

Facility Name & ID Number Breese Nursing Home

0036012 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 _____

	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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,686	3,519	2,981	15,186	8	
9	SNF/PED					9	
10	ICF	4,270	5,898		10,168	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	12,956	9,417	2,981	25,354	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.02%

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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 38 and days of care provided 2,981

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 Breese Nursing Home # 0036012 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	176,648	531	8,227	185,406		185,406		185,406		1
2	Food Purchase		138,939		138,939		138,939	(285)	138,654		2
3	Housekeeping	60,643	11,668		72,311		72,311		72,311		3
4	Laundry	45,730	11,429		57,159		57,159		57,159		4
5	Heat and Other Utilities			95,767	95,767		95,767		95,767		5
6	Maintenance	49,435	1,324	47,621	98,380		98,380		98,380		6
7	Other (specify):*			11,321	11,321		11,321		11,321		7
8	TOTAL General Services	332,456	163,891	162,936	659,283		659,283	(285)	658,998		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,305,404	60,085	9,817	1,375,306		1,375,306		1,375,306		10
10a	Therapy			410,551	410,551		410,551		410,551		10a
11	Activities	35,254	2,282	2,140	39,676		39,676		39,676		11
12	Social Services	52,412		2,582	54,994		54,994		54,994		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,393,070	62,367	431,090	1,886,527		1,886,527		1,886,527		16
	C. General Administration										
17	Administrative	79,060			79,060		79,060		79,060		17
18	Directors Fees										18
19	Professional Services			32,638	32,638		32,638	(66)	32,572		19
20	Dues, Fees, Subscriptions & Promotions			19,164	19,164	300	19,464	(11,941)	7,523		20
21	Clerical & General Office Expenses	110,887	10,038	61,467	182,392		182,392	(28,365)	154,027		21
22	Employee Benefits & Payroll Taxes			269,697	269,697		269,697	(11,289)	258,408		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,775	1,775	(300)	1,475		1,475		24
25	Other Admin. Staff Transportation		6,826		6,826		6,826	(6,529)	297		25
26	Insurance-Prop.Liab.Malpractice			59,718	59,718		59,718		59,718		26
27	Other (specify):*										27
28	TOTAL General Administration	189,947	16,864	444,459	651,270		651,270	(58,190)	593,080		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,915,473	243,122	1,038,485	3,197,080		3,197,080	(58,475)	3,138,605		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:

01/01/2007

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			97,447	97,447		97,447	19,875	117,322			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			202,576	202,576		202,576	(31,513)	171,063			32
33	Real Estate Taxes			23,133	23,133		23,133		23,133			33
34	Rent-Facility & Grounds			12,000	12,000		12,000		12,000			34
35	Rent-Equipment & Vehicles			1,974	1,974		1,974		1,974			35
36	Other (specify):* Mortgage Ins. Prem.			11,743	11,743		11,743		11,743			36
37	TOTAL Ownership			348,873	348,873		348,873	(11,638)	337,235			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,216	21,263	101,479		101,479		101,479			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		80,216	82,583	162,799		162,799		162,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,915,473	323,338	1,469,941	3,708,752		3,708,752	(70,113)	3,638,639			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:

01/01/2007

Ending:

12/31/2007

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	(285)	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	19,875	30		9
10	Interest and Other Investment Income	(31,513)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,936)	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	(9,362)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(66)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,883)	21		24
25	Fund Raising, Advertising and Promotional	(1,152)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(34,791)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,113)		\$	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))	\$ (70,113)		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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Breese Nursing HomeID# 0036012Report Period Beginning: 01/01/2007Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To eliminate owners' health insurance	\$ (11,289)	22	1
2	To eliminate civic dues	(121)	20	2
3	To eliminate expense for 2008 IDPH			3
4	license paid in 2007	(995)	20	4
5	To eliminate non-care related expenses	(311)	20	5
6	To eliminate non-care related expenses	(15,546)	21	6
7	To eliminate non-care related expenses	(6,529)	25	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				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	(34,791)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home

0036012

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	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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(285)	0	0	0	0	0	0	0	0	0	0	(285)	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	(285)	0	(285)	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	(66)	0	0	0	0	0	0	0	0	0	0	(66)	19
20	Fees, Subscriptions & Promotions	(11,941)	0	0	0	0	0	0	0	0	0	0	(11,941)	20
21	Clerical & General Office Expenses	(28,365)	0	0	0	0	0	0	0	0	0	0	(28,365)	21
22	Employee Benefits & Payroll Taxes	(11,289)	0	0	0	0	0	0	0	0	0	0	(11,289)	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	(6,529)	0	0	0	0	0	0	0	0	0	0	(6,529)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,190)	0	(58,190)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,475)	0	(58,475)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Breese Nursing Home

0036012

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 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)	
	D. Ownership													
30	Depreciation	19,875	0	0	0	0	0	0	0	0	0	0	19,875	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,513)	0	0	0	0	0	0	0	0	0	0	(31,513)	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	(11,638)	0	0	0	0	0	0	0	0	0	0	(11,638)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(70,113)	0	0	0	0	0	0	0	0	0	0	(70,113)	45

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Breese Nursing Home

0036012

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 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: **01/01/2007** 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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number

Breese Nursing Home

0036012

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	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	Gershman Investment Group		X	Refinance Mortgage	\$17,832.17	3/16/2000	\$ 2,478,900	\$ 2,341,812	3/16/2035	8.1250	\$ 191,284	1							
2												2							
3							Amortization of Loan Costs				3,257	3							
4												4							
5												5							
Working Capital																			
6	Mark Halloran & Garrett	X		Working Captial		12/31/02	137,531	90,021		7.0000	8,035	6							
7	Reuter											7							
8												8							
9	TOTAL Facility Related				\$17,832.17		\$ 2,616,431	\$ 2,431,833			\$ 202,576	9							
B. Non-Facility Related*																			
10												10							
11							Interest Income				(31,513)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (31,513)	14							
15	TOTALS (line 9+line14)						\$ 2,616,431	\$ 2,431,833			\$ 171,063	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,743 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.)

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

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	112		1990	1975	\$ 1,750,695	\$ 55,578	31.5	\$ 55,578	\$	\$ 988,816	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beg Balance		1990		10,000	317	31.5	317		5,647	9
10	Roof		1990		101,563	3,224	31.5	3,224		56,048	10
11	Air Conditioner		1990		2,828	90	31.5	90		1,577	11
12	Interior Renovation		1990		1,292	41	31.5	41		699	12
13	Air Conditioner Pad		1990		2,645		15			2,645	13
14	Roof		1991		48,265	1,532	31.5	1,532		25,599	14
15	Handrails		1991		4,884	155	31.5	155		2,564	15
16	Soffits & Siding		1991		11,204	356	31.5	356		5,938	16
17	Carpet		1991		1,987		7			1,987	17
18	Air Conditioner		1991		4,755	151	31.5	151		2,484	18
19	HVAC - Dining Room		1991		5,510	175	31.5	175		2,668	19
20	Cubicle Tracking		1992		1,815		7			1,815	20
21	Plastering		1992		1,952	62	31.5	62		914	21
22	Cubicle Tracking		1993		657		20	33	33	484	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	10,163	25
26	Front Door		1994		1,368	35	10		(35)	1,368	26
27	Electric Wiring		1994		9,131	234	20	457	223	6,165	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	1,035	32
33	Dining Room Improvements		1994		2,558	66	27	95	29	1,240	33
34	Plumbing		1994		4,528	116	20	226	110	3,132	34
35	Ceiling Tile		1994		614	16	12		(16)	614	35
36	Laundry Improvements		1994		1,162	30	27	43	13	595	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:

01/01/2007 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	Administrative Office Improvements	1994	\$ 1,048	\$ 27	15	\$ 70	\$ 43	\$ 961	37
38	Water Softener	1994	3,661	94	12		(94)	3,661	38
39	Air Conditioners	1994	31,460	807	10		(807)	31,460	39
40	Window Blinds	1995	6,010		20	300	300	3,631	40
41	Land Improvements	1995	1,224	72	10		(72)	1,224	41
42	Sign	1995	2,455		12	50	50	2,456	42
43	Parking Lot Lighting	1995	7,456		15	497	497	6,337	43
44	Flag Pole	1995	1,511	89	20	76	(13)	958	44
45	Landscaping	1995	2,206	130	10		(130)	2,206	45
46	Landscaping	1996	2,927		10			2,927	46
47	Kitchen Renovations	1996	13,339		25	534	534	6,139	47
48	Window Screens	1996	914		5			914	48
49	Remodel Nurse Station	1996	1,077		25	43	43	495	49
50	Reception Room Addition	1996	3,721		25	149	149	1,712	50
51	Doors - Alzheimer Unit	1996	1,030		25	41	41	473	51
52	Shrubs	1997	1,001	59	15	67	8	702	52
53	Fence	1997	1,141	67	15	76	9	824	53
54	Fixtures	1997	2,835		10	118	118	2,835	54
55	Window	2000	35,000	897	10	3,500	2,603	28,000	55
56	Light Fixtures	2000	1,500	38	10	150	112	1,200	56
57	Sink Fixtures	2000	7,350	188	20	368	180	2,941	57
58	10 Ton HVAC	2000	10,000	256	17	588	332	4,704	58
59	Water Softener	2000	40,000	1,026	12	3,333	2,307	26,665	59
60	Water Heater	2000	1,500	39	15	100	61	800	60
61	Air Handling Unit	2000	3,000	77	15	200	123	1,600	61
62	Rear Parking Lot	2000	44,000	2,598	15	2,933	335	23,465	62
63	Dumpster Pad	2000	900	53	15	60	7	480	63
64	Shower Room Remodel	2001	15,000	385	15	1,000	615	7,000	64
65	Grab Bars	2002	4,800	123	15	320	197	1,920	65
66	Tuck Point	2002	1,000	26	15	67	41	402	66
67	RegROUT	2002	1,500	39	15	100	61	600	67
68	Air Handler	2002	3,000	77	15	200	123	1,200	68
69	Remodel Sprayout Room	2002	2,481	64	15	165	101	1,108	69
70	TOTAL (lines 4 thru 69)		\$ 2,334,700	\$ 75,023		\$ 78,431	\$ 3,408	\$ 1,392,626	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:

01/01/2007 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	
1	Totals from Page 12A, Carried Forward		\$ 2,334,700	\$ 75,023		\$ 78,431	\$ 3,408	\$ 1,392,626	1
2	Drainage	2002	1,500	65	15	100	35	600	2
3	Roof	2003	3,697	117	10	370	253	1,603	3
4	Floor Tile	2004	47,390	1,215	10	4,739	3,524	14,217	4
5	Door Alarm	2004	6,074	156	10	607	451	2,327	5
6	Telephone & Intercom System	2006	6,736	674	10	674		843	6
7	Hot Water Heater	2006	5,143	514	10	514		771	7
8	Concrete Sidewalks	2006	6,960	464	15	464		619	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	TOTAL (lines 1 thru 33)		\$ 2,412,200	\$ 78,228		\$ 85,899	\$ 7,671	\$ 1,413,606	34

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:

01/01/2007

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	\$ 226,496	\$ 17,523	\$ 29,060	\$ 11,537	5-20 yrs	\$ 163,369	71
72	Current Year Purchases	8,165	616	616		10-12 yrs	616	72
73	Fully Depreciated Assets	378,922					378,922	73
74								74
75	TOTALS	\$ 613,583	\$ 18,139	\$ 29,676	\$ 11,537		\$ 542,907	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	4,345	77
78	Facility Business	1993 Ford E150	2003	9,500	1,080	1,385	305	4	9,500	78
79										79
80	TOTALS			\$ 35,626	\$ 1,080	\$ 1,747	\$ 667		\$ 35,626	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)	\$ 3,076,809	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,447	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,322	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,875	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,992,139	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

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

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: \$ 1,974 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

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.

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>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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	3,712	\$ 131,088	\$	3,712	\$ 131,088	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,070	58,032		1,070	58,032	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2 & 3	hrs		8,195	221,431		8,195	221,431	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 prescrpts				80,216		80,216	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				21,263			21,263	13
14	TOTAL			\$	12,977	\$ 431,814	\$ 80,216	12,977	\$ 512,030	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: 01/01/2007Ending: 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 729,486	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>48,000</u>)	617,570		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,341		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)	\$ 1,382,897	\$	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	646,787		16
17	Accumulated Depreciation (book methods)	(1,905,841)		17
18	Deferred Charges	88,493		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)	\$ 1,242,596	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,625,493	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 116,837	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,071		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,757		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Shareholders</u>	90,021		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 334,886	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,341,812		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)	\$ 2,341,812	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,676,698	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (51,205)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,625,493	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (30,972)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (30,972)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 51,767	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	\$ (72,000)	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)	\$ (20,233)	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)	\$ (51,205)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home# 0036012Report Period Beginning: 01/01/2007Ending: 12/31/2007

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	\$ 2,976,011	1
2	Discounts and Allowances for all Levels	(193,955)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,782,056	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	905,351	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 905,351	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	285	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	69,824	19
20	Radiology and X-Ray	15,208	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,317	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	31,513	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,513	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	4,282	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,282	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,808,519	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	659,283	31
32	Health Care	1,886,527	32
33	General Administration	651,270	33
B. Capital Expense			
34	Ownership	348,873	34
C. Ancillary Expense			
35	Special Cost Centers	101,479	35
36	Provider Participation Fee	61,320	36
D. Other Expenses (specify):			
37	<u>Bad Debt Expense</u>	48,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,756,752	40
41	Income before Income Taxes (line 30 minus line 40)**	51,767	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 51,767	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: 01/01/2007

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	1,682	1,814	\$ 56,655	\$ 31.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,278	9,757	212,459	21.78	3
4	Licensed Practical Nurses	20,858	21,991	404,120	18.38	4
5	CNAs & Orderlies	52,043	55,062	608,857	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,635	3,794	35,254	9.29	10
11	Social Service Workers	3,576	3,901	52,412	13.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,946	17,833	176,648	9.91	15
16	Dishwashers					16
17	Maintenance Workers	3,645	3,963	49,435	12.47	17
18	Housekeepers	7,201	7,339	60,643	8.26	18
19	Laundry	5,447	5,613	45,730	8.15	19
20	Administrator	1,829	2,035	54,994	27.02	20
21	Assistant Administrator					21
22	Other Administrative	1,203	1,203	24,065	20.00	22
23	Office Manager					23
24	Clerical	7,551	8,204	110,888	13.52	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	2,036	2,044	23,313	11.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,930	144,553	\$ 1,915,473 *	\$ 13.25	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	179	\$ 8,227	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	12	465	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,902	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	1,780	11,3	44
45	Social Service Consultant	Contract	1,740	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	191	\$ 20,114		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

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2007 Ending: 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? 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. \$ 11,034 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. \$ 285
- (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? Yes If no, please explain.
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

BREESE NURSING HOME
RECLASSIFICATIONS
MEDICAID COST REPORT
12/31/2007

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(475)	24
DUES, SUBSCRIPTIONS & PROMOTIONS	475	20
TO RECLASS DUES RECORDED IN TRAVEL & SEMINAR		
DUES, SUBSCRIPTIONS & PROMOTIONS	(175)	20
TRAVEL & SEMINARS	175	24
TO RECLASS DUES RECORDED IN TRAVEL & SEMINAR		

CARING FIRST, INC. D/B/A BREESE NURSING HOME
 TRAVEL AND SEMINAR SCHEDULE
 ATTACHMENT TO SCHEDULE XIX PART G
 12/31/2007

<u>SEMINAR PARTICIPANT</u>	<u>JOB TITLE</u>	<u>DATE(S)</u>	<u>CITY</u>	<u>TITLE OF SEMINAR</u>	<u>SPONSOR</u>	<u>COST</u>	<u>SEMINAR LODGING/ TRAVEL/MEALS</u>
Barb Berndsen & Lori Beckemyer	Administrator & Director of Nursing	3/14/2007	Springfield, IL	The 2007 Seminar Series for Nsg Hm Profs	Illinois Council on Long Term Care	290	-
Barb Berndsen	Administrator	8/22/2008	Mt. Vernon, IL	Illinois Health Care Association	Illinois Health Care Association	75	
Barb Berndsen & Lori Beckemyer	Administrator & Director of Nursing	8/25/2007	Mt. Vernon, IL	Illinois MDS-Based Medicaid Payment System	Illinois Health Care Association	260	50
Barb Berndsen	Administrator	5/10/2007	Springfield, IL	Illinois Area Agency on Aging	Illinois Department on Aging	159	106
Barb Berndsen & Lori Beckemyer	Administrator & Director of Nursing	10/9/2007	Fairview Hts, IL	LTC DON Conference	Symphony Mobilex	175	
Jodine Jackson	Corporate Office	10/17-10/18, 10/24-10/25, 11/7-11/8/07	Breese, IL	36 Hour Activity Director's Course	Outcome Services of Illinois	360	
						1,319	156
					Total Seminar Lodging/Travel/Meals	156	
					CPR Training	-	
					Other Travel Expense <\$250		
					Home Office Travel & Seminar		
					Total Travel & Seminar, Line 24	1,475	

CARING FIRST, INC. D/B/A BREESE NURSING HOME
ATTACHMENT TO SCHEDULE V, LINE 25
12/31/2007

OTHER ADMIN. STAFF TRANSPORTATION:
MILEAGE REIMBURSEMENT

\$ 297

\$ 297

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