FOR BHF USE

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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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0036012

Facility Name: Breese Nursing Home

Address: 1155 North First St (Number) Breese (City) 62230 (Zip Code)

County: Clinton

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Halloran
(Title) President, Caring First, Inc.

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, Il 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	39	Skilled (SNF)	39	14,235	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,898	4,158	1,824	8,880	8
9	SNF/PED					9
10	ICF	7,887	9,975		17,862	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,785	14,133	1,824	26,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.42%

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 [X]

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

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 [X] Date 03/06/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 1,647

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	176,077	1,274	5,662	183,013		183,013		183,013			1
2	Food Purchase		162,501		162,501		162,501	(5,788)	156,713			2
3	Housekeeping	81,031	13,559		94,590		94,590		94,590			3
4	Laundry	47,074	15,473		62,547		62,547		62,547			4
5	Heat and Other Utilities			125,933	125,933		125,933		125,933			5
6	Maintenance	59,341	10,146	29,242	98,729		98,729		98,729			6
7	Other (specify):* Trash Removal/ Medical Waste Removal			12,593	12,593		12,593		12,593			7
8	**TOTAL General Services**	363,523	202,953	173,430	739,906		739,906	(5,788)	734,118			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,505,870	96,887	6,420	1,609,177		1,609,177		1,609,177			10
10a	Therapy											10a
11	Activities	39,064	2,047	1,653	42,764		42,764		42,764			11
12	Social Services	44,484		5,105	49,589		49,589		49,589			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,589,418	98,934	19,178	1,707,530		1,707,530		1,707,530			16
	C. General Administration											
17	Administrative	120,475			120,475		120,475		120,475			17
18	Directors Fees											18
19	Professional Services			33,563	33,563		33,563	(858)	32,705			19
20	Dues, Fees, Subscriptions & Promotions			23,580	23,580		23,580	(17,097)	6,483			20
21	Clerical & General Office Expenses	69,710	18,128	67,785	155,623		155,623	(10,536)	145,087			21
22	Employee Benefits & Payroll Taxes			300,748	300,748		300,748		300,748			22
23	Inservice Training & Education											23
24	Travel and Seminar			50	50		50		50			24
25	Other Admin. Staff Transportation		9,426		9,426		9,426	(9,426)				25
26	Insurance-Prop.Liab.Malpractice			59,224	59,224		59,224		59,224			26
27	Other (specify):*											27
28	**TOTAL General Administration**	190,185	27,554	484,950	702,689		702,689	(37,917)	664,772			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,143,126	329,441	677,558	3,150,125		3,150,125	(43,705)	3,106,420			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: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			106,880	106,880		106,880	2,520	109,400			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,308	103,308		103,308	(3,207)	100,101			32
33	Real Estate Taxes			42,304	42,304		42,304		42,304			33
34	Rent-Facility & Grounds			12,000	12,000		12,000		12,000			34
35	Rent-Equipment & Vehicles			1,218	1,218		1,218		1,218			35
36	Other (specify):* Mortgage Insurance			11,382	11,382		11,382		11,382			36
37	TOTAL Ownership			277,092	277,092		277,092	(687)	276,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,777	431,833	472,610		472,610		472,610			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,465	218,465		218,465		218,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		40,777	650,298	691,075		691,075		691,075			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,143,126	370,218	1,604,948	4,118,292		4,118,292	(44,392)	4,073,900			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: 01/01/2014 Ending: 12/31/2014

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,788)	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	2,520	30		9
10	Interest and Other Investment Income	(3,207)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,913)	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	(12,552)	20		19
20	Contributions	(1,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(858)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(21,494)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,392)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,392)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS **Page 5A**

