
17	25	Other Admin. Staff Transport.	Resident Days	83,607	13			14,184		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	83,607	13			14,184		18
19	30	Depreciation	Resident Days	83,607	13			14,184		19
20	31	Amortization	Resident Days	83,607	13			14,184		20
21	32	Interest	Resident Days	83,607	13	34,704		14,184	5,888	21
22	33	Real Estate Taxes	Resident Days	83,607	13			14,184		22
23	34	Rent-Facility and Grounds	Resident Days	83,607	13			14,184		23
24	35	Rent-Equipment & Vehicles	Resident Days	83,607	13			14,184		24
25	TOTALS					\$ 164,414	\$		\$ 27,893	25

Facility Name & ID Number

Bement Health Care Center

0053173

Report Period Beginning:

1/1/2017

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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										\$	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$	9									
B. Non-Facility Related*																				
10							Interest Income Offset			(505)	10									
11							Home Office Allocation-PHQ			5,888	11									
12							Home Office Allocation-PHCM			265	12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$ 5,648	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 5,648	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

Facility Name & ID Number Bement Health Care Center

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1/1/2017 Ending:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,000 B. General Construction Type: Exterior Brick 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: 246,000 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 74 4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

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12/31/2017

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		1996		\$ 776,400	\$	35	\$ 22,183	\$ 34,053	\$ 488,094	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping		1996		3,650		20			3,650	9
10	Various Improvements		1996		3,746		20			3,746	10
11	Painting and Remodeling		1996		3,155		20			3,155	11
12	Curtains		1996		4,928		20			4,928	12
13	Walkway		1996		361		20			361	13
14	Alarm and Fire Equipment		1996		4,437		20			4,437	14
15	Sign		1996		434		20			434	15
16	Heating and Unit Platform		1996		1,219		20			1,219	16
17	300 Gallon Tank		1997		1,370		20			1,370	17
18	Install Gas Line		1997		1,862		20	17	17	1,862	18
19	Steel Door		1997		1,170		20	2	2	1,170	19
20	New Gas Line		1997		1,875		20	66	66	1,875	20
21	Zone Line Heaters		1997		730		20	7	7	730	21
22	Zone Line Heaters		1997		754		20	21	21	754	22
23	Generator Repair		1997		6,112		20	274	274	6,112	23
24	Ase Blacktop		1998		10,062		20	503	503	9,810	24
25	Electrical Service Generator Work		1998		1,846		20	92	92	1,795	25
26	Zone Line Heaters		1998		716		20	36	36	701	26
27	Kickplates, Handrails		1999		1,803		20	90	90	1,666	27
28	Grade Driveway and Parking Lot		1999		3,100		20	155	155	2,868	28
29	Parking Lot Sealant		1999		1,060		20	53	53	981	29
30	Door Frame Protectors		2000		1,059		20	53	53	927	30
31	Nine Windows		2000		2,289		20	114	114	1,997	31
32	Zone Line Heater(Reclass from Equipment)		2000		\$ 1,312	\$	20	\$ 66	66	1,087	32
33	Carpet		2001		1,297		7			1,297	33
34	Fire system		2001		22,829		39	585	585	9,070	34
35	Air System		2001		9,985		39	256	256	3,968	35
36	Fire Door		2001		770		39	20		323	36

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

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

See Page 12A, Line 70 for total

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Gutters	2004	6,783		39	174	\$ 174	\$ 2,175	37
38	4 Awnings(Reclass from Equipment)	2005	3,281		10			3,281	38
39	Concrete/Sealer	2006	8,450		20	423	423	4,441	39
40	New Rooftop unit	2007	17,449		20	872	872	8,284	40
41	Boiler	2007	16,750		15	1,117	1,117	10,611	41
42	Concrete Work and Gutter Replacement	2008	5,818		20	291	291	2,619	42
43	Nurses Station	2009	6,002		7			6,002	43
44	Air Handler	2010	4,844		15	322	322	2,093	44
45	Water Heater	2011	3,637		7	520	520	2,860	45
46	Glass Replacement in Resident Windows	2014	6,465		15	431	431	1,509	46
47	Roof Replacement	2014	88,936		25	3,557	3,557	12,450	47
48	Anchors and Bolts for Roof	2014	3,057		7	437	437	1,530	48
49	Exterior Painting and Awning Replacement	2014	3,661		15	244	244	854	49
50	Exterior Painting of Building	2015	7,180		15	479	479	1,677	50
51	Shower Rooms Installation	2016	16,342		15	1,090	1,090	1,635	51
52	Air Conditoner Compressor Repair	2016	4,193		7	600	600	900	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked			662			(662)		63
64	Building Booked			20,004			(20,004)		64
65	Building Improvement Booked			11,330			(11,330)		65
66									66
67	2017-Home Office Allocation-Building Improvements		6,488			156	156		67
68	2017-Home Office Allocation-Land Improvements		597			39	39		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,080,264	\$ 31,996		\$ 35,345	\$ 15,199	\$ 623,308	70

