

Facility Name & ID Number Bement Health Care Center

0046052 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			1,192	1,192	8
9	SNF/PED					9
10	ICF	11,355	5,330		16,685	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,355	5,330	1,192	17,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.63%

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 1,192

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	97,183	13,787	459	111,429		111,429	1,496	112,925		1
2	Food Purchase		108,284		108,284		108,284	(1,079)	107,205		2
3	Housekeeping	79,204	26,737		105,941		105,941	17	105,958		3
4	Laundry	41,720	18,080		59,800		59,800	1	59,801		4
5	Heat and Other Utilities			75,299	75,299		75,299	255	75,554		5
6	Maintenance	27,199	15,087	19,719	62,005		62,005	2,084	64,089		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							683	683		7
8	TOTAL General Services	245,306	181,975	95,477	522,758		522,758	3,457	526,215		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	537,341	50,973	96,310	684,624		684,624	3,217	687,841		10
10a	Therapy		1,147	111,095	112,242		112,242		112,242		10a
11	Activities	25,032	453	426	25,911		25,911	(345)	25,566		11
12	Social Services	23,718	171		23,889		23,889		23,889		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							879	879		15
16	TOTAL Health Care and Programs	586,091	52,744	216,831	855,666		855,666	3,751	859,417		16
	C. General Administration										
17	Administrative	58,194			58,194		58,194	11,136	69,330		17
18	Directors Fees										18
19	Professional Services			13,842	13,842		13,842	3,023	16,865		19
20	Dues, Fees, Subscriptions & Promotions			10,791	10,791		10,791	455	11,246		20
21	Clerical & General Office Expenses		6,676	28,802	35,478		35,478	22,631	58,109		21
22	Employee Benefits & Payroll Taxes			113,190	113,190		113,190		113,190		22
23	Inservice Training & Education							292	292		23
24	Travel and Seminar							464	464		24
25	Other Admin. Staff Transportation			6,641	6,641		6,641	1,682	8,323		25
26	Insurance-Prop.Liab.Malpractice			12,169	12,169		12,169	685	12,854		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,250	7,250		27
28	TOTAL General Administration	58,194	6,676	185,435	250,305		250,305	47,618	297,923		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	889,591	241,395	497,743	1,628,729		1,628,729	54,826	1,683,555		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

#0046052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			38,387	38,387		38,387	11,309	49,696			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			251,095	251,095		251,095	3,086	254,181			32
33	Real Estate Taxes			39,471	39,471		39,471	585	40,056			33
34	Rent-Facility & Grounds							36	36			34
35	Rent-Equipment & Vehicles			7,410	7,410		7,410	471	7,881			35
36	Other (specify):*											36
37	TOTAL Ownership			336,363	336,363		336,363	15,487	351,850			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,470		23,470		23,470		23,470			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Non-allowable Cost		362	(7,185)	(6,823)		(6,823)	6,823				43
44	TOTAL Special Cost Centers		23,832	25,665	49,497		49,497	6,823	56,320			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	889,591	265,227	859,771	2,014,589		2,014,589	77,136	2,091,725			45

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

**See schedule of adjustments attached at end of cost report.

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				4
5	Telephone, TV & Radio in Resident Rooms	(743)	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	9,612	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(224)	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	2,985	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	(21,852)	43		24
25	Fund Raising, Advertising and Promotional	(4,425)	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 See Pg. 5A	25,862	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 11,215		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	65,921	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 65,921		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 77,136		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.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Bement Health Care Center

