

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

<p>I. IDPH License ID Number: <u>0036012</u></p> <p>Facility Name: <u>Breese Nursing Home</u></p> <p>Address: <u>1155 N First St Breese 62230</u> <small>Number City Zip Code</small></p> <p>County: <u>Clinton</u></p> <p>Telephone Number: <u>(618) 526-4521</u> Fax # <u>(618) 526-2833</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/09/1990</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>J. Terry Dooling</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Type or Print Name) <u>Mark Halloran</u> (Title) <u>President, Caring First, Inc.</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>See Accountant's Compilation Report</u> (Date) _____ (Print Name and Title) <u>J. Terry Dooling, Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Mark Halloran</u> (Title) <u>President, Caring First, Inc.</u>	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Date) _____ (Print Name and Title) <u>J. Terry Dooling, Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Mark Halloran</u> (Title) <u>President, Caring First, Inc.</u>							
Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Date) _____ (Print Name and Title) <u>J. Terry Dooling, Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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>14,274</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>73</u>	Intermediate (ICF)	<u>73</u>	<u>26,718</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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>1,308</u>	<u>3,695</u>	<u>2,564</u>	<u>7,567</u>	8
9	SNF/PED					9
10	ICF	<u>10,711</u>	<u>7,936</u>		<u>18,647</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,019</u>	<u>11,631</u>	<u>2,564</u>	<u>26,214</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.95%

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 2,564

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	163,969	405	5,922	170,296		170,296		170,296		1
2	Food Purchase		141,925		141,925		141,925	(810)	141,115		2
3	Housekeeping	78,717	9,541		88,258	168	88,426		88,426		3
4	Laundry	43,295	16,462		59,757		59,757		59,757		4
5	Heat and Other Utilities			108,755	108,755		108,755		108,755		5
6	Maintenance	53,345		52,847	106,192		106,192		106,192		6
7	Other (specify):*			13,498	13,498		13,498		13,498		7
8	TOTAL General Services	339,326	168,333	181,022	688,681	168	688,849	(810)	688,039		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,358,476	73,199	6,030	1,437,705		1,437,705		1,437,705		10
10a	Therapy										10a
11	Activities	22,435	1,936	1,540	25,911		25,911		25,911		11
12	Social Services	42,877		1,447	44,324		44,324		44,324		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,423,788	75,135	15,017	1,513,940		1,513,940		1,513,940		16
	C. General Administration										
17	Administrative	70,481			70,481		70,481		70,481		17
18	Directors Fees										18
19	Professional Services			40,890	40,890		40,890	(3,767)	37,123		19
20	Dues, Fees, Subscriptions & Promotions			23,301	23,301	(228)	23,073	(16,421)	6,652		20
21	Clerical & General Office Expenses	108,591	9,461	59,044	177,096	60	177,156	(20,444)	156,712		21
22	Employee Benefits & Payroll Taxes			295,019	295,019		295,019	(16,598)	278,421		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,873	3,873		3,873		3,873		24
25	Other Admin. Staff Transportation		7,164		7,164		7,164	(7,158)	6		25
26	Insurance-Prop.Liab.Malpractice			43,694	43,694		43,694		43,694		26
27	Other (specify):*										27
28	TOTAL General Administration	179,072	16,625	465,821	661,518	(168)	661,350	(64,388)	596,962		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,942,186	260,093	661,860	2,864,139		2,864,139	(65,198)	2,798,941		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:

01/01/2012

Ending:

12/31/2012

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			87,657	87,657		87,657	3,580	91,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			108,736	108,736		108,736	(1,337)	107,399			32
33	Real Estate Taxes			42,213	42,213		42,213		42,213			33
34	Rent-Facility & Grounds			13,000	13,000		13,000		13,000			34
35	Rent-Equipment & Vehicles			1,260	1,260		1,260		1,260			35
36	Other (specify):*			11,839	11,839		11,839		11,839			36
37	TOTAL Ownership			264,705	264,705		264,705	2,243	266,948			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,169	475,497	548,666		548,666		548,666			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,338	269,338		269,338		269,338			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		73,169	744,835	818,004		818,004		818,004			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,942,186	333,262	1,671,400	3,946,848		3,946,848	(62,955)	3,883,893			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:

01/01/2012

Ending:

12/31/2012

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	(810)	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	3,580	30		9
10	Interest and Other Investment Income	(1,337)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,082)	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	(12,020)	20		19
20	Contributions	(1,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,767)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50)	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	(41,369)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,955)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (62,955)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To eliminate owners' health insurance	\$ (16,598)	22	1
2	To eliminate non-care related expenses	(266)	20	2
3	To eliminate non-care related expenses	(14,362)	21	3
4	To eliminate non-care related expenses	(7,158)	25	4
5	To eliminate expense for 2013 & 2014 IDPH License Fee	(3,980)	20	5
6	To record 2012 IDPH Fee paid in 2011	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	Total		(41,369)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(810)	0	0	0	0	0	0	0	0	0	0	(810)	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	(810)	0	0	0	0	0	0	0	0	0	0	(810)	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	(3,767)	0	0	0	0	0	0	0	0	0	0	(3,767)	19
20	Fees, Subscriptions & Promotions	(16,421)	0	0	0	0	0	0	0	0	0	0	(16,421)	20
21	Clerical & General Office Expenses	(20,444)	0	0	0	0	0	0	0	0	0	0	(20,444)	21
22	Employee Benefits & Payroll Taxes	(16,598)	0	0	0	0	0	0	0	0	0	0	(16,598)	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	(7,158)	0	0	0	0	0	0	0	0	0	0	(7,158)	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	(64,388)	0	0	0	0	0	0	0	0	0	0	(64,388)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,198)	0	0	0	0	0	0	0	0	0	0	(65,198)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Breese Nursing Home# 0036012

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	3,580	0	0	0	0	0	0	0	0	0	0	3,580	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,337)	0	0	0	0	0	0	0	0	0	0	(1,337)	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	2,243	0	0	0	0	0	0	0	0	0	0	2,243	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(62,955)	0	0	0	0	0	0	0	0	0	0	(62,955)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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		12	30.00	Salary	\$ 12,066	17, 1	1
2	Garrett C. Reuter		Counsel	50.00		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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:

01/01/2012

Ending:

12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Gershman Investment Group		X	Refinance Mortgage	\$13,698.00	9/1/10	\$ 2,469,400	\$ 2,342,422	10/1/35	4.4800	\$ 106,358	1								
2								Amortization of Loan Costs			2,378	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$13,698.00		\$ 2,469,400	\$ 2,342,422			\$ 108,736	9								
B. Non-Facility Related*																				
10												10								
11								Interest Income			(1,337)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (1,337)	14								
15	TOTALS (line 9+line14)						\$ 2,469,400	\$ 2,342,422			\$ 107,399	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,839 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2011 report.		\$ 50,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 44,713	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (5,787)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 48,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 42,213	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2007	22,217	8
	2008	23,171	9
	2009	48,503	10
	2010	49,714	11
	2011	47,423	12
The payment on line 2 includes payment for 2011 taxes of \$47,423, net of a refund of 2009 taxes of \$2,710.			
The accrual used on line 4 was based on the 2011 tax year.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 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 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-06-22-252-008</u>	<u>Sec 22 Twp 2 Rng 4 Pt W 1/2 NE</u>	\$ <u>47,423.23</u>	\$ <u>47,423.23</u>
2. _____	<u>NE 4A</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>47,423.23</u></u>	\$ <u><u>47,423.23</u></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 and 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:

01/01/2012 Ending:

12/31/2012

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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	112		1990	1975	\$ 1,750,695	\$ 55,578	31.5	\$ 55,578	\$	\$ 1,266,701	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Beg Balance	1990		10,000	317	31.5	317		7,236	9
10		Roof (Disposed 2012)				2,461		269	(2,192)		10
11		Air Conditioner	1990		2,828	90	31.5	90		2,024	11
12		Interior Renovation	1990		1,292	41	31.5	41		904	12
13		Air Conditioner Pad	1990		2,645		15			2,645	13
14		Roof	1991			1,468	31.5	1,532	64		14
15		Handrails	1991		4,884	155	31.5	155		3,340	15
16		Soffits & Siding	1991		11,204	356	31.5	356		7,717	16
17		Carpet	1991		1,987		7			1,987	17
18		Air Conditioner	1991		4,755	151	31.5	151		3,239	18
19		HVAC - Dining Room	1991		5,510	175	31.5	175		3,542	19
20		Cubicle Tracking	1992		1,815		7			1,815	20
21		Plastering	1992		1,952	62	31.5	62		1,224	21
22		Cubicle Tracking	1993		657		20	33	33	648	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			263	15		(263)		25
26		Laundry Improvements	1994		1,162	30	27	43	13	810	26
27		Front Door	1994		1,368	35	10		(35)	1,368	27
28		Electric Wiring	1994		9,131	234	20	457	223	8,446	28
29		Back Patio	1994		5,137		10			5,137	29
30		Landscaping	1994		1,221		10			1,221	30
31		Front Parking Lot	1994		80,603		10			80,603	31
32		Lighting & Ceiling	1994		2,110		10			2,110	32
33		Gutters & Shutters (Disposed 2012)				53		78	25		33
34		Dining Room Improvements	1994		2,558	66	27	95	29	1,714	34
35		Plumbing	1994		4,528	116	20	226	110	4,264	35
36		Ceiling Tile	1994		614	16	12		(16)	614	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:

01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37	Water Softener	1994	\$	\$ 90	12	\$	\$ (90)	\$
38	Administrative Office Improvements	1994	1,048	27	15		(27)	1,048
39	Air Conditioners	1994	31,460	807	10		(807)	31,460
40	Window Blinds	1995	6,010		20	301	301	5,134
41	Land Improvements	1995	1,224		10			1,224
42	Sign	1995	2,455		12			2,455
43	Parking Lot Lighting	1995	7,456		15			7,456
44	Flag Pole	1995	1,511		20	74	74	1,335
45	Landscaping	1995	2,206		10			2,206
46	Landscaping	1996	2,927		10			2,927
47	Kitchen Renovations	1996	13,339		25	534	534	8,804
48	Window Screens	1996	914		5			914
49	Remodel Nurse Station	1996	1,077		25	43	43	711
50	Reception Room Addition	1996	3,721		25	149	149	2,455
51	Doors - Alzheimer Unit	1996	1,030		25	41	41	680
52	Shrubs	1997	1,001	30	15	33	3	1,001
53	Fence	1997	1,141	34	15	12	(22)	1,141
54	Fixtures	1997	2,835		10			2,835
55	Window	2000	35,000	897	10		(897)	35,000
56	Light Fixtures	2000	1,500	38	10		(38)	1,500
57	Sink Fixtures	2000	7,350	188	20	368	180	4,778
58	10 Ton HVAC	2000	10,000	256	17	588	332	7,647
59	Water Heater	2000	1,500	38	15	100	62	1,300
60	Air Handling Unit	2000	3,000	77	15	200	123	2,600
61	Rear Parking Lot	2000	44,000	2,598	15	2,933	335	38,133
62	Dumpster Pad	2000	900	53	15	60	7	780
63	Shower Room Remodel	2001	15,000	385	15	1,000	615	12,000
64	Grab Bars	2002	4,800	123	15	320	197	3,520
65	Tuck Point	2002	1,000	26	15	67	41	734
66	RegROUT	2002	1,500	38	15	100	62	1,100
67	Air Handler	2002	3,000	77	15	200	123	2,200
68	Remodel Sprayout Room	2002	2,481	64	15	165	101	1,937
69	Drainage	2002	1,500	62	15	100	38	1,100
70	TOTAL (lines 4 thru 69)		\$ 2,129,900	\$ 67,726		\$ 67,046	\$ (680)	\$ 1,604,782