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

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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	\$ 60,873	\$ 6,759	\$ 6,645	\$ (114)	5-10 yrs.	\$ 26,705	71
72	Current Year Purchases	6,721	433	480	47	7 yrs.	480	72
73	Fully Depreciated Assets	53,921					53,921	73
74	Home Office Allocation			7,966	7,966			74
75	TOTALS	\$ 121,515	\$ 7,192	\$ 15,091	\$ 7,899		\$ 81,106	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	Resident Care	06 Ford	2005	29,265					29,265	76
77										77
78										78
79										79
80	TOTALS			\$ 29,265	\$	\$	\$		\$ 29,265	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)	\$ 1,264,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,188	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,436	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,248	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 733,679	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		1,294	87
88					88
89					89
90					90
91	TOTALS	\$ 15,094	\$	\$ 1,294	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

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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 23,343 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Bement Health Care Center

0053173

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 16,205
Dishwasher	701
Copier	5,469
Home Office Allocation	968
	<u>23,343</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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input 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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	\$	4,284	\$ 64,257	\$	4,284	\$ 64,257	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,207	18,112		1,207	18,112	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,638	69,573		4,638	69,573	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				18,401		18,401	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			\$	10,129	\$ 151,942	\$ 18,401	10,129	\$ 170,343	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**# **0053173**Report Period Beginning: **1/1/2017**Ending: **12/31/2017****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2017**

(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	\$ (1,188,361)	\$ (1,188,361)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,540</u>)	392,598	392,598	3
4	Supply Inventory (priced at <u>Cost</u>)	8,889	8,889	4
5	Short-Term Investments			5
6	Prepaid Insurance	13,268	13,268	6
7	Other Prepaid Expenses	453	453	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit, Emp. Ed Loans</u>	7,190	7,190	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (765,963)	\$ (765,963)	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	782,888	14
15	Leasehold Improvements, at Historical Cost	302,137	297,376	15
16	Equipment, at Historical Cost	150,780	150,780	16
17	Accumulated Depreciation (book methods)	(706,631)	(733,679)	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 (spe <u>Farm Property</u>)	13,800	13,800	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 594,295	\$ 544,765	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (171,668)	\$ (221,198)	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 382,596	\$ 382,596	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,245	58,245	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,293	64,293	31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,052	35,052	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	30,661	30,661	36
37	<u>Accrued Management Fees</u>	377,207	377,207	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 948,054	\$ 948,054	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 948,054	\$ 948,054	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,119,722)	\$ (1,169,252)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (171,668)	\$ (221,198)	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,153,621)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Filed	3,343	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,150,278)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,556	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)	\$ 30,556	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)	\$ (1,119,722)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bement Health Care Center

0053173

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,079,975	1
2	Discounts and Allowances for all Levels	(137,703)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,942,272	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	269,213	6
7	Oxygen	1,082	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 270,295	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	1,872	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,076	20
21	Other Medical Services	6,665	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,824	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	505	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 505	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,409	28
28a	<u>Miscellaneous Revenue</u>	1,558	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,967	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,285,863	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	426,145	31
32	Health Care	1,109,170	32
33	General Administration	425,682	33
B. Capital Expense			
34	Ownership	94,952	34
C. Ancillary Expense			
35	Special Cost Centers	84,582	35
36	Provider Participation Fee	114,776	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,255,307	40
41	Income before Income Taxes (line 30 minus line 40)**	30,556	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 30,556	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,326,484	44
45	Private Pay - Net Inpatient Revenue	492,092	45
46	Medicare - Net Inpatient Revenue	85,322	46
47	Other-(specify) <u>Insurance Net Revenue</u>	38,374	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,942,272	49

