



Facility Name & ID Number Breese Nursing Home# 0036012 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>39</u>	Skilled (SNF)	<u>39</u>	<u>14,347</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>73</u>	Intermediate (ICF)	<u>73</u>	<u>26,645</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>112</u>	TOTALS	<u>112</u>	<u>40,992</u>	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	<u>7,214</u>	<u>4,037</u>	<u>3,236</u>	<u>14,487</u>	8
9	SNF/PED					9
10	ICF	<u>3,627</u>	<u>6,865</u>		<u>10,492</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,841</u>	<u>10,902</u>	<u>3,236</u>	<u>24,979</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.94%

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? Yes

G. Do pages 3 &amp; 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 3,236Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	160,987	1,586	6,632	169,205		169,205	169,205			1
2	Food Purchase		134,468		134,468		134,468	(716)	133,752		2
3	Housekeeping	55,862	13,078		68,940		68,940		68,940		3
4	Laundry	46,471	13,515		59,986		59,986		59,986		4
5	Heat and Other Utilities			115,728	115,728		115,728		115,728		5
6	Maintenance	45,118	564	69,057	114,739		114,739		114,739		6
7	Other (specify):* Trash & Med Waste			12,875	12,875		12,875		12,875		7
8	<b>TOTAL General Services</b>	<b>308,438</b>	<b>163,211</b>	<b>204,292</b>	<b>675,941</b>		<b>675,941</b>	<b>(716)</b>	<b>675,225</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,328,732	68,514	4,220	1,401,466		1,401,466		1,401,466		10
10a	Therapy		8	503,051	503,059		503,059		503,059		10a
11	Activities	37,925	2,921	2,604	43,450		43,450		43,450		11
12	Social Services	54,694		2,888	57,582		57,582		57,582		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,421,351</b>	<b>71,443</b>	<b>518,763</b>	<b>2,011,557</b>		<b>2,011,557</b>		<b>2,011,557</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	84,033			84,033		84,033		84,033		17
18	Directors Fees										18
19	Professional Services			27,164	27,164		27,164	(1,049)	26,115		19
20	Dues, Fees, Subscriptions & Promotions			19,017	19,017		19,017	(13,159)	5,858		20
21	Clerical & General Office Expenses	112,806	13,189	61,665	187,660		187,660	(16,624)	171,036		21
22	Employee Benefits & Payroll Taxes			235,751	235,751		235,751	(12,063)	223,688		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,136	1,136		1,136		1,136		24
25	Other Admin. Staff Transportation		7,077		7,077		7,077	(6,762)	315		25
26	Insurance-Prop.Liab.Malpractice			49,066	49,066		49,066		49,066		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>196,839</b>	<b>20,266</b>	<b>393,799</b>	<b>610,904</b>		<b>610,904</b>	<b>(49,657)</b>	<b>561,247</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,926,628</b>	<b>254,920</b>	<b>1,116,854</b>	<b>3,298,402</b>		<b>3,298,402</b>	<b>(50,373)</b>	<b>3,248,029</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Breese Nursing Home #0036012 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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
	<b>D. Ownership</b>										
30	Depreciation			94,135	94,135	94,135	12,233	106,368			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			197,257	197,257	197,257	(11,361)	185,896			32
33	Real Estate Taxes			21,117	21,117	21,117		21,117			33
34	Rent-Facility & Grounds			12,000	12,000	12,000		12,000			34
35	Rent-Equipment & Vehicles			2,163	2,163	2,163		2,163			35
36	Other (specify):* <b>Mortgage Insurance Premium</b>			11,622	11,622	11,622		11,622			36
37	<b>TOTAL Ownership</b>			338,294	338,294	338,294	872	339,166			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		65,178	22,914	88,092	88,092		88,092			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			61,488	61,488	61,488		61,488			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		65,178	84,402	149,580	149,580		149,580			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,926,628	320,098	1,539,550	3,786,276	3,786,276	(49,501)	3,736,775			45