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12A, Carried Forward		\$ 2,129,900	\$ 67,726		\$ 67,046	\$ (680)	\$ 1,604,782
2	Roof	2003	3,697	117	10	370	253	3,451
3	Floor Tile	2004	47,390	1,215	10	4,739	3,524	37,912
4	Door Alarm	2004	6,074	156	10	607	451	5,365
5	Telephone & Intercom System	2006	6,736	674	10	674		4,210
6	Hot Water Heater	2006	5,143	514	10	514		3,343
7	Concrete Sidewalks	2006	6,960	464	15	464		2,939
8	Fire Alarm	2011	18,582	1,858	10	1,858		2,168
9	Roof Repair	2011	35,195	3,520	10	903	(2,617)	902
10	Sprinkler	2011	78,346	3,134	25	3,134		3,656
11	Water Softener	2011	8,960	896	10	896		1,045
12	Roof Repair	2012	137,503		10			
13	Sprinkler	2012	52,000	1,560	25	1,560		1,560
14	Door Knobs	2012	250	25	10	25		25
15								
16								
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20								
21								
22								
23								
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26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 2,536,736	\$ 81,859		\$ 82,790	\$ 931	\$ 1,671,358

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 84,703	\$ 5,419	\$ 8,068	\$ 2,649	5-20 yrs	\$ 43,073	71
72	Current Year Purchases	22,752	379	379		5-12 yrs	379	72
73	Fully Depreciated Assets	509,367					509,367	73
74								74
75	TOTALS	\$ 616,822	\$ 5,798	\$ 8,447	\$ 2,649		\$ 552,819	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1993 Ford F150	2003	\$ 9,500	\$	\$	\$		\$ 9,500	76
77										77
78										78
79										79
80	TOTALS			\$ 9,500	\$	\$	\$		\$ 9,500	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)	\$ 3,178,458	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,657	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,237	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,580	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,233,677	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Breese Nursing Home

0036012

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 1,260

Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				73,038		73,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Schedule</u>	39,3			13,217	475,497	131	13,217	475,628	13
14	TOTAL			\$	13,217	\$ 475,497	\$ 73,169	13,217	\$ 548,666	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

0036012

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 643,510	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	953,984		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	64,317		6
7	Other Prepaid Expenses	55,138		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,734,449	\$	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	2,594,541		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	623,900		16
17	Accumulated Depreciation (book methods)	(2,184,086)		17
18	Deferred Charges	54,094		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)	\$ 1,103,849	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,838,298	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 60,199	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,247		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,852		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 264,298	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,342,422		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)	\$ 2,342,422	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,606,720	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 231,578	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,838,298	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 123,660	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 123,660	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	287,918	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	(180,000)	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)	\$ 107,918	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)	\$ 231,578	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,262,247	1
2	Discounts and Allowances for all Levels	58,399	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,320,646	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	835,819	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 835,819	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	810	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	90,215	19
20	Radiology and X-Ray	9,133	20
21	Other Medical Services	1,083	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 101,241	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,337	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,337	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	655	28
28a	<u>Loss on Disposal of Assets</u>	(24,932)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (24,277)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,234,766	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	688,681	31
32	Health Care	1,513,940	32
33	General Administration	661,518	33
B. Capital Expense			
34	Ownership	264,705	34
C. Ancillary Expense			
35	Special Cost Centers	548,666	35
36	Provider Participation Fee	269,338	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,946,848	40
41	Income before Income Taxes (line 30 minus line 40)**	287,918	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 287,918	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,333,870	44
45	Private Pay - Net Inpatient Revenue	1,379,142	45
46	Medicare - Net Inpatient Revenue	607,634	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,320,646	49

