

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Home

0036012 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	14,235	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 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	1,354	2,508	2,501	6,363	8
9	SNF/PED					9
10	ICF	7,780	7,412	162	15,354	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,134	9,920	2,663	21,717	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.12%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 1,891

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	151,491	1,194	5,887	158,572		158,572		158,572		1
2	Food Purchase		140,975		140,975		140,975	(679)	140,296		2
3	Housekeeping	58,410	11,927		70,337		70,337		70,337		3
4	Laundry	53,154	10,931		64,085		64,085		64,085		4
5	Heat and Other Utilities			106,306	106,306		106,306		106,306		5
6	Maintenance	59,737	17,262	34,061	111,060		111,060		111,060		6
7	Other (specify):* Trash/Medical Waste Removal			7,644	7,644		7,644		7,644		7
8	TOTAL General Services	322,792	182,289	153,898	658,979		658,979	(679)	658,300		8
	B. Health Care and Programs										
9	Medical Director			14,250	14,250		14,250		14,250		9
10	Nursing and Medical Records	1,648,708	102,349	10,146	1,761,203		1,761,203		1,761,203		10
10a	Therapy										10a
11	Activities	43,895	2,181	1,541	47,617		47,617		47,617		11
12	Social Services	47,347		1,541	48,888		48,888		48,888		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,739,950	104,530	27,478	1,871,958		1,871,958		1,871,958		16
	C. General Administration										
17	Administrative	82,248			82,248		82,248		82,248		17
18	Directors Fees										18
19	Professional Services			37,967	37,967		37,967	(3,685)	34,282		19
20	Dues, Fees, Subscriptions & Promotions			27,367	27,367		27,367	(17,055)	10,312		20
21	Clerical & General Office Expenses	101,250	9,538	87,663	198,451		198,451	(1,065)	197,386		21
22	Employee Benefits & Payroll Taxes			296,799	296,799		296,799		296,799		22
23	Inservice Training & Education										23
24	Travel and Seminar			200	200		200		200		24
25	Other Admin. Staff Transportation		5,226		5,226		5,226	(5,226)			25
26	Insurance-Prop.Liab.Malpractice			61,383	61,383		61,383		61,383		26
27	Other (specify):*										27
28	TOTAL General Administration	183,498	14,764	511,379	709,641		709,641	(27,031)	682,610		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,246,240	301,583	692,755	3,240,578		3,240,578	(27,710)	3,212,868		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 Caring First, Inc. d/b/a Breese Nursing Home

#0036012

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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			103,708	103,708		103,708	(3,904)	99,804			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,884	77,884		77,884	(4,808)	73,076			32
33	Real Estate Taxes			51,504	51,504		51,504		51,504			33
34	Rent-Facility & Grounds			13,000	13,000		13,000		13,000			34
35	Rent-Equipment & Vehicles			1,646	1,646		1,646		1,646			35
36	Other (specify):* Mortgage Insurance			9,860	9,860		9,860		9,860			36
37	TOTAL Ownership			257,602	257,602		257,602	(8,712)	248,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,665	352,744	410,409		410,409		410,409			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,894	181,894		181,894		181,894			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		57,665	534,638	592,303		592,303		592,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,246,240	359,248	1,484,995	4,090,483		4,090,483	(36,422)	4,054,061			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	(679)	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	(3,904)	30		9
10	Interest and Other Investment Income	(4,808)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,065)	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	(11,811)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,685)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,379)	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	(8,091)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,422)		\$	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))	\$ (36,422)		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

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

ID# 0036012

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To eliminate non-care related expenses	\$ (875)	20	1
2	To eliminate non-care related expenses	(5,226)	25	2
3	To eliminate 2019 IDPH license paid in 2018	(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	(8,091)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Home# 0036012

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	(679)	0	0	0	0	0	0	0	0	0	0	(679)	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	(679)	0	0	0	0	0	0	0	0	0	0	(679)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,685)	0	0	0	0	0	0	0	0	0	0	(3,685)	19
20	Fees, Subscriptions & Promotions	(17,055)	0	0	0	0	0	0	0	0	0	0	(17,055)	20
21	Clerical & General Office Expenses	(1,065)	0	0	0	0	0	0	0	0	0	0	(1,065)	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	(5,226)	0	0	0	0	0	0	0	0	0	0	(5,226)	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	(27,031)	0	0	0	0	0	0	0	0	0	0	(27,031)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,710)	0	0	0	0	0	0	0	0	0	0	(27,710)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(3,904)	0	0	0	0	0	0	0	0	0	0	(3,904) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(4,808)	0	0	0	0	0	0	0	0	0	0	(4,808) 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	(8,712)	0	0	0	0	0	0	0	0	0	0	(8,712) 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)	(36,422)	0	0	0	0	0	0	0	0	0	0	(36,422) 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				
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.

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Hom # 0036012 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		9	22.00	Salary	\$ 12,000	17,1	1
2	Steve Macaluso	Owner		25.00		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	\$ 30,382		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 Caring First, Inc. d/b/a Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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

0036012

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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		8	9	10					
		Related**					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	\$ 1,917,602	10/1/35	0.0385	\$ 75,506	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	\$ 1,917,602			\$ 77,884	9				
B. Non-Facility Related*																
10												10				
11	Interest Income Offset		X								(4,808)	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (4,808)	14				
15	TOTALS (line 9+line14)						\$ 2,469,400	\$ 1,917,602			\$ 73,076	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,860 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 2017 report.	\$	53,000	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.)	\$	51,504	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,496)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	53,000	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.	\$	51,504	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	44,890	8
	2014	44,586	9
	2015	50,648	10
	2016	51,232	11
	2017	51,504	12

The accrual used on line 4 was based on the 2017 tax year.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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' PREPARATION REPORT

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Home

0036012

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,286 B. General Construction Type: Exterior Masonry Frame Reinforced Concrete Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>174,242</u>	<u>1990</u>	<u>\$ 15,400</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	174,242		\$ 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		\$ 55,578	\$	\$ 1,600,167	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beg. Balance		1990		10,000	317	31.5	317		9,140	9
10											10
11	Interior Renovation		1990		1,292	41	31.5	41		1,150	11
12	Air Conditioner Pad		1990		2,645		15			2,645	12
13	Handrails		1991		4,884	155	31.5	155		4,271	13
14	Soffits & Siding		1991		11,204	356	31.5	356		9,851	14
15	Plastering		1992		1,952	62	31.5	62		1,596	15
16	Laundry Improvements		1994		1,162	30	27	43	13	1,069	16
17	Front Door		1994		1,368	35	10		(35)	1,368	17
18	Electric Wiring		1994		9,131	234	20		(234)	9,131	18
19	Back Patio		1994		5,137		10			5,137	19
20	Front Parking Lot		1994		80,603		10			80,603	20
21	Lighting & Ceiling Fans		1994		2,110		10			2,110	21
22	Plumbing		1994		4,528	116	20		(116)	4,528	22
23	Ceiling Tile		1994		614	16	12		(16)	614	23
24	Window Blinds		1995		6,010		20			6,010	24
25	Land Improvements		1995		1,224		10			1,224	25
26	Sign		1995		2,455		12			2,455	26
27	Parking Lot Lighting		1995		7,456		15			7,456	27
28	Flag Pole		1995		1,511		20			1,511	28
29	Landscaping		1996		2,927		10			2,927	29
30	Kitchen Renovations		1996		13,339		25	534	534	12,005	30
31	Window Screens		1996		914		25			914	31
32	Remodel Nurses Stations		1996		1,077		25	43	43	969	32
33	Reception Rom Addition		1996		3,721		25	149	149	3,349	33
34	Doors - Alzheimer Unit		1996		1,030		25	41	41	927	34
35	Fence		1997		1,141		15			1,141	35
36	Fixtures		1997		2,835		10			2,835	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 Caring First, Inc. d/b/a Breese Nursing Home

0036012

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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

	1	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	New Windows	2000	\$ 35,000	\$ 897	10		\$ (897)	\$ 35,000	37
38	Light Fixtures	2000	1,500	38	10		(38)	1,500	38
39	Sink Fixtures	2000	7,350	188	20	367	179	6,983	39
40	Air Handling Unit	2000	3,000	77	15		(77)	3,000	40
41	Rear Parking Unit	2000	44,000		15			44,000	41
42	Dumpster Pad	2000	900		15			900	42
43	Grab Bars	2002	4,800	123	15		(123)	4,800	43
44	Truck Point	2002	1,000	26	15		(26)	1,000	44
45	RegROUT	2002	1,500	38	15		(38)	1,500	45
46	Air Handler	2002	3,000	77	15		(77)	3,000	46
47	Remodel Spravout Room	2002	2,481	64	15		(64)	2,481	47
48	Drainage	2002	1,500	31	15		(31)	1,500	48
49	Floor Tile	2004	47,390	1,215	10		(1,215)	47,390	49
50	Door Alarm	2004	6,074	156	10		(156)	6,074	50
51	Telephone & Intercom System	2006	6,736		10			6,736	51
52	Concrete Sidewalks	2006	6,960	464	15	464		5,723	52
53	Fire Alarm	2011	18,582	1,858	10	1,858		13,317	53
54	Roof Repair	2011	35,195	3,520	10	902	(2,618)	6,317	54
55	Sprinkler	2011	78,346	3,134	25	3,134		22,459	55
56	Water Softener	2011	8,960	896	10	896		6,421	56
57	Roof Repair	2012	137,503	13,750	10	13,750		82,502	57
58	Sprinkler	2012	52,000	2,080	25	2,080		14,040	58
59	Door Knobs	2012	250	25	10	25		175	59
60	Water Heater	2013	5,295	530	10	530		3,089	60
61	3 Ton Air Handler	2013	1,945	195	10	195		1,135	61
62	Roof Repairs	2013	12,999	1,300	10	1,300		7,474	62
63	2 Water Heaters	2013	10,590	1,059	10	1,059		6,089	63
64	Rooftop Unit with heat pump	2014	6,780	678	10	678		3,221	64
65	Water Heater	2014	5,295	530	10	530		2,427	65
66	American Standard A/C Economizer	2016	12,090	1,209	10	1,209		3,023	66
67	HVAC System	2017	9,875	658	15	658		1,042	67
68	Water Heater	2017	5,295	530	10	530		1,015	68
69	Prepped & Painted All Hallways & Doorjamb	2018	6,200	310	5	310		310	69
70	TOTAL (lines 4 thru 69)		\$ 2,513,356	\$ 92,596		\$ 87,794	\$ (4,802)	\$ 2,122,746	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,513,356	\$ 92,596		\$ 87,794	\$ (4,802)	\$ 2,122,746	1
2	Replaced Sewer Line at West Side Nurses Station	2018	5,126	313	15	313		313	2
3	Wiring of Wall Heaters throughout Building	2018	5,575	341	15	341		341	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	TOTAL (lines 1 thru 33)		\$ 2,524,057	\$ 93,250		\$ 88,448	\$ (4,802)	\$ 2,123,400	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	\$ 97,180	\$ 8,466	\$ 9,364	\$ 898	5-20 yrs	\$ 50,046	71
72	Current Year Purchases	11,127	654	654		5-20 yrs	654	72
73	Fully Depreciated Assets	415,949					415,949	73
74								74
75	TOTALS	\$ 524,256	\$ 9,120	\$ 10,018	\$ 898		\$ 466,649	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	Facility	Van	2017	6,694	1,338	1,338		5	2,120	77
78										78
79										79
80	TOTALS			\$ 16,194	\$ 1,338	\$ 1,338	\$		\$ 11,620	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)	\$ 3,079,907	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 103,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,804	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,904)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,601,669	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 N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section N/A

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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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?

YES NO

16. Rental Amount for movable equipment: \$ 1,646

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 N/A</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 prescripts				57,665		57,665	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				352,744			352,744	13
14	TOTAL			\$		\$ 352,744	\$ 57,665		\$ 410,409	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 367,644	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (155,000))	789,118		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	31,744		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)	\$ 1,206,006	\$	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	2,506,445		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	540,879		16
17	Accumulated Depreciation (book methods)	(2,536,425)		17
18	Deferred Charges	39,828		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)	\$ 566,127	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,772,133	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 353,760	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,523		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,329		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,000		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)	\$ 543,612	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,917,602		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)	\$ 1,917,602	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,461,214	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (689,081)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,772,133	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (588,305)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (588,305)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(100,776)	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)	\$ (100,776)	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)	\$ (689,081)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Caring First, Inc. d/b/a Breese Nursing Home

0036012

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,319,778	1
2	Discounts and Allowances for all Levels	(37,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,282,651	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	589,317	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 589,317	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		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	74,747	19
20	Radiology and X-Ray	9,983	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 84,730	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,808	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,808	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous - MPIC Capital Reimb and Other	27,522	28
28a	Meals	679	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,201	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,989,707	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	658,979	31
32	Health Care	1,871,958	32
33	General Administration	709,641	33
B. Capital Expense			
34	Ownership	257,602	34
C. Ancillary Expense			
35	Special Cost Centers	410,409	35
36	Provider Participation Fee	181,894	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,090,483	40
41	Income before Income Taxes (line 30 minus line 40)**	(100,776)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (100,776)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,360,170	44
45	Private Pay - Net Inpatient Revenue	1,362,572	45
46	Medicare - Net Inpatient Revenue	514,397	46
47	Other-(specify) <u>Insurance</u>	45,512	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,282,651	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Caring First, Inc. d/b/a Breese Nursing Home

0036012

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	2,806	2,827	\$ 62,788	\$ 22.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,675	9,870	248,698	25.20	3
4	Licensed Practical Nurses	36,836	37,519	553,751	14.76	4
5	CNAs & Orderlies	80,883	82,480	765,795	9.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,813	3,853	43,895	11.39	10
11	Social Service Workers	2,603	2,629	47,347	18.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,706	13,096	151,491	11.57	15
16	Dishwashers					16
17	Maintenance Workers	3,432	3,472	59,737	17.21	17
18	Housekeepers	5,665	5,834	58,410	10.01	18
19	Laundry	4,702	4,858	53,154	10.94	19
20	Administrator	2,050	2,066	53,399	25.85	20
21	Assistant Administrator					21
22	Other Administrative	1,196	1,196	28,849	24.12	22
23	Office Manager					23
24	Clerical	5,077	5,116	101,250	19.79	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	1,634	1,634	17,676	10.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,078	176,450	\$ 2,246,240 *	\$ 12.73	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	\$ 5,887	1,3	35
36	Medical Director	Contract 14,250	9,3	36
37	Medical Records Consultant	700	10,3	37
38	Nurse Consultant	5,925	10,3	38
39	Pharmacist Consultant	Contract 1,764	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 1,541	11,3	44
45	Social Service Consultant	Contract 1,541	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 31,608		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