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

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	(716)	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	12,233	30		9
10	Interest and Other Investment Income	(11,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,917)	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	(10,745)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,049)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(800)	21		24
25	Fund Raising, Advertising and Promotional	(2,973)	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	(32,173)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (49,501)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (49,501)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	To eliminate owners' health insurance	\$ (12,063)	22	1
2	To eliminate non-care related expenses	(13,907)	21	2
3	To eliminate non-care related expenses	(6,762)	25	3
4	To eliminate civic dues	(125)	20	4
5	To eliminate non-care related expenses	(311)	20	5
6	To add IDPH 2008 License Fee deferred in 2007	995	20	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				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	<b>Total</b>	(32,173)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(716)	0	0	0	0	0	0	0	0	0	0	(716)	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	<b>TOTAL General Services</b>	<b>(716)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(716)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(1,049)	0	0	0	0	0	0	0	0	0	0	(1,049)	19
20	Fees, Subscriptions & Promotions	(13,159)	0	0	0	0	0	0	0	0	0	0	(13,159)	20
21	Clerical & General Office Expenses	(16,624)	0	0	0	0	0	0	0	0	0	0	(16,624)	21
22	Employee Benefits & Payroll Taxes	(12,063)	0	0	0	0	0	0	0	0	0	0	(12,063)	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	(6,762)	0	0	0	0	0	0	0	0	0	0	(6,762)	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	<b>TOTAL General Administration</b>	<b>(49,657)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(49,657)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(50,373)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(50,373)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Breese Nursing Home

# 0036012 Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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	12,233	0	0	0	0	0	0	0	0	0	0	12,233	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,361)	0	0	0	0	0	0	0	0	0	0	(11,361)	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	<b>TOTAL Ownership</b>	<b>872</b>	<b>0</b>	<b>872</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(49,501)</b>	<b>0</b>	<b>(49,501)</b>	<b>45</b>									

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark E. Halloran	50.00%					
Garrett C. Rueter	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: 01/01/2008 Ending: 12/31/2008

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark E. Halloran	President		50.00%	0	12	30.00	Salary	\$ 12,066	17,1	1
2	Garrett C. Reuter		Counsel	50.00%	0	12	30.00	Salary	12,066	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	\$ 24,132		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Breese Nursing Home

# 0036012 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Gershman Investment Group		X	Refinance Mortgage	\$17,832.17	3/16/2000	\$ 2,478,900	\$ 2,319,323	3/16/2035	8.1250	\$ 189,369	1								
2												2								
3							Amortization of Loan Costs				3,257	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Mark Halloran & Garrett											6								
7	Reuter		X	Working Capital		12/31/02	90,021	39,067		7.0000	4,631	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$17,832.17		\$ 2,568,921	\$ 2,358,390			\$ 197,257	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11							Interest Income				(11,361)	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(11,361)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,568,921	\$ 2,358,390			\$ 185,896	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,622 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.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)



**IMPORTANT NOTICE**

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

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

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

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

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-06-22-252-008</u>	<u>Sec 22 Twp 2 Rng 4 Pt W 1/2 NE</u>	\$ <u>22,217.00</u>	\$ <u>22,217.00</u>
2. _____	<u>NE 4A</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>22,217.00</u>	\$ <u>22,217.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

**C. Tax Bills**

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

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

Facility Name & ID Number Breese Nursing Home

# 0036012 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**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>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>174,242</b>		<b>\$ 15,400</b>	<b>3</b>

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	112		1990	1975	\$ 1,750,695	\$ 55,578	31.5	\$ 55,578	\$	\$ 1,044,394	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Beg Balance	1990		10,000	317	31.5	317		5,964	9
10		Roof	1990		101,563	3,224	31.5	3,224		59,272	10
11		Air Conditioner	1990		2,828	90	31.5	90		1,667	11
12		Interior Renovation	1990		1,292	41	31.5	41		740	12
13		Air Conditioner Pad	1990		2,645		15			2,645	13
14		Roof	1991		48,265	1,532	31.5	1,532		27,131	14
15		Handrails	1991		4,884	155	31.5	155		2,719	15
16		Soffits & Siding	1991		11,204	356	31.5	356		6,294	16
17		Carpet	1991		1,987		7			1,987	17
18		Ar Conditioner	1991		4,755	151	31.5	151		2,635	18
19		HVAC - Dining Room	1991		5,510	175	31.5	175		2,843	19
20		Cubicle Tracking	1992		1,815		7			1,815	20
21		Plastering	1992		1,952	62	31.5	62		976	21
22		Cubicle Tracking	1993		657		20	33	33	517	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	534	260	10,698	25
26		Front Door	1994		1,368	35	10		(35)	1,368	26
27		Electric Wiring	1994		9,131	234	20	457	223	6,622	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	1,113	32
33		Dining Room Improvements	1994		2,558	66	27	95	29	1,335	33
34		Plumbing	1994		4,528	116	20	226	110	3,358	34
35		Ceiling Tile	1994		614	16	12		(16)	614	35
36		Laundry Improvements	1994		1,162	30	27	43	13	638	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

