

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036012

Facility Name: Breese Nursing Home

Address: 1155 North First Street Breese 62230
 Number City Zip Code

County: Clinton

Telephone Number: (618) 526-4521 **Fax #** (618) 526-2833

HFS ID Number: 37-1259462001

Date of Initial License for Current Owners: 03/09/1990

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) Compilation Report Attached (Date) _____

(Print Name and Title) Cindy A. Tefteller, Partner

(Firm Name & Address) C.J. Schlosser & Compnay
233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home# 0036012 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	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	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	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	8,384	6,726	2,828	17,938	8
9	SNF/PED					9
10	ICF	6,189	3,878		10,067	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,573	10,604	2,828	28,005	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 68.51%

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

0 (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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 03/06/1990

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

YES Date 03/06/1990 NO

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

YES NO If YES, enter number
of beds certified 13 and days of care provided 2,828Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	179,420	1,190	6,254	186,864		186,864		186,864		1
2	Food Purchase		137,511		137,511		137,511	(480)	137,031		2
3	Housekeeping	58,101	16,077		74,178		74,178		74,178		3
4	Laundry	47,131	10,979		58,110		58,110		58,110		4
5	Heat and Other Utilities			97,504	97,504		97,504		97,504		5
6	Maintenance	75,154	485	38,555	114,194		114,194		114,194		6
7	Other (specify):* Sanitation			8,174	8,174		8,174		8,174		7
8	TOTAL General Services	359,806	166,242	150,487	676,535		676,535	(480)	676,055		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,321,307	59,990	13,028	1,394,325		1,394,325		1,394,325		10
10a	Therapy		103	328,960	329,063		329,063		329,063		10a
11	Activities	34,801	1,941	1,498	38,240		38,240		38,240		11
12	Social Services	52,881	50	4,793	57,724		57,724		57,724		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,408,989	62,084	354,279	1,825,352		1,825,352		1,825,352		16
	C. General Administration										
17	Administrative	78,342			78,342		78,342		78,342		17
18	Directors Fees										18
19	Professional Services			27,112	27,112		27,112	(2,910)	24,202		19
20	Dues, Fees, Subscriptions & Promotions			12,043	12,043		12,043	(3,439)	8,604		20
21	Clerical & General Office Expenses	116,412	12,615	52,970	181,997		181,997	(1,621)	180,376		21
22	Employee Benefits & Payroll Taxes			251,356	251,356		251,356	(7,718)	243,638		22
23	Inservice Training & Education					100	100		100		23
24	Travel and Seminar			658	658	(100)	558		558		24
25	Other Admin. Staff Transportation		6,493		6,493		6,493		6,493		25
26	Insurance-Prop.Liab.Malpractice			59,905	59,905		59,905	(20,963)	38,942		26
27	Other (specify):*										27
28	TOTAL General Administration	194,754	19,108	404,044	617,906		617,906	(36,651)	581,255		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,963,549	247,434	908,810	3,119,793		3,119,793	(37,131)	3,082,662		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Breese Nursing Home #0036012 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			96,366	96,366		96,366	21,705	118,071			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,361	206,361		206,361	(15,808)	190,553			32
33	Real Estate Taxes			23,538	23,538		23,538		23,538			33
34	Rent-Facility & Grounds			12,000	12,000		12,000		12,000			34
35	Rent-Equipment & Vehicles			2,299	2,299		2,299		2,299			35
36	Other (specify):* Mort. Ins. Prem.			11,854	11,854		11,854		11,854			36
37	TOTAL Ownership			352,418	352,418		352,418	5,897	358,315			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,522	26,784	102,306		102,306		102,306			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		75,522	88,104	163,626		163,626		163,626			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,963,549	322,956	1,349,332	3,635,837		3,635,837	(31,234)	3,604,603			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home# 0036012

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(480)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,705	30		9
10	Interest and Other Investment Income	(15,808)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,621)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,238)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,718)	22		21
22	Special Legal Fees & Legal Retainers	(2,910)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,071)	20		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	(20,093)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,234)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (31,234)		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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY					
48		49		50	51
					52