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

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

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

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

Facility Name & ID Number Bement Health Care Center

0053173

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	2,074	2,138	\$ 49,972	\$ 23.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,835	7,075	199,768	28.24	3
4	Licensed Practical Nurses	6,064	6,068	132,190	21.78	4
5	CNAs & Orderlies	26,105	26,141	344,741	13.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,905	2,028	26,154	12.90	9
10	Activity Assistants					10
11	Social Service Workers	905	905	15,741	17.39	11
12	Dietician					12
13	Food Service Supervisor	1,816	1,936	29,657	15.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,667	9,932	95,158	9.58	15
16	Dishwashers					16
17	Maintenance Workers	1,782	1,782	29,424	16.51	17
18	Housekeepers	4,740	4,808	50,084	10.42	18
19	Laundry	1,809	1,952	22,715	11.64	19
20	Administrator	2,080	2,080	63,855	30.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,926	2,018	27,624	13.69	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 PG20A</u>	2,635	2,771	70,181	25.33	33
34	TOTAL (lines 1 - 33)	70,343	71,634	\$ 1,157,264 *	\$ 16.16	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	12	\$ 562	L1, C3	35
36	Medical Director	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,722	L10, C3	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)	12	\$ 13,284		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	35	\$ 1,717	L10, C3	50
51	Licensed Practical Nurses	125	4,215	L10, C3	51
52	Certified Nurse Assistants/Aides	169	4,644	L10, C3	52
53	TOTAL (lines 50 - 52)	329	\$ 10,576		53

Bement Health Care Center

0053173

Period Beginning 1/1/2017

Period End 12/31/2017

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	1,950	2,086	58,875	28.22
Transportation	14	14	223	15.93
Marketing	671	671	11,083	16.52
TOTAL	<u>2,635</u>	<u>2,771</u>	<u>70,181</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kristie Bailey	Administrator	0	\$ 3,192	Workers' Compensation Insurance	\$ 21,030	IDPH License Fee	\$ 1,990	
Dawn Job	Administrator	0	26,548	Unemployment Compensation Insurance	18,095	Advertising: Employee Recruitment	1,402	
Paula Mason	Administrator	0	6,872	FICA Taxes	82,905	Health Care Worker Background Check (Indicate # of checks performed <u>155</u>)	1,043	
Sheri Szachnitowski	Administrator	0	27,243	Employee Health Insurance	1,865	Miscellaneous Licenses & Permits	699	
				Employee Meals		Miscellaneous Dues & Subscriptions	1,112	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	74	
				Employee Relations	1,681			
				Employee Retirement	1,176			
				Home Office Allocation	15,415			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,855			Less: Public Relations Expense	(160)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,160	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 198,400					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 198,400					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Honkamp, Krueger and Co.	Accounting Services		\$ 142				Out-of-State Travel	\$
Ability Network	Computer Services		4,566					
Mediacom	Computer Services		1,637				In-State Travel	
Allscripts	Consulting Fees		888	N/A				
							Seminar Expense	
							Home Office Allocation	47
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,233	TOTAL		\$	TOTAL	\$ 47

* Attach copy of IMRF notifications

**See instructions.

Bement Health Care Center

0053173

Period Beginning

1/1/2017

Period End

12/31/2017

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,233
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	114
Arnstein & Lehr	Legal	766
SB2	Legal	481
Miscellaneous	Legal	9
Miller Hall and Triggs	Legal	122
Smith Amundsen	Legal	47
Healthcare Resources International	Legal	84
Hunziker Law	Legal	1
Lexis Nexis	Legal	5
Baker Tilly Virchow Krause	Legal	427
Secretary of State	Legal	34
Gemino	Legal	31
CliftonLarsonAllen	Accounting	2342
Ginoli & Co.	Accounting	2957
Baker Tilly Virchow Krause	Accounting	85
Gemino	Accounting	1313
Miscellaneous	Computer Services	64
Change Healthcare	Computer Services	5
360 Networks	Computer Services	26
Matrix Care	Computer Services	2386
Stratus Networks	Computer Services	285
Kemper Technology	Computer Services	162
AT&T	Computer Services	4
Ability Network	Computer Services	176
CIAN	Computer Services	198
Comcast	Computer Services	11
CCH	Computer Services	10
Charter Communications	Computer Services	20
Allscripts	Computer Services	177
ATS	Computer Services	181
Citrix Systems	Computer Services	17
Optimizer	Other Prof Fees	32
Ankura	Other Prof Fees	514
David Budde	Other Prof Fees	24
Sargent Consulting	Other Prof Fees	9911
Alix Partners	Other Prof Fees	8830
Demonica Kemper	Other Prof Fees	21
Brad Barkley	Other Prof Fees	84
MPAC Healthcare	Other Prof Fees	13
Higgs Appraisal	Other Prof Fees	6
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		<u><u>39,210</u></u>

Facility Name & ID Number Bement Health Care Center# 0053173

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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. IHCA-\$952
- (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? N/A
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,874 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? No
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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 114,776
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. \$ 1,872
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 845
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 564
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees