

		FOR BHF USE					

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**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)**

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 North First St</u> <u>Breese</u> <u>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 border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<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>01/01/2016</u> to <u>12/31/2016</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"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark Halloran</u></td> </tr> <tr> <td></td> <td>(Title) <u>President, Caring First, Inc.</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Accountant's Preparation Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark Halloran</u>		(Title) <u>President, Caring First, Inc.</u>	Paid Preparer	(Signed) <u>See Accountant's Preparation Report</u>	(Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	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	
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	39	Skilled (SNF)	39	14,274	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,718	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	897	3,947	2,412	7,256	8
9	SNF/PED					9
10	ICF	7,982	7,989	4	15,975	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,879	11,936	2,416	23,231	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.67%

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 2,406

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	159,538	226	6,154	165,918		165,918		165,918		1
2	Food Purchase		139,317		139,317		139,317	(2,876)	136,441		2
3	Housekeeping	75,777	11,578		87,355		87,355		87,355		3
4	Laundry	53,322	11,141		64,463		64,463		64,463		4
5	Heat and Other Utilities			111,895	111,895		111,895		111,895		5
6	Maintenance	53,468	39,256	38,560	131,284		131,284		131,284		6
7	Other (specify):* Trash/Medical Waste Removal			14,355	14,355		14,355		14,355		7
8	TOTAL General Services	342,105	201,518	170,964	714,587		714,587	(2,876)	711,711		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,458,185	88,965	6,655	1,553,805		1,553,805		1,553,805		10
10a	Therapy										10a
11	Activities	53,820	1,214	1,999	57,033		57,033		57,033		11
12	Social Services	41,417		1,999	43,416		43,416		43,416		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,553,422	90,179	16,653	1,660,254		1,660,254		1,660,254		16
	C. General Administration										
17	Administrative	135,822			135,822		135,822		135,822		17
18	Directors Fees										18
19	Professional Services			26,297	26,297		26,297	(1,469)	24,828		19
20	Dues, Fees, Subscriptions & Promotions			26,252	26,252		26,252	(17,937)	8,315		20
21	Clerical & General Office Expenses	67,922	10,035	88,363	166,320		166,320	(1,767)	164,553		21
22	Employee Benefits & Payroll Taxes			320,026	320,026		320,026		320,026		22
23	Inservice Training & Education										23
24	Travel and Seminar			550	550		550		550		24
25	Other Admin. Staff Transportation		5,749		5,749		5,749	(5,749)			25
26	Insurance-Prop.Liab.Malpractice			62,250	62,250		62,250		62,250		26
27	Other (specify):*										27
28	TOTAL General Administration	203,744	15,784	523,738	743,266		743,266	(26,922)	716,344		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,099,271	307,481	711,355	3,118,107		3,118,107	(29,798)	3,088,309		29

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

SEE ACCOUNTANTS' PREPARATION 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:

01/01/2016

Ending:

12/31/2016

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			105,575	105,575		105,575	(3,680)	101,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,804	83,804		83,804	(1,870)	81,934			32
33	Real Estate Taxes			55,648	55,648		55,648		55,648			33
34	Rent-Facility & Grounds			12,000	12,000		12,000		12,000			34
35	Rent-Equipment & Vehicles			1,244	1,244		1,244		1,244			35
36	Other (specify):* Mortgage Insurance			10,589	10,589		10,589		10,589			36
37	TOTAL Ownership			268,860	268,860		268,860	(5,550)	263,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,115	359,096	414,211		414,211		414,211			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,918	195,918		195,918		195,918			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		55,115	555,014	610,129		610,129		610,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,099,271	362,596	1,535,229	3,997,096		3,997,096	(35,348)	3,961,748			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(2,876)	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	(3,680)	30		9
10	Interest and Other Investment Income	(1,870)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,767)	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	(13,512)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,469)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,100)	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	(9,074)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,348)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (35,348)		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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To eliminate non-care related expenses	\$ (1,335)	20	1
2	To eliminate non-care related expenses	(5,749)	25	2
3	Eliminate 2017 IDPH license paid in 2016	(1,990)	20	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				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	(9,074)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	(2,876)	0	0	0	0	0	0	0	0	0	0	(2,876)	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	(2,876)	0	0	0	0	0	0	0	0	0	0	(2,876)	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	(1,469)	0	0	0	0	0	0	0	0	0	0	(1,469)	19
20	Fees, Subscriptions & Promotions	(17,937)	0	0	0	0	0	0	0	0	0	0	(17,937)	20
21	Clerical & General Office Expenses	(1,767)	0	0	0	0	0	0	0	0	0	0	(1,767)	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	(5,749)	0	0	0	0	0	0	0	0	0	0	(5,749)	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	(26,922)	0	0	0	0	0	0	0	0	0	0	(26,922)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,798)	0	0	0	0	0	0	0	0	0	0	(29,798)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(3,680)	0	0	0	0	0	0	0	0	0	0	(3,680) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,870)	0	0	0	0	0	0	0	0	0	0	(1,870) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(5,550)	0	0	0	0	0	0	0	0	0	0	(5,550) 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)	(35,348)	0	0	0	0	0	0	0	0	0	0	(35,348) 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	75	None		None		
Steve Macaluso	25					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Section N/A	\$			\$	\$	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' PREPARATION REPORT

Facility Name & ID Number

Breese Nursing Home

0036012

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Breese Nursing Home

0036012

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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/Owner		75.00	0	9	22.00	Salary	\$ 11,604	17,1	1
2	Steve Macaluso	Owner		25.00	0	14	34.00	Salary	18,382	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	\$ 29,986		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' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	Schedule N/A				\$	\$		\$	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' PREPARATION REPORT

Facility Name & ID Number

Breese Nursing Home

0036012

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Gershman Investment Group		X	Refinance Mortgage	\$12,959.60	9/1/10	\$ 2,469,400	\$ 2,074,603	10/1/35	0.0385	\$ 81,426	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				\$12,959.60		\$ 2,469,400	\$ 2,074,603			\$ 83,804	9						
B. Non-Facility Related*																		
10												10						
11	Interest Income Offset		X								(1,870)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (1,870)	14						
15	TOTALS (line 9+line14)						\$ 2,469,400	\$ 2,074,603			\$ 81,934	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 10,589 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' PREPARATION 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**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1.	Real Estate Tax accrual used on 2015 report.			\$	46,000	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.)			\$	50,648	2	
3.	Under or (over) accrual (line 2 minus line 1).			\$	4,648	3	
4.	Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	51,000	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.			\$	55,648	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:							
	2011	47,423	8	FOR BHF USE ONLY			
	2012	44,371	9				
	2013	44,890	10	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
	2014	44,586	11				
	2015	50,648	12	14	PLUS APPEAL COST FROM LINE 5	\$	14
The payment on line 2 includes payment for 2015 tax year.				15	LESS REFUND FROM LINE 6	\$	15
The accrual used on line 4 was based on the 2015 tax year.				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' PREPARATION REPORT

2015 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 2015 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 2015.

(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 2N Rng 4W PT W 1/2 N</u>	\$ <u>50,648.00</u>	\$ <u>50,648.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>50,648.00</u></u>	\$ <u><u>50,648.00</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

01/01/2016 Ending:

12/31/2016

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 174,242, 1990, \$ 15,400, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 174,242, (blank), \$ 15,400, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

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		\$ 1,489,013	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beg Balance		1990		10,000	317	31.5	317		8,504	9
10											10
11	Air Conditioner		1990		2,828	90	31.5	90		2,384	11
12	Interior Renovation		1990		1,292	41	31.5	41		1,068	12
13	Air Conditioner Pad		1990		2,645		15			2,645	13
14	Handrails		1991		4,884	155	31.5	155		3,960	14
15	Soffits & Siding		1991		11,204	356	31.5	356		9,141	15
16	HVAC - Dining Room - Disposed 2016					168	31.5	175	7		16
17	Cubicle Tracking		1992		1,815		7			1,815	17
18	Plastering		1992		1,952	62	31.5	62		1,472	18
19	Air Conditioning		1993		5,877	151	10		(151)	5,877	19
20	Laundry Improvements		1994		1,162	30	27	43	13	982	20
21	Front Door		1994		1,368	35	10		(35)	1,368	21
22	Electric Wiring		1994		9,131	234	20		(234)	9,131	22
23	Back Patio		1994		5,137		10			5,137	23
24	Front Parking Lot		1994		80,603		10			80,603	24
25	Lighting & Ceiling Fans		1994		2,110		10			2,110	25
26	Dining Room Improvements		1994		2,558	66	27	95	29	2,093	26
27	Plumbing		1994		4,528	116	20		(116)	4,528	27
28	Ceiling Tile		1994		614	16	12		(16)	614	28
29	Administrative Office Improvements - Disposed 2016					26	15		(26)		29
30	Air Conditioners		1994		31,460	807	10		(807)	31,460	30
31	Window Blinds		1995		6,010		20			6,010	31
32	Land Improvements		1995		1,224		10			1,224	32
33	Sign		1995		2,455		12			2,455	33
34	Parking Lot Lighting		1995		7,456		15			7,456	34
35	Flag Pole		1995		1,511		20			1,511	35
36	Landscaping		1996		2,927		10			2,927	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' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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	Kitchen Renovations	1996	\$ 13,339	\$	25	\$ 533	\$ 533	\$ 10,938	37
38	Window Screens	1996	914		5			914	38
39	Remodel Nurses Station	1996	1,077		25	43	43	883	39
40	Reception Room Addition	1996	3,721		25	149	149	3,051	40
41	Doors - Alzheimer Unit	1996	1,030		25	41	41	844	41
42	Fence	1997	1,141		15			1,141	42
43	Fixtures	1997	2,835		10			2,835	43
44	New Windows	2000	35,000	897	10		(897)	35,000	44
45	Light fixtures	2000	1,500	38	10		(38)	1,500	45
46	Sink Fixtures	2000	7,350	188	20	367	179	6,248	46
47	10 Ton HVAC - Disposed 2016			245	17	589	344		47
48	Air Handling Unit	2000	3,000	77	15		(77)	3,000	48
49	Rear Parking Lot	2000	44,000		15			44,000	49
50	Dumpster Pad	2000	900		15			900	50
51	Shower Room Remodel - Disposed 2016			369	15		(369)		51
52	Grab Bars	2002	4,800	123	15	320	197	4,800	52
53	Tuck Point	2002	1,000	26	15	66	40	1,000	53
54	RegROUT	2002	1,500	38	15	100	62	1,500	54
55	Air Handler	2002	3,000	77	15	200	123	3,000	55
56	Remodel Sprayout Room	2002	2,481	64	15	48	(16)	2,481	56
57	Drainage	2002	1,500	62	15	100	38	1,500	57
58	Floor Tile	2004	47,390	1,215	10		(1,215)	47,390	58
59	Door Alarm	2004	6,074	156	10		(156)	6,074	59
60	Telephone & Intercom System	2006	6,736	505	10	505		6,736	60
61	Hot Water Heater - Disposed 2016			257	10	257			61
62	Concrete Sidewalks	2006	6,960	464	15	464		4,795	62
63	Fire Alarm	2011	18,582	1,858	10	1,858		9,600	63
64	Roof Repair	2011	35,195	3,520	10	903	(2,617)	4,513	64
65	Sprinkler	2011	78,346	3,134	25	3,134		16,192	65
66	Water Softener	2011	8,960	896	10	896		4,629	66
67	Roof Repair	2012	137,503	13,750	10	13,750		55,000	67
68	Sprinkler	2012	52,000	2,080	25	2,080		9,880	68
69	Door Knobs	2012	250	25	10	25		125	69
70	TOTAL (lines 4 thru 69)		\$ 2,481,530	\$ 88,312		\$ 83,340	\$ (4,972)	\$ 1,975,957	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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		\$ 2,481,530	\$ 88,312		\$ 83,340	\$ (4,972)	\$ 1,975,957	1
2	Water Heater	2013	5,295	530	10	530		2,031	2
3	3 Ton Air Handler	2013	1,945	195	10	195		747	3
4	Roof Repairs	2013	12,999	1,300	10	1,300		4,875	4
5	2 Water Heaters	2013	10,590	1,059	10	1,059		3,971	5
6	Rooftop unit with heat pump	2014	6,780	678	10	678		1,864	6
7	Water Heater	2014	5,295	529	10	529		1,368	7
8	American Standard A/C & Economizer	2016	12,090	605	10	605		605	8
9	Disposed Items			1,377			(1,377)		9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,536,524	\$ 94,585		\$ 88,236	\$ (6,349)	\$ 1,991,418	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 87,215	\$ 10,399	\$ 13,068	\$ 2,669	5-20 yrs	\$ 38,244	71
72	Current Year Purchases	4,962	591	591		5-20 yrs	591	72
73	Fully Depreciated Assets	418,841					418,841	73
74								74
75	TOTALS	\$ 511,018	\$ 10,990	\$ 13,659	\$ 2,669		\$ 457,676	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	1993 Ford E150	2003	\$ 9,500	\$	\$	\$	4	\$ 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)	\$ 3,072,442	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,575	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,895	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,680)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,458,594	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' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 1,244

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	<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' PREPARATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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				55,115		55,115	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Lab, X-Ray, Therapy</u>	39,3				359,096			359,096	13
14	TOTAL			\$		\$ 359,096	\$ 55,115		\$ 414,211	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' PREPARATION REPORT