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	To eliminate civic dues	\$ (125)	20
2	To record 2006 license paid for in 2005	995	26
3	To offset liability insurance dividend	(6,963)	26
4	To offset return of capital contributions		
5	expensed in prior years	(14,000)	26
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48			
49	Total	(20,093)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(480)	0	0	0	0	0	0	0	0	0	0	(480)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(480)	0	0	0	0	0	0	0	0	0	0	(480)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,910)	0	0	0	0	0	0	0	0	0	0	(2,910)	19
20	Fees, Subscriptions & Promotions	(3,439)	0	0	0	0	0	0	0	0	0	0	(3,439)	20
21	Clerical & General Office Expenses	(1,621)	0	0	0	0	0	0	0	0	0	0	(1,621)	21
22	Employee Benefits & Payroll Taxes	(7,718)	0	0	0	0	0	0	0	0	0	0	(7,718)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(20,963)	0	0	0	0	0	0	0	0	0	0	(20,963)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(36,651)	0	0	0	0	0	0	0	0	0	0	(36,651)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,131)	0	0	0	0	0	0	0	0	0	0	(37,131)	29

STATE OF ILLINOIS

Facility Name & ID Number Breese Nursing Home

0036012 Report Period Beginning:

01/01/2006 Ending:

Summary B

12/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	21,705	0	0	0	0	0	0	0	0	0	0	21,705	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,808)	0	0	0	0	0	0	0	0	0	0	(15,808)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	5,897	0	5,897	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(31,234)	0	(31,234)	45									

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 E. Halloran	50.00%					
Garrett C. Reuter	50.00%					

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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 E. Halloran	President		50.00%	0	12	30.00%	Salary	\$ 12,033	17,1	1
2	Garrett C. Reuter		Counsel	50.00%	0	12	30.00%	Salary	12,033	17,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,066		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Gershman Investment Group		X	Refinance Mortgage	\$17,832.17	3/16/2000	\$ 2,478,900	\$ 2,366,325	3/16/2035	8.1250	\$ 193,050	1								
2												2								
3							Amortization of Loan Costs				3,257	3								
4												4								
5												5								
Working Capital																				
6	Mark Halloran & Garrett	X		Working Capital		12/31/02	137,531	137,541		7.0000	10,054	6								
7	Reuter											7								
8												8								
9	TOTAL Facility Related				\$17,832.17		\$ 2,616,431	\$ 2,503,866			\$ 206,361	9								
B. Non-Facility Related*																				
10												10								
11							Interest Income				(15,808)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(15,808)	14								
15	TOTALS (line 9+line14)						\$ 2,616,431	\$ 2,503,866			\$ 190,553	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,854 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 24,100	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.)		\$ 23,338	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (762)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 24,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 23,538	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	24,416	8
	2002	24,198	9
	2003	22,904	10
	2004	23,190	11
	2005	23,338	12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<u>The payment on line 2 was for the 2005 tax year.</u>			
<u>The accrual used on line 4 was based on the 2005 tax year.</u>			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Breese Nursing Home COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036012

CONTACT PERSON REGARDING THIS REPORT Mark Halloran, President

TELEPHONE (618) 632-2500 FAX #: (618) 622-0800

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>06-06-22-252-008</u>	<u>Sec 22 Twp 2 Rng 4 Pt W 1/2 NE</u>	\$ <u>23,337.58</u>	\$ <u>23,337.58</u>
2. _____	<u>NE 4A</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>23,337.58</u>	\$ <u>23,337.58</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Breese Nursing Home