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To eliminate non-care related expenses	$ (25)	20	1
2	To eliminate non-care related expenses	(8,623)	21	2
3	To eliminate non-care related expenses	(9,426)	25	3
4	To eliminate Fines and Penalties	(1,430)	20	4
5	To eliminate 2015 IDPH license purchased in 2014	(1,990)	20	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				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**	(21,494)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,788)	0	0	0	0	0	0	0	0	0	0	(5,788)	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**	(5,788)	0	0	0	0	0	0	0	0	0	0	(5,788)	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	(858)	0	0	0	0	0	0	0	0	0	0	(858)	19
20	Fees, Subscriptions & Promotions	(17,097)	0	0	0	0	0	0	0	0	0	0	(17,097)	20
21	Clerical & General Office Expenses	(10,536)	0	0	0	0	0	0	0	0	0	0	(10,536)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	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	(9,426)	0	0	0	0	0	0	0	0	0	0	(9,426)	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**	(37,917)	0	0	0	0	0	0	0	0	0	0	(37,917)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,705)	0	0	0	0	0	0	0	0	0	0	(43,705)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,520	0	0	0	0	0	0	0	0	0	0	2,520	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,207)	0	0	0	0	0	0	0	0	0	0	(3,207)	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**	(687)	0	0	0	0	0	0	0	0	0	0	(687)	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)**	(44,392)	0	0	0	0	0	0	0	0	0	0	(44,392)	45

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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%					
Estate of Garret 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 [X] 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

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark E. Halloran	President		50.00		12	30.00	Salary	$ 11,838	17,1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,838		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: 01/01/2014 Ending: 2/31/2014

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 [X]

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

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

	1 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: 01/01/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Gershman Investment Group		X	Refinance Mortgage	$13,698.00	9-1-10	$ 2,469,400	$ 2,218,312	10/1/35	4.4800	$ 100,930	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	$ 2,218,312			$ 103,308	9
	B. Non-Facility Related*											
10												10
11								Interest Income			(3,207)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,207)	14
15	TOTALS (line 9+line14)						$ 2,469,400	$ 2,218,312			$ 100,101	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 11,382 **Line #** 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 44,890	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,110)	3
4. Real Estate Tax accrual used for 2014 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** $ 2,586 **For** 2011 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (2,586)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 42,304	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	48,503	8
	2010	49,714	9
	2011	47,423	10
	2012	44,371	11
	2013	44,890	12

The payment on line 2 includes payment for 2013 tax year.
The accrual used on line 4 was based on the 2013 tax year.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-22-252-008	Sec 22 Twp 2 Rng 4 Pt W 1/2 NE	$ 44,890.57	$ 44,890.57
2.		NE 4A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,890.57	$ 44,890.57