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	\$ 571,763	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (85,000))	909,741		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	31,471		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)	\$ 1,530,475	\$	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	2,518,912		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	520,946		16
17	Accumulated Depreciation (book methods)	(2,369,352)		17
18	Deferred Charges	44,583		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)	\$ 730,489	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,260,964	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 341,522	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,572		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000		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)	\$ 500,147	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,074,603		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)	\$ 2,074,603	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,574,750	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (313,786)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,260,964	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (444,117)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (444,117)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	130,331	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) Treasury Stock Purchased		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 130,331	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)	\$ (313,786)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 3,343,606	1
2	Discounts and Allowances for all Levels	43,789	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,387,395	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	680,273	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 680,273	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	2,876	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	73,193	19
20	Radiology and X-Ray	7,917	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 83,986	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,870	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,870	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	579	28
28a	Loss on disposal	(26,676)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (26,097)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,127,427	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	714,587	31
32	Health Care	1,660,254	32
33	General Administration	743,266	33
B. Capital Expense			
34	Ownership	268,860	34
C. Ancillary Expense			
35	Special Cost Centers	414,211	35
36	Provider Participation Fee	195,918	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,997,096	40
41	Income before Income Taxes (line 30 minus line 40)**	130,331	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 130,331	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,069,600	44
45	Private Pay - Net Inpatient Revenue	1,718,275	45
46	Medicare - Net Inpatient Revenue	598,620	46
47	Other-(specify) <u>Insurance</u>	900	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,387,395	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' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	2,037	2,128	\$ 70,294	\$ 33.03	1
2	Assistant Director of Nursing	2,027	2,190	47,465	21.67	2
3	Registered Nurses	8,928	9,511	233,883	24.59	3
4	Licensed Practical Nurses	20,306	21,463	405,028	18.87	4
5	CNAs & Orderlies	53,275	56,436	681,411	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,055	5,220	53,820	10.31	10
11	Social Service Workers	3,060	3,197	41,417	12.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,432	14,353	159,538	11.12	15
16	Dishwashers					16
17	Maintenance Workers	4,055	4,327	53,468	12.36	17
18	Housekeepers	7,919	8,479	75,777	8.94	18
19	Laundry	5,768	6,056	53,322	8.80	19
20	Administrator	2,308	2,308	61,235	26.53	20
21	Assistant Administrator	1,735	1,868	44,601	23.88	21
22	Other Administrative	1,153	1,153	29,986	26.01	22
23	Office Manager					23
24	Clerical	3,567	3,932	67,922	17.27	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	1,764	1,764	20,104	11.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,389	144,385	\$ 2,099,271 *	\$ 14.54	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	\$ 6,154	1, 3	35
36	Medical Director	Contract 6,000	9, 3	36
37	Medical Records Consultant	980	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Contract 1,298	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 1,999	11, 3	44
45	Social Service Consultant	Contract 1,999	12, 3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 18,430		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' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Mark Halloran	Owner	75	\$ 11,604	Workers' Compensation Insurance	\$ 152,152	IDPH License Fee	\$ 1,990				
Steve Macaluso	Owner	25	18,382	Unemployment Compensation Insurance	10,473	Advertising: Employee Recruitment	666				
Jodine Jackson	Administrator	0	61,235	FICA Taxes	154,764	Health Care Worker Background Check (Indicate # of checks performed _____)	550				
Krista Lanter	Assistant Admin.	0	44,601	Employee Health Insurance		Patient Background Checks	350				
				Employee Meals		Dues, Subscriptions, & Licenses	2,407				
				Illinois Municipal Retirement Fund (IMRF)*		Pioneer Coalition Dues	150				
				Employee Appreciation	2,637	Dues & Fees	2,202				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,822	TOTAL (agree to Schedule V, line 22, col.8)		\$ 320,026	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 8,315		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount			
Section Not Applicable	\$			Section Not Applicable		\$	Out-of-State Travel	\$			
							In-State Travel				
							Seminar Expense	550			
							Entertainment Expense (agree to Sch. V, line 24, col. 8)	()			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 550			
C. Professional Services											
Vendor/Payee	Type	Amount									
C.J. Schlosser & Company L.L.C.	Accounting	\$ 15,573									
Giffin, Winning & Bodewes	Collections (Eliminated)	1,469									
Tragresser & Assoc	Accounting	40									
Paychex	Payroll Services	9,215									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 26,297								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Breese Nursing Home

0036012

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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. \$ 4,220 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 195,918
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. \$ 2,876
- (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

SEE ACCOUNTANTS' PREPARATION REPORT