0036012 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,286 B. General Construction Type: Exterior Masonry Frame Reinforced Concrete 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>174,242</u>	<u>1990</u>	<u>\$ 15,400</u>	1
2					2
3	TOTALS	174,242		\$ 15,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	112		1990	1975	\$ 1,750,695	\$ 55,578	31.5	\$ 55,578	\$	\$ 933,238	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Beg Balance	1990		10,000	317	31.5	317		5,330	9
10		Roof	1990		101,563	3,224	31.5	3,224		52,824	10
11		Air Conditioner	1990		2,828	90	31.5	90		1,487	11
12		Interior Renovation	1990		1,292	41	31.5	41		658	12
13		Air Conditioner Pad	1990		2,645		15			2,645	13
14		Roof	1991		48,265	1,532	31.5	1,532		24,067	14
15		Handrails	1991		4,884	155	31.5	155		2,409	15
16		Soffits & Siding	1991		11,204	356	31.5	356		5,583	16
17		Carpet	1991		1,987		7			1,987	17
18		Air Conditioner	1991		4,755	151	31.5	151		2,333	18
19		HVAC - Dining Room	1991		5,510	175	31.5	175		2,493	19
20		Cubicle Tracking	1992		1,815		7			1,815	20
21		Plastering	1992		1,952	62	31.5	62		852	21
22		Cubicle Tracking	1993		657		20	33	33	451	22
23		Carpet & Tile	1993		1,481		5			1,481	23
24		Air Conditioning	1993		5,877	151	10		(151)	5,877	24
25		Fire Alarm	1993		10,700	274	15	713	439	9,450	25
26		Front Door	1994		1,368	35	10		(35)	1,368	26
27		Electric Wiring	1994		9,131	234	20	457	223	5,708	27
28		Back Patio	1994		5,137	303	10		(303)	5,137	28
29		Landscaping	1994		1,221	72	10		(72)	1,221	29
30		Front Parking Lot	1994		80,603	4,760	10		(4,760)	80,603	30
31		Lighting & Ceiling	1994		2,110		10			2,110	31
32		Gutters & Shutters	1994		2,111	54	27	78	24	957	32
33		Dining Roome Improvements	1994		2,558	66	27	95	29	1,146	33
34		Plumbing	1994		4,528	116	20	227	111	2,906	34
35		Ceiling Tile	1994		614	16	12	35	19	614	35
36		Laundry Improvements	1994		1,162	30	27	43	13	552	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	Administrative Office Improvements	1994	\$ 1,048	\$ 27	15	\$ 70	\$ 43	\$ 891	37
38	Water Softener	1994	3,661	94	12	51	(43)	3,661	38
39	Air Conditioners	1994	31,460	807	10		(807)	31,460	39
40	Window Blinds	1995	6,010		20	300	300	3,330	40
41	Land Improvements	1995	1,224	72	10		(72)	1,224	41
42	Sign	1995	2,455		12	205	205	2,406	42
43	Parking Lot Lighting	1995	7,456		15	497	497	5,840	43
44	Flag Pole	1995	1,511	89	20	76	(13)	882	44
45	Landscaping	1995	2,206	130	10		(130)	2,206	45
46	Landscaping	1996	2,927		10	145	145	2,927	46
47	Kitchen Renovations	1996	13,339		25	534	534	5,605	47
48	Window Screens	1996	914		5			914	48
49	Remodel Nurse Station	1996	1,077		25	43	43	452	49
50	Reception Room Addition	1996	3,721		25	149	149	1,563	50
51	Doors - Alzheimer Unit	1996	1,030		25	41	41	432	51