ID# 0046052

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ 18,510	43	1
2	X-Rays-Part A	12,572	43	2
3	Offset Contract Nursing refund	(739)	10	3
4	Offset Miscellaneous Food Revenue	(1,131)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(2,726)	21	5
6	Nonallowable Dues	(200)	20	6
7	Farm Land Depreciation	(79)	30	7
8	Day Care Revenue	(345)	11	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	25,862		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bement Health Care Center# 0046052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,496	0	0	0	0	0	0	0	0	0	1,496	1
2	Food Purchase	(1,131)	52	0	0	0	0	0	0	0	0	0	(1,079)	2
3	Housekeeping	0	17	0	0	0	0	0	0	0	0	0	17	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	255	0	0	0	0	0	0	0	0	0	255	5
6	Maintenance	0	2,084	0	0	0	0	0	0	0	0	0	2,084	6
7	Other (specify):*	0	683	0	0	0	0	0	0	0	0	0	683	7
8	TOTAL General Services	(1,131)	4,588	0	0	0	0	0	0	0	0	0	3,457	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(739)	3,956	0	0	0	0	0	0	0	0	0	3,217	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(345)	0	0	0	0	0	0	0	0	0	0	(345)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	879	0	0	0	0	0	0	0	0	0	879	15
16	TOTAL Health Care and Programs	(1,084)	4,835	0	0	0	0	0	0	0	0	0	3,751	16
	C. General Administration													
17	Administrative	0	11,136	0	0	0	0	0	0	0	0	0	11,136	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,023	0	0	0	0	0	0	0	0	0	3,023	19
20	Fees, Subscriptions & Promotions	(200)	0	655	0	0	0	0	0	0	0	0	455	20
21	Clerical & General Office Expenses	(2,726)	0	25,357	0	0	0	0	0	0	0	0	22,631	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	292	0	0	0	0	0	0	0	0	292	23
24	Travel and Seminar	0	0	464	0	0	0	0	0	0	0	0	464	24
25	Other Admin. Staff Transportation	0	0	1,682	0	0	0	0	0	0	0	0	1,682	25
26	Insurance-Prop.Liab.Malpractice	0	0	685	0	0	0	0	0	0	0	0	685	26
27	Other (specify):*	0	0	7,250	0	0	0	0	0	0	0	0	7,250	27
28	TOTAL General Administration	(2,926)	14,159	36,385	0	47,618	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,141)	23,582	36,385	0	54,826	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bement Health Care Center

0046052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,533	0	1,776	0	0	0	0	0	0	0	0	11,309	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3,086	0	0	0	0	0	0	0	0	3,086	32
33	Real Estate Taxes	0	0	585	0	0	0	0	0	0	0	0	585	33
34	Rent-Facility & Grounds	0	0	36	0	0	0	0	0	0	0	0	36	34
35	Rent-Equipment & Vehicles	0	0	471	0	0	0	0	0	0	0	0	471	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,533	0	5,954	0	15,487	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	6,823	0	0	0	0	0	0	0	0	0	0	6,823	43
44	TOTAL Special Cost Centers	6,823	0	0	0	0	0	0	0	0	0	0	6,823	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,215	23,582	42,339	0	77,136	45							

Facility Name & ID Number

Bement Health Care Center

0046052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,496	\$ 1,496	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	52	52	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	255	255	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,084	2,084	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	683	683	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,956	3,956	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	879	879	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	11,136	11,136	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,023	3,023	12	
13	V							13	
14	Total		\$			\$ 23,582	\$ *	23,582	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%	\$ 655	\$	655	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	25,357		25,357	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	292		292	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	464		464	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,682		1,682	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	685		685	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,250		7,250	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,776		1,776	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,086		3,086	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	585		585	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	36		36	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	471		471	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		\$			\$ 42,339	\$ *	42,339	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:

01/01/2007

Ending:

12/31/2007

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	See Schedule 7A	0.73	1.33	Salary	\$ 11,136	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,136		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:

01/01/2007

Ending: **2/31/2007**

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	1,316,550	66	\$ 110,171	\$ 17,877	\$ 1,496	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	52	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	17	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	255	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	2,084	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	683	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	3,956	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	879	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	11,136	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	3,023	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	655	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	25,357	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	292	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	464	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	1,682	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	685	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	7,250	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	1,776	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	3,086	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	585	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	36	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	471	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422	\$ 65,921	25

Facility Name & ID Number

Bement Health Care Center

0046052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		7	8	9	10						
		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	LaSalle Bank		X	Mortgage	Varies	1/17/07	\$ 3,000,000	\$ 2,965,900	12/31/13	Varies	\$ 249,806	1						
2	State Bank of Toulon		X	Van	\$572.65	08/05/05	29,265	16,789	08/05/10	0.0650	1,289	2						
3												3						
4							Home Office Allocation				3,086	4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$572.65		\$ 3,029,265	\$ 2,982,689			\$ 254,181	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	\$ 2,982,689			\$ 254,181	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 2006 report.		\$	36,000	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.)	2006	\$	36,971	2
3. Under or (over) accrual (line 2 minus line 1).		\$	971	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	38,500	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			585	
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.		\$	40,056	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	32,667	8
	2003	32,082	9
	2004	34,960	10
	2005	35,961	11
	2006	36,971	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>36,971.34</u>	\$ <u>36,971.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>36,971.34</u>	\$ <u>36,971.34</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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:

	1	2	3	4	
A. Land.	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:

01/01/2007 Ending: 12/31/2007

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	\$ 265,622	4
5										5
6										6
7	Home Office Allocation		2007	9,966			243	243		7
8										8
	Improvement Type**									
9	Landscaping		1996	3,650		20	183	183	2,120	9
10	Parking Lot		1996	1,669		20	83	83	937	10
11	Driveway		1996	1,050		20	53	53	608	11
12	Painting and Remodeling		1996	3,155		20	158	158	1,816	12
13	Curtains		1996	4,928		20	246	246	2,851	13
14	Walkway		1996	361		20	18	18	210	14
15	Alarm and Fire Equipment		1996	4,437		20	222	222	2,571	15
16	Sign		1996	434		20	22	22	276	16
17	Heating and Unit Platform		1996	1,219		20	61	61	783	17
18	300 Gallon Tank		1997	1,370		20	69	69	757	18
19	Install Gas Line		1997	1,862		20	93	93	1,008	19
20	Steel Door		1997	1,170		20	59	59	637	20
21	New Gas Line		1997	1,875		20	94	94	963	21
22	Gas Water Heater		1997	5,008		20	250	250	2,544	22
23	Zone Line Heaters		1997	730		20	37	37	390	23
24	Zone Line Heaters		1997	754		20	38	38	391	24
25	Generator Repair		1997	6,112		20	306	306	3,084	25
26	Ase Blacktop		1998	10,062		20	503	503	4,780	26
27	Electrical Service Generator Work		1998	1,846		20	92	92	875	27
28	Zone Line Heaters		1998	716		20	36	36	341	28
29	Heater		1999	4,956		20	248	248	2,107	29
30	Kickplates, Handrails		1999	1,803		20	90	90	766	30
31	Grade Driveway and Parking Lot		1999	3,100		20	155	155	1,318	31
32	Parking Lot Sealant		1999	1,060		20	53	53	451	32
33	Garage		2000	8,892		20	445	445	3,335	33
34	Door Frame Protectors		2000	1,059		20	53	53	397	34
35	Nine Windows		2000	2,289		20	114	114	857	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:

01/01/2007 Ending: 12/31/2007

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	\$ 493	37
38	Carpet	2001	1,297		7	185	185	1,204	38
39	Fire system	2001	22,829		39	585	585	3,805	39
40	Air System	2001	9,985		39	256	256	1,664	40
41	Fire Door	2001	826		39	21	21	138	41
42	Water Heater	2002	3,975		39	102	102	612	42
43	Gutters	2004	6,783		39	174	174	609	43
44									44
45	Sidewalks	2005	1,484		20	74	74	185	45
46	4 Awnings(Reclass from Equipment)	2005	3,281		10	328	328	820	46
47	Concrete/Sealer	2006	8,450		20	423	423	634	47
48	New Rooftop unit	2007	17,449		20	436	436	436	48
49	Boiler	2007	16,750		15	558	558	558	49
50									50
51									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			5,265			(5,265)		61
62									62
63									63
64									64
65									65
66	2007-Home Office Allocation-Building Improvements		667			40	40		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 960,767	\$ 26,555		\$ 29,562	\$ 3,007	\$ 313,953	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:

01/01/2007

Ending:

12/31/2007

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	\$ 167,721	\$ 4,343	\$ 12,305	\$ 7,962	7-10	\$ 154,171	71
72	Current Year Purchases	9,666	1,791	483	(1,308)	10	483	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,493	1,493			74
75	TOTALS	\$ 177,387	\$ 6,134	\$ 14,281	\$ 8,147		\$ 154,654	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	5,619	5,853	234	5	14,633	77
78										78
79										79
80	TOTALS			\$ 60,764	\$ 5,619	\$ 5,853	\$ 234		\$ 46,133	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)	\$ 1,232,518	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,387	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,696	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,388	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 514,740	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	500	87
88	Offset on Page 5A				88
89					89
90					90
91	TOTALS	\$ 15,094	\$ 79	\$ 500	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		<u>Home Office Allocation</u>			<u>36</u>			6
7	TOTAL				\$ <u>36</u>			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: \$ 7,881 Description: See 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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 1,806
Dishwasher	420
Maint Equipment	20
Medical Equipment	5,164
Home Office Allocation	471
	<u>7,881</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	L. 10A, C. 3	hrs	\$	3,689	\$ 55,331	\$	3,689	\$ 55,331	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		112	1,686		112	1,686	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 2,3	hrs		3,605	54,078	1,147	3,605	55,225	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				23,470		23,470	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	7,406	\$ 111,095	\$ 24,617	7,406	\$ 135,712	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 3,344,956	\$ 3,344,956	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	190,672	190,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,465	9,465	6
7	Other Prepaid Expenses	1,532	1,532	7
8	Accounts Receivable (owners or related parties)	550,722	550,722	8
9	Other(specify): <u>Employee Education Loan</u>	1,088	1,088	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,098,435	\$ 4,098,435	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	790,112	14
15	Leasehold Improvements, at Historical Cost	192,948	170,655	15
16	Equipment, at Historical Cost	255,526	238,151	16
17	Accumulated Depreciation (book methods)	(503,423)	(514,740)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>Farm Property</u>	14,075	14,075	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 739,272	\$ 731,853	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,837,707	\$ 4,830,288	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 308,009	\$ 308,009	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,670	60,670	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,174	2,174	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,500	38,500	32
33	Accrued Interest Payable	21,087	21,087	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	14,693	14,693	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 445,133	\$ 445,133	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,789	16,789	39
40	Mortgage Payable	2,965,900	2,965,900	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)	\$ 2,982,689	\$ 2,982,689	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,427,822	\$ 3,427,822	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,409,885	\$ 1,402,466	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,837,707	\$ 4,830,288	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,346,658	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(4,155)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,342,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	67,382	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)	\$ 67,382	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)	\$ 1,409,885	24 *