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Administrative Office Improvements	1994	\$ 1,048	\$ 27	15	\$ 70	\$ 43	\$ 1,031	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	301	301	3,932	40
41	Land Improvements	1995	1,224	72	10		(72)	1,224	41
42	Sign	1995	2,455		12			2,455	42
43	Parking Lot Lighting	1995	7,456		15	497	497	6,834	43
44	Flag Pole	1995	1,511	89	20	76	(13)	1,034	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	6,673	47
48	Window Screens	1996	914		5			914	48
49	Remodel Nurse Station	1996	1,077		25	43	43	538	49
50	Reception Room Addition	1996	3,721		25	149	149	1,861	50
51	Doors - Alzheimer Unit	1996	1,030		25	41	41	514	51
52	Shrubs	1997	1,001	59	15	67	8	769	52
53	Fence	1997	1,141	67	15	76	9	900	53
54	Fixtures	1997	2,835		10			2,835	54
55	Window	2000	35,000	897	10	3,500	2,603	31,500	55
56	Light Fixtures	2000	1,500	38	10	150	112	1,350	56
57	Sink Fixtures	2000	7,350	188	20	368	180	3,309	57
58	10 Ton HVAC	2000	10,000	256	17	588	332	5,292	58
59	Water Softener	2000	40,000	1,026	12	3,333	2,307	29,998	59
60	Water Heater	2000	1,500	38	15	100	62	900	60
61	Air Handling Unit	2000	3,000	77	15	200	123	1,800	61
62	Rear Parking Lot	2000	44,000	2,598	15	2,933	335	26,398	62
63	Dumpster Pad	2000	900	53	15	60	7	540	63
64	Shower Room Remodel	2001	15,000	385	15	1,000	615	8,000	64
65	Grab Bars	2002	4,800	123	15	320	197	2,240	65
66	Tuck Point	2002	1,000	26	15	67	41	469	66
67	RegROUT	2002	1,500	38	15	100	62	700	67
68	Air Handler	2002	3,000	77	15	200	123	1,400	68
69	Remodel Sprayout Room	2002	2,481	64	15	165	101	1,273	69
70	TOTAL (lines 4 thru 69)		\$ 2,334,700	\$ 75,021		\$ 78,085	\$ 3,064	\$ 1,470,711	70

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

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,334,700	\$ 75,021		\$ 78,085	\$ 3,064	\$ 1,470,711	1
2	Drainage	2002	1,500	62	15	100	38	700	2
3	Roof	2003	3,697	117	10	370	253	1,973	3
4	Floor Tile	2004	47,390	1,215	10	4,739	3,524	18,956	4
5	Door Alarm	2004	6,074	156	10	607	451	2,934	5
6	Telephone & Intercom System	2006	6,736	674	10	674		1,517	6
7	Hot Water Heater	2006	5,143	514	10	514		1,285	7
8	Concrete Sidewalks	2006	6,960	464	15	464		1,083	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	\$ 78,223		\$ 85,553	\$ 7,330	\$ 1,499,159	34

\*\*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: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 177,237	\$ 15,280	\$ 20,815	\$ 5,535	5-20 yrs	\$ 127,376	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	436,346					436,346	73
74								74
75	TOTALS	\$ 613,583	\$ 15,280	\$ 20,815	\$ 5,535		\$ 563,722	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	Wheelchair Lift	1996	\$ 4,345	\$	\$	\$	12	\$ 4,345	76
77	Facility Business	1993 Ford E150	2003	9,500				4	9,500	77
78										78
79										79
80	TOTALS			\$ 13,845	\$	\$	\$		\$ 13,845	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)	\$ 3,055,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,503	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,368	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,865	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,076,726	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.

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	<b>TOTAL</b>				\$			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 2,163

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	<b>TOTAL</b>		\$	\$	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.

**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)	
<b>TOTAL TRAINED</b>	

- (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.