52	Shrubs	1997	1,001	59	15	67	8	635	52
53	Fence	1997	1,141	67	15	76	9	748	53
54	Fixtures	1997	2,835		10	283	283	2,716	54
55	Window	2000	35,000	897	10	3,500	2,603	24,500	55
56	Light Fixtures	2000	1,500	38	10	150	112	1,050	56
57	Sink Fixtures	2000	7,350	188	20	368	180	2,573	57
58	10 Ton HVAC	2000	10,000	256	17	588	332	4,116	58
59	Water Softener	2000	40,000	1,026	12	3,333	2,307	23,332	59
60	Water Heater	2000	1,500	38	15	100	62	700	60
61	Air Handling Unit	2000	3,000	77	15	200	123	1,400	61
62	Rear Parking Lot	2000	44,000	2,598	15	2,933	335	20,532	62
63	Dumpster Pad	2000	900	53	15	60	7	420	63
64	Shower Room Remodel	2001	15,000	385	15	1,000	615	6,000	64
65	Grab Bars	2002	4,800	123	15	320	197	1,600	65
66	Tuck Point	2002	1,000	26	15	67	41	335	66
67	RegROUT	2002	1,500	39	15	100	61	500	67
68	Air Handler	2002	3,000	77	15	200	123	1,000	68
69	Remodel Spravout Room	2002	2,481	64	15	165	101	943	69
70	TOTAL (lines 4 thru 69)		\$ 2,334,700	\$ 75,022		\$ 78,983	\$ 3,961	\$ 1,314,195	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
1	Totals from Page 12A, Carried Forward		\$ 2,334,700	\$ 75,022		\$ 78,983	\$ 3,961	\$ 1,314,195	1
2	Drainage	2002	1,500	73	15	100	27	500	2
3	Roof	2003	3,697	117	10	370	253	1,233	3
4	Floor Tile	2004	47,390	1,215	10	4,739	3,524	9,478	4
5	Door Alarm	2004	6,074	156	10	607	451	1,720	5
6	Telephone & Intercom System	2006	6,736	169	10	169		169	6
7	Hot Water Heater	2006	5,143	257	10	257		257	7
8	Concrete Sidewalks	2006	6,960	155	15	155		155	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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	TOTAL (lines 1 thru 33)		\$ 2,412,200	\$ 77,164		\$ 85,380	\$ 8,216	\$ 1,327,707	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 236,991	\$ 17,995	\$ 29,887	\$ 11,892	5-20 Yrs	\$ 148,778	71
72	Current Year Purchases	4,041	67	67		5 Yrs	67	72
73	Fully Depreciated Assets	364,386					364,386	73
74								74
75	TOTALS	\$ 605,418	\$ 18,062	\$ 29,954	\$ 11,892		\$ 513,231	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 Business	1991 Van	1991	\$ 21,781	\$	\$	\$	5	\$ 21,781	76
77	Facility Business	Wheelchair Lift	1996	4,345		362	362	12	3,983	77
78	Facility Business	1993 Ford E150	2003	9,500	1,140	2,375	1,235	4	8,115	78
79										79
80	TOTALS			\$ 35,626	\$ 1,140	\$ 2,737	\$ 1,597		\$ 33,879	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 3,068,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 96,366	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 118,071	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 21,705	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,874,817	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	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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?