* This must agree with page 17, line 47.

Bement Health Care Center
0046052
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

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	\$ 1,754,669	1
2	Discounts and Allowances for all Levels	96,222	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,850,891	3
B. Ancillary Revenue			
4	Day Care	345	4
5	Other Care for Outpatients		5
6	Therapy	167,663	6
7	Oxygen	5,045	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 173,053	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	1,131	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	48,296	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,500	20
21	Other Medical Services	2,635	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 54,562	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	3,465	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,465	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,081,971	30

		2	
	Expenses	Amount	
A. Operating Expenses			
31	General Services	522,758	31
32	Health Care	855,666	32
33	General Administration	250,305	33
B. Capital Expense			
34	Ownership	336,363	34
C. Ancillary Expense			
35	Special Cost Centers	16,647	35
36	Provider Participation Fee	32,850	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,014,589	40
41	Income before Income Taxes (line 30 minus line 40)**	67,382	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 67,382	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 a division of a 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: 01/01/2007

Ending: 12/31/2007

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	1,427	1,507	\$ 37,078	\$ 24.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,321	4,585	97,430	21.25	3
4	Licensed Practical Nurses	6,919	7,459	132,433	17.75	4
5	CNAs & Orderlies	26,319	27,395	270,400	9.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	20,962	10.08	9
10	Activity Assistants	538	538	4,070	7.57	10
11	Social Service Workers	2,080	2,080	23,718	11.40	11
12	Dietician					12
13	Food Service Supervisor	465	469	4,396	9.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,028	12,312	92,787	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,064	27,199	13.18	17
18	Housekeepers	9,529	9,616	79,204	8.24	18
19	Laundry	4,840	5,176	41,720	8.06	19
20	Administrator	1,838	2,022	58,194	28.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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)					33
34	TOTAL (lines 1 - 33)	74,448	77,303	\$ 889,591 *	\$ 11.51	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	9	\$ 459	L. 1, C. 3	35
36	Medical Director	Monthly	9,000	L. 9, C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	650	L. 10, C. 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	\$ 10,109		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	94	\$ 4,796	L. 10, C. 3	50
51	Licensed Practical Nurses	148	5,450	L. 10, C. 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	242	\$ 10,246		53

Bement Health Care Center
0046052
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
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Total (agree to Schedule V, line 19, column 3)		13,842
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Non-allowable legal expense

Home Office Allocation

Pearl & Associates	Legal	20
Addy Bush & Assoc	Legal	10
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	44
Duane Morris	Legal	68
Ginoli & Co.	Accountants	691
RSM McGladrey	Accountants	120
McGladrey & Pullen	Accountants	182
Emdeon Business Services	Computer Services	47
Advanced Answers on Demand	Computer Services	1,282
Access 2 Go	Computer Services	97
Ivans	Computer Services	85
Kemper Technology	Computer Services	201
Adminastar Federal	Computer Services	25
Logmein	Computer Services	16
E-Health Data Solutions	Computer Services	126
Miscellaneous Vendors	Miscellaneous	7

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u><u>16,865</u></u>
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Facility Name & ID Number Bement Health Care Center# 0046052Report Period Beginning: 01/01/2007Ending: 12/31/2007**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 \$4778
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,271 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,850
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. \$ 1,131
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co. 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