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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? [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	174,242	1990	$ 15,400	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		1990	1975	$ 1,750,695	$ 55,578	31.5	$ 55,578	$	$ 1,377,857	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beg Balance			1990	10,000	317	31.5	317		7,870	9
10											10
11	Air Conditioner			1990	2,828	90	31.5	90		2,204	11
12	Interior Renovation			1990	1,292	41	31.5	41		986	12
13	Air Conditioner Pad			1990	2,645		15			2,645	13
14	Handrails			1991	4,884	155	31.5	155		3,650	14
15	Soffits & Siding			1991	11,204	356	31.5	356		8,429	15
16	Air Conditioner			1991	4,755	151	31.5	151		3,541	16
17	HVAC- Dining Room			1991	5,510	175	31.55	175		3,892	17
18	Cubicle Tracking			1992	1,815		7			1,815	18
19	Plastering			1992	1,952	62	31.5	62		1,348	19
20	Cubicle Tracking			1993	657		20			657	20
21	Carpet & Tile			1993	1,481		5			1,481	21
22	Air Conditioning			1993	5,877	151	10		(151)	5,877	22
23	Laundry Improvements			1994	1,162	30	27	43	13	896	23
24	Front Door			1994	1,368	35	10		(35)	1,368	24
25	Electric Wiring			1994	9,131	234	20	228	(6)	9,131	25
26	Back Patio			1994	5,137		10			5,137	26
27	Front Parking Lot			1994	80,603		10			80,603	27
28	Lighting & Ceiling Fans			1994	2,110		10			2,110	28
29	Dining Room Improvements			1994	2,558	66	27	95	29	1,903	29
30	Plumbing			1994	4,528	116	20	37	(79)	4,528	30
31	Ceiling Tile			1994	614	16	12		(16)	614	31
32											32
33											33
34											34
35											35
36											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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Administrative Office Improvements	1994	$ 1,048	$ 27	15	$	$ (27)	$ 1,048	37
38	Air Conditioners	1994	31,460	807	10		(807)	31,460	38
39	Window Blinds	1995	6,010		20	300	300	5,735	39
40	Land Improvements	1995	1,224		10			1,224	40
41	Sign	1995	2,455		12			2,455	41
42	Parking Lot Lighting	1995	7,456		15			7,456	42
43	Flag Pole	1995	1,511		20	76	76	1,486	43
44	Landscaping	1996	2,927		10			2,927	44
45	Kitchen Renovations	1996	13,339		25	534	534	9,871	45
46	Window Screens	1996	914		5			914	46
47	Remodel Nurse Station	1996	1,077		25	43	43	797	47
48	Reception Room Additon	1996	3,721		25	149	149	2,753	48
49	Doors-Alzheimer Unit	1996	1,030		25	41	41	762	49
50	Shrubs	1997	508		15			508	50
51	Fence	1997	1,141		15			1,141	51
52	Fixtures	1997	2,835		10			2,835	52
53	New Windows	2000	35,000	897	10		(897)	35,000	53
54	Light fixtures	2000	1,500	38	10		(38)	1,500	54
55	Sink Fixtures	2000	7,350	188	20	368	180	5,513	55
56	10 Ton HVAC	2000	10,000	256	17	588	332	8,824	56
57	Air Handling Unit	2000	3,000	77	15	200	123	3,000	57
58	Rear Parking Lot	2000	44,000	2,598	15	2,933	335	44,000	58
59	Dumpster Pad	2000	900	53	15	60	7	900	59
60	Shower Room Remodel	2001	15,000	385	15	1,000	615	14,000	60
61	Grab Bars	2002	4,800	123	15	320	197	4,160	61
62	Tuck Point	2002	1,000	26	15	67	41	867	62
63	Regrout	2002	1,500	38	15	100	62	1,300	63
64	Air Handler	2002	3,000	77	15	200	123	2,600	64
65	Remodel Sprayout Room	2002	2,481	64	15	165	101	2,268	65
66	Drainage	2002	1,500	62	15	100	38	1,300	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,122,493	$ 63,289		$ 64,572	$ 1,283	$ 1,727,146	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,122,493	$ 63,289		$ 64,572	$ 1,283	$ 1,727,146	1
2	Floor Tile	2004	47,390	1,215	10	4,739	3,524	47,390	2
3	Door Alarm	2004	6,074	156	10	101	(55)	6,074	3
4	Telephone & Intercom System	2006	6,736	674	10	674		5,558	4
5	Hot Water Heater	2006	5,143	514	10	514		4,371	5
6	Concrete Sidewalks	2006	6,960	464	15	464		3,867	6
7	Fire Alarm	2011	18,582	1,858	10	1,858		5,884	7
8	Roof Repair	2011	35,195	3,520	10	903	(2,617)	2,707	8
9	Sprinkler	2011	78,346	3,134	25	3,134		9,924	9
10	Water Softener	2011	8,960	896	10	896		2,837	10
11	Roof Repair	2012	137,503	13,750	10	13,750		27,500	11
12	Sprinkler	2012	52,000	2,080	25	2,080		5,720	12
13	Door Knobs	2012	250	25	10	25		75	13
14	Water Heater	2013	5,295	530	10	530		971	14
15	3 Ton Air Handler	2013	1,945	195	10	195		357	15
16	Roof Repairs	2013	12,999	1,300	10	1,300		2,275	16
17	2 Water Heaters	2013	10,590	1,059	10	1,059		1,853	17
18	Rooftop unit with heat pump	2014	6,780	508	10	508		508	18
19	Water Heater	2014	5,295	309	10	309		309	19
20	Disposed Items			2,285			(2,285)		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)		$ 2,568,536	$ 97,761		$ 97,611	$ (150)	$ 1,855,326	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 112,721	$ 8,200	$ 10,870	$ 2,670	5-20 yrs	$ 64,708	71
72	Current Year Purchases	24,775	919	919		5-12 yrs	919	72
73	Fully Depreciated Assets	405,218					405,218	73
74								74
75	TOTALS	$ 542,714	$ 9,119	$ 11,789	$ 2,670		$ 470,845	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 E150	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)	$ 3,136,150	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,880	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 109,400	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,520	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,335,671	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: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 1,218 Description: Dietary Equipment Leased
    (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	Section Not Applicable		$	$	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