N/A YES N/A NO

16. Rental Amount for movable equipment: \$ 2,299

Description: Dishwasher

(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	<u>Section Not Applicable</u>		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Breese Nursing Home

0036012

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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,2 & 3	hrs	\$	2,912	\$ 102,959	\$ 80	2,912	\$ 103,039	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,240	49,620		1,240	49,620	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2 & 3	hrs		5,991	176,380	23	5,991	176,403	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				75,522		75,522	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-ray & Laboratory	39,3				26,784			26,784	13
14	TOTAL			\$	10,143	\$ 355,743	\$ 75,625	10,143	\$ 431,368	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home# 0036012Report Period Beginning: 01/01/2006

Ending:

12/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2006

(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	\$ 647,157	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	737,558		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,800		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,421,015	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,400		13
14	Buildings, at Historical Cost	2,397,757		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	638,622		16
17	Accumulated Depreciation (book methods)	(1,808,394)		17
18	Deferred Charges	91,750		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,335,135	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,756,150	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 145,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,662		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,506		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,300		32
33	Accrued Interest Payable	16,022		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Shareholders</u>	137,541		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 420,797	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,366,325		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)	\$ 2,366,325	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,787,122	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (30,972)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,756,150	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (200,395)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (200,395)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	199,423	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	(30,000)	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)	\$ 169,423	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)	\$ (30,972)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home# 0036012Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	\$ 3,168,219	1
2	Discounts and Allowances for all Levels	(183,424)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,984,795	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	735,097	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 735,097	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	480	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,187	19
20	Radiology and X-Ray	17,933	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 77,600	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,808	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,808	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	21,960	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,960	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,835,260	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	676,535	31
32	Health Care	1,825,352	32
33	General Administration	617,906	33
B. Capital Expense			
34	Ownership	352,418	34
C. Ancillary Expense			
35	Special Cost Centers	102,306	35
36	Provider Participation Fee	61,320	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,635,837	40
41	Income before Income Taxes (line 30 minus line 40)**	199,423	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,423	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet filed 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	1,684	1,822	\$ 49,424	\$ 27.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,089	14,145	289,191	20.44	3
4	Licensed Practical Nurses	17,914	19,038	340,707	17.90	4
5	CNAs & Orderlies	54,405	58,042	618,547	10.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,489	3,870	34,801	8.99	10
11	Social Service Workers	3,916	4,299	52,881	12.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,604	18,502	179,420	9.70	15
16	Dishwashers					16
17	Maintenance Workers	5,612	6,008	75,154	12.51	17
18	Housekeepers	6,762	7,036	58,101	8.26	18
19	Laundry	5,745	5,981	47,131	7.88	19
20	Administrator	1,887	2,117	54,276	25.64	20
21	Assistant Administrator					21
22	Other Administrative	1,203	1,203	24,066	20.00	22
23	Office Manager					23
24	Clerical	8,352	9,012	116,412	12.92	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	1,996	2,052	23,438	11.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,658	153,127	\$ 1,963,549 *	\$ 12.82	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	135	\$ 6,254	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	17	670	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,320	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,498	11,3	44
45	Social Service Consultant	Contract	1,498	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	152	\$ 17,240		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ Section N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	
Mark Halloran	Owner	50.00	\$ 12,033	Workers' Compensation Insurance	\$ 70,675	IDPH License Fee	\$ 995	
Garrett Reuter	Owner	50.00	12,033	Unemployment Compensation Insurance	19,345	Advertising: Employee Recruitment	1,816	
Joseph Hussman	Administrator	0.00	9,880	FICA Taxes	150,144	Health Care Worker Background Check		
Barbara Berndsen	Administrator	0.00	44,396	Employee Health Insurance		(Indicate # of checks performed)	2,300	
				Employee Meals		Promotional Advertising	2,071	
				Illinois Municipal Retirement Fund (IMRF)*		Dues, Subscriptions, & Licenses	2,620	
				Employee Appreciation	420	Miscellaneous Expenses	873	
				Flexible Spending Plan Fees	1,199			
				401 (K) Fees	1,855			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 78,342			Non-allowable advertising	(2,071)	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 243,638	
Section Not Applicable							TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 8,604	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)								
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
C.J. Schlosser & Co.	Accounting	\$ 12,375	Section Not Applicable			Out-of-State Travel	\$	
Wenzel & Associates	Accounting	1,096						
Greensfelder, Hemker, & Gale	Legal	281				In-State Travel	313	
Giffin, Winning, Cohen, & Bodewes	Legal	4,905						
Paychex, Inc.	Accounting	8,455				Seminar Expense	245	
						Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 27,112				TOTAL	\$ 558

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Breese Nursing Home

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

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? No
If YES, give association name and amount. N/A
- (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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,833 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. \$ 61,320
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? None
- (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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 480
- (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? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? 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: C.J. Schlosser & Company, L.L.C. 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 not finalized; report to follow
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

CARING FIRST, INC. D/B/A BREESE NURSING HOME
 RECLASSIFICATIONS
 MEDICAID COST REPORT
 12/31/2006

	<u>AMOUNT</u>	<u>LN #</u>
A		
INSERVICE TRAINING & EDUCATION	100	23
SEMINARS & TRAVEL	(100)	24
TO RECLASSIFY INSERVICE EXPENSES		

CARING FIRST, INC. D/B/A BREESE NURSING HOME
 ATTACHMENT TO SCHEDULE V, LINE 25
 12/31/2006

OTHER ADMIN. STAFF TRANSPORTATION: MILEAGE REIMBURSEMENT	<u>\$ 6,493</u>
	<u>\$ 6,493</u>

** ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTED WHICH WERE LESS THAN \$250.00 EACH.

CARING FIRST, INC. D/B/A BREESE NURSING HOME
 ATTACHMENT TO SCHEDULE XVII, LINE 28
 12/31/2006

LTC Liability Insurance Dividend	\$ 6,963
LTC Return of Capital	14,000
Forfeited Flexible Spending A/C Money from 2005	372
Miscellaneous	625
	<u>\$ 21,960</u>