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Breese Nursing Home**

0036012

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,362	2,422	\$ 60,830	\$ 25.12	1
2	Assistant Director of Nursing	960	1,033	19,359	18.74	2
3	Registered Nurses	9,162	9,861	232,158	23.54	3
4	Licensed Practical Nurses	18,175	19,548	380,233	19.45	4
5	CNAs & Orderlies	53,039	55,831	645,470	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,207	2,294	22,435	9.78	10
11	Social Service Workers	3,187	3,315	42,877	12.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,804	14,630	163,969	11.21	15
16	Dishwashers					16
17	Maintenance Workers	3,549	3,868	53,345	13.79	17
18	Housekeepers	7,594	7,827	78,717	10.06	18
19	Laundry	4,345	4,475	43,295	9.67	19
20	Administrator					20
21	Assistant Administrator	1,706	1,782	46,349	26.01	21
22	Other Administrative	1,207	1,207	24,131	19.99	22
23	Office Manager					23
24	Clerical	6,927	7,491	108,591	14.50	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	1,787	1,787	20,427	11.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,011	137,371	\$ 1,942,186 *	\$ 14.14	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	118	\$ 5,922	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	19	866	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	783	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	1,365	11,3	44
45	Social Service Consultant	Contract	1,365	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	137	\$ 16,301		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. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Mark Halloran	Owner	50	\$ 12,066	Workers' Compensation Insurance	\$ 107,473	IDPH License Fee	\$ 995	
Garrett Reuter	Owner	50	12,066	Unemployment Compensation Insurance	20,640	Advertising: Employee Recruitment	177	
Krista Lanter	Assitant Admin.	0	46,349	FICA Taxes	148,408	Health Care Worker Background Check (Indicate # of checks performed <u>51</u>)	765	
				Employee Health Insurance		<u>Patient Background Checks</u>		
				Employee Meals		Promotional Advertising	50	
				Illinois Municipal Retirement Fund (IMRF)*		Dues, subscriptions, & licenses	3,762	
				Employee Appreciation	1,900	Donations and Public Relations	2,319	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,481					
B. Administrative - Other								
Description			Amount					
Section Not Applicable			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
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		\$ 22,985	Section Not Applicable			Out-of-State Travel	\$
Paychex	Accounting		10,015					
Tragesser & Associates, PC	Accounting		1,100				In-State Travel	375
Wenzel & Associates	Accounting		1,024					
Giffin, Winning, Cohen & Bodewes	Legal		5,292				Seminar Expense	
Greensfelder	Legal		474				Tuition and Administrator Exam Fees to Obtain Administrator License	3,498
Note:							Entertainment Expense	()
Total Legal Service	\$5,766						(agree to Sch. V, line 24, col. 8)	
Less: Non-Allowable	(3,767)						TOTAL	\$ 3,873
Adjusted Total	\$1,999							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,890	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Section Not Applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,457 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 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. \$ 269,338
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. \$ 810
- (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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: C.J. Schlosser & Company, L.L.C.
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

CARING FIRST, INC.
IDPH ID #0036012
ATTACHMENT TO SCHEDULE XVII
12/31/2012

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 287,918
DEPRECIATION ADJUSTMENT	3,008
TRAVEL AND ENTERTAINMENT	599
OFFICERS' LIFE INSURANCE PREMIUMS	7,609
CONVERSION TO CASH BASIS ADJUSTMENTS	(329,531)
TAX NET LOSS	<u>\$ (30,397)</u>

CARING FIRST, INC.
 RECLASSIFICATIONS
 MEDICAID COST REPORT
 12/31/2012

	<u>AMOUNT</u>	<u>LN #</u>
A		
DUES, FEES AND SUBSCRIPTIONS	(40)	20
CLERICAL & GENERAL OFFICE EXPENSES	40	21
TO RECLASS EXPENSES RELATED TO COMPUTER MAINTENANCE		
B		
DUES, FEES AND SUBSCRIPTIONS	(20)	20
CLERICAL & GENERAL OFFICE EXPENSES	20	21
TO RECLASS BANK FEES		
C		
FACILITY DUES AND SUBSCRIPTIONS	(168)	20
HOUSEKEEPING	168	3
TO RECLASS EXPENSES RELATED TO HOUSEKEEPING SUPPLIES		

Caring First, Inc. d/b/a Breese Nursing Home

Attachment to Schedule XIV

12/31/2012

		1	2	3	4	5	6	7	8
			Staff		Outside Practitioner (other Than Consultant)		Supplies (Actual or Allocated)	Total Units (Col 2 + 4)	Total Cost (Col 3 + 5)
Line #	Service	Schuler V Line & Column Referenc e	Units of Service	Cost	Units of Service	Cost	Cost		

12 Other:

Licensed Occupational Therapist	39,8				5,567	175,222		5,567	175,222
Licensed Speech Therapist	39,8				1,256	78,902		1,256	78,902
Licensed Physical Therapist	39,8				6,394	194,794	131	6,394	194,925
X-Ray	39,3					6,284		-	6,284
Laboratory	39,3					20,295		-	20,295

Total to Schedule XIV, Line 12

-	-	13,217	475,497	131	13,217	475,628
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