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	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		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 prescrpts				40,777		40,777	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab, X-Ray, Therapies	39, 3				431,833			431,833	13
14	TOTAL			$		$ 431,833	$ 40,777		$ 472,610	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

STATE OF ILLINOIS

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 770,733	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 62,826)	868,830		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,025		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,690,088	$	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	2,621,949		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	551,615		16
17	Accumulated Depreciation (book methods)	(2,280,729)		17
18	Deferred Charges	49,339		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)**	$ 957,574	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,647,662	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 120,280	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,983		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,845		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	Accrued Provider Tax	25,840		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 362,948	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,218,312		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)**	$ 2,218,312	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,581,260	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 66,402	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,647,662	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Breese Nursing Home **#** 0036012 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 40,439	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 40,439	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,963	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 25,963	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)**	$ 66,402	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,333,014	1
2	Discounts and Allowances for all Levels	67,416	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,400,430	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	701,886	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 701,886	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	5,788	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	29,329	19
20	Radiology and X-Ray	7,086	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 42,203	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,207	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,207	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,729	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,729	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,149,455	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	739,906	31
32	Health Care	1,707,530	32
33	General Administration	702,689	33
	B. Capital Expense		
34	Ownership	277,092	34
	C. Ancillary Expense		
35	Special Cost Centers	472,610	35
36	Provider Participation Fee	218,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,118,292	40
41	**Income before Income Taxes (line 30 minus line 40)****	31,163	41
42	**Income Taxes**	(5,200)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,963	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,320,672	44
45	Private Pay - Net Inpatient Revenue	1,681,260	45
46	Medicare - Net Inpatient Revenue	371,948	46
47	Other-(specify) Insurance	26,550	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,400,430	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: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,187	2,307	$ 61,233	$ 26.54	1
2	Assistant Director of Nursing	1,718	1,867	35,548	19.04	2
3	Registered Nurses	11,477	12,089	290,754	24.05	3
4	Licensed Practical Nurses	19,476	20,723	390,042	18.82	4
5	CNAs & Orderlies	56,853	59,968	707,568	11.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,809	3,996	39,064	9.78	10
11	Social Service Workers	3,276	3,477	44,484	12.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,286	15,217	176,077	11.57	15
16	Dishwashers					16
17	Maintenance Workers	3,891	4,191	59,341	14.16	17
18	Housekeepers	8,875	9,176	81,031	8.83	18
19	Laundry	4,842	4,992	47,074	9.43	19
20	Administrator	1,920	2,080	60,000	28.85	20
21	Assistant Administrator	1,761	1,918	48,637	25.36	21
22	Other Administrative	592	592	11,838	20.00	22
23	Office Manager					23
24	Clerical	5,379	5,875	69,710	11.87	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	1,814	1,814	20,725	11.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,156	150,282	$ 2,143,126 *	$ 14.26	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	109	$ 5,662	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	16	720	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	871	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	1,653	11,3	44
45	Social Service Consultant	Contract	1,653	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	125	$ 16,559		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Halloran	Owner	50	$ 11,838
Krista Lanker	Assitant Admin.	0	48,637
Jodine Jackson	Administrator	0	60,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 120,475

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Co.	Accounting	$ 22,575
Paychex	Accounting	8,265
Giffin, Winning, Cohen & Bodewes	Legal Fees - IDPH Survey	1,683
Greensfelder, Hemker & Gale	Legal Fees	182
Giffin, Winning, Cohen & Bodewes	Collections (Eliminated)	858
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 33,563

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,905
Unemployment Compensation Insurance	16,059
FICA Taxes	160,932
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	1,852
TOTAL (agree to Schedule V, line 22, col.8)	$ 300,748

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
Section Not Applicable		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	568
Health Care Worker Background Check	445
(Indicate # of checks performed)	
Patient Background Checks	250
Dues, subscriptions, & licenses	1,665
Pioneer Coalition Dues	150
Dues & Fees	1,415
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,483

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	50
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Amount of Expense Amortized Per Year								
					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													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Breese Nursing Home** **#** **0036012** **Report Period Beginning:** **01/01/2014** **Ending:** **12/31/2014**

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. $ **12,017** 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 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. $ **218,465**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **5,788**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.