Facility Name &amp; ID Number

Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

## 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	\$	4,665	\$ 168,626	\$	4,665	\$ 168,626	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,075	72,174		1,075	72,174	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2 & 3	hrs		11,374	262,251		11,374	262,251	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				65,178		65,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>X-Ray &amp; Laboratory</u>	39, 2				22,914			22,914	13
14	TOTAL			\$	17,114	\$ 525,965	\$ 65,178	17,114	\$ 591,143	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Breese Nursing Home# 0036012Report Period Beginning: 01/01/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 700,793	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 48,000 )	1,052,915		3
4	Supply Inventory (priced at )	17,125		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,321		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,788,154	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,400		13
14	Buildings, at Historical Cost	2,397,756		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	625,006		16
17	Accumulated Depreciation (book methods)	(1,978,195)		17
18	Deferred Charges	85,235		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,145,202	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,933,356	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 334,143	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,167		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,457		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,100		32
33	Accrued Interest Payable	15,704		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Shareholders</u>	39,097		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 536,668	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,319,323		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,319,323	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,855,991	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 77,365	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,933,356	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (51,205)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (51,205)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	258,570	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	(130,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 128,570</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 77,365</b>	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Breese Nursing Home# 0036012Report Period Beginning: 01/01/2008Ending: 12/31/2008**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,104,995	1
2	Discounts and Allowances for all Levels	(129,315)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,975,680</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	991,078	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 991,078</b>	8
<b>C. Other Operating Revenue</b>			
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		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	72,008	19
20	Radiology and X-Ray	7,870	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 79,878</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11,361	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 11,361</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	11,032	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 11,032</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,069,029</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	675,941	31
32	Health Care	2,011,517	32
33	General Administration	610,904	33
<b>B. Capital Expense</b>			
34	Ownership	338,334	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	88,092	35
36	Provider Participation Fee	61,488	36
<b>D. Other Expenses (specify):</b>			
37	<b>Bad Debt Expense</b>	24,183	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,810,459</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>258,570</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 258,570</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,575	1,696	\$ 52,293	\$ 30.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,854	10,494	242,677	23.13	3
4	Licensed Practical Nurses	19,145	20,101	386,216	19.21	4
5	CNAs & Orderlies	52,341	55,290	624,512	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,846	4,050	37,925	9.36	10
11	Social Service Workers	3,796	4,063	54,694	13.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,775	15,435	160,987	10.43	15
16	Dishwashers					16
17	Maintenance Workers	3,316	3,572	45,118	12.63	17
18	Housekeepers	6,143	6,285	55,862	8.89	18
19	Laundry	6,009	6,152	46,471	7.55	19
20	Administrator	2,245	2,311	59,902	25.92	20
21	Assistant Administrator					21
22	Other Administrative	1,207	1,207	24,131	19.99	22
23	Office Manager					23
24	Clerical	7,746	8,356	112,806	13.50	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	1,999	2,006	23,034	11.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,997	141,018	\$ 1,926,628 *	\$ 13.66	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	137	\$ 6,526	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	17	791	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Contract	1,552	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,604	11,3	44
45	Social Service Consultant	Contract	2,888	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 20,361		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

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	\$ 12,066	Workers' Compensation Insurance	\$ 50,604	IDPH License Fee	\$ 995	
Garrett Reuter	Owner	50.00	12,066	Unemployment Compensation Insurance	24,776	Advertising: Employee Recruitment	569	
Barbara Berndsen	Administrator	0.00	59,901	FICA Taxes	147,316	Health Care Worker Background Check (Indicate # of checks performed _____)	1,000	
				Employee Health Insurance		Patient Background Checks		
				Employee Meals		Promotional Advertising		
				Illinois Municipal Retirement Fund (IMRF)*		Dues, Subscriptions, & Licenses	3,294	
				Employee Appreciation	992			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,033			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Section Not Applicable								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 223,688	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,858	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C.J. Schlosser & Co.	Accounting		\$ 16,318	Section Not Applicable			Out-of-State Travel	\$
Wenzel & Associates	Accounting		240					
Paychex, Inc.	Accounting		7,884				In-State Travel	
Giffin, Winning, Cohen & Bodewes	Legal		2,574					
Greensfelder	Legal		148				Seminar Expense	1,136
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 27,164	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 1,136

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; 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? None
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,322 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. \$ 61,488  
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. \$ 716
- (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.

CARING FIRST, INC.  
IDPH ID #0036012  
ATTACHMENT TO SCHEDULE XVII  
12/31/2008

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 258,570
DEPRECIATION ADJUSTMENT	7,421
TRAVEL & ENTERTAINMENT	1,038
OFFICERS' LIFE INSURANCE PREMIUMS	6,054
CONVERSION TO CASH BASIS ADJUSTMENTS	(182,035)
TAX NET INCOME	<u>\$ 91,048</u>