

		FOR BHF USE					

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**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2020)**

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><b>I. IDPH License ID Number:</b> <u>0036012</u></p> <p><b>Facility Name:</b> <u>Breese Nursing Home</u></p> <p><b>Address:</b> <u>1155 North First St</u> <u>Breese</u> <u>62230</u>        Number City Zip Code</p> <p><b>County:</b> <u>Clinton</u></p> <p><b>Telephone Number:</b> <u>(618) 526-4521</u> Fax # <u>(618) 526-2833</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>03/09/1990</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Cindy A. Tefteller</u> <b>Telephone Number:</b> <u>(618) 465-7717</u>  <b>Email Address:</b> _____</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 type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Martha Jackson</u> (Title) <u>Administrator, Breese Nursing Home</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name &amp; Address) <u>C.J. Schlosser &amp; Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p align="right"><b>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</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martha Jackson</u> (Title) <u>Administrator, Breese Nursing Home</u>	Paid Preparer	(Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name & Address) <u>C.J. Schlosser &amp; Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Breese Nursing Home

# 0036012 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

**III. STATISTICAL DATA**

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

	1	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	922	2,656	751	4,329	8
9	SNF/PED					9
10	ICF	3,889	6,792	86	10,767	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,811	9,448	837	15,096	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 36.83%**

**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 651

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: 12/31/2020 Fiscal Year: 12/31/2020

\* 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: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	141,748		5,167	146,915		146,915		146,915		1
2	Food Purchase		118,806		118,806		118,806		118,806		2
3	Housekeeping	101,280	13,529		114,809		114,809		114,809		3
4	Laundry	62,298	9,584		71,882		71,882		71,882		4
5	Heat and Other Utilities			93,642	93,642		93,642		93,642		5
6	Maintenance		10,002	54,038	64,040		64,040		64,040		6
7	Other (specify):* <b>Trash/Medical Waste Removal</b>			12,225	12,225		12,225		12,225		7
8	<b>TOTAL General Services</b>	305,326	151,921	165,072	622,319		622,319		622,319		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,110	7,110		7,110		7,110		9
10	Nursing and Medical Records	1,393,698	150,095	3,016	1,546,809		1,546,809		1,546,809		10
10a	Therapy										10a
11	Activities	34,292	1,903	1,557	37,752		37,752		37,752		11
12	Social Services	1,233		1,557	2,790		2,790		2,790		12
13	CNA Training										13
14	Program Transportation	5,369			5,369		5,369		5,369		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,434,592	151,998	13,240	1,599,830		1,599,830		1,599,830		16
	<b>C. General Administration</b>										
17	Administrative	116,449			116,449		116,449		116,449		17
18	Directors Fees										18
19	Professional Services			51,252	51,252		51,252		51,252		19
20	Dues, Fees, Subscriptions & Promotions			14,905	14,905		14,905	(11,240)	3,665		20
21	Clerical & General Office Expenses	35,762	7,239	71,938	114,939		114,939	(1,202)	113,737		21
22	Employee Benefits & Payroll Taxes			264,035	264,035		264,035		264,035		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation		3,870		3,870		3,870	(3,870)			25
26	Insurance-Prop.Liab.Malpractice			82,624	82,624		82,624		82,624		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	152,211	11,109	484,754	648,074		648,074	(16,312)	631,762		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,892,129	315,028	663,066	2,870,223		2,870,223	(16,312)	2,853,911		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			107,853	107,853		107,853	(4,419)	103,434		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			71,490	71,490		71,490	(1,391)	70,099		32
33	Real Estate Taxes			50,978	50,978		50,978		50,978		33
34	Rent-Facility & Grounds			24,000	24,000		24,000		24,000		34
35	Rent-Equipment & Vehicles			3,412	3,412		3,412		3,412		35
36	Other (specify):* Mortgage Insurance			9,062	9,062		9,062		9,062		36
37	<b>TOTAL Ownership</b>			266,795	266,795		266,795	(5,810)	260,985		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		21,464	94,760	116,224		116,224		116,224		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			160,776	160,776		160,776		160,776		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		21,464	255,536	277,000		277,000		277,000		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,892,129	336,492	1,185,397	3,414,018		3,414,018	(22,122)	3,391,896		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

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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				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	(4,419)	30		9
10	Interest and Other Investment Income	(1,391)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,202)	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	(225)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,808)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,217)	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	(5,860)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (22,122)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (22,122)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To Eliminate Non-Care Related Expenses	\$ (3,870)	25	1
2	To Eliminate 2021 IDPH License Paid in 2020	(1,990)	20	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,860)		49

**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 Macluso	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:

01/01/2020

Ending:

12/31/2020

**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 &amp; ID Number

Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

## 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	Administrative	75.00		9	22.00	Salary	\$ 22,615	17, 1	1
2	Steve Macaluso	Owner	Administrative	25.00		14	34.00	Salary	28,427	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	\$ 51,042		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: 01/01/2020 Ending: 2/31/2020

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

Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Gershman Investment Group		X	Refinance Mortgage	\$12,959.60	9/1/10	\$ 2,469,400	\$ 1,748,055	10/1/35	0.0385	\$ 69,112	1								
2							Amortization of Loan Costs				2,378	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$12,959.60		\$ 2,469,400	\$ 1,748,055			\$ 71,490	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11	Interest Income Offset		X								(1,391)	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (1,391)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,469,400	\$ 1,748,055			\$ 70,099	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 9,062      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 2019 report.		\$	<b>48,500</b>	<b>1</b>
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.)		\$	<b>48,478</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(22)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>51,000</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,978</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<u>50,648</u>	<u>8</u>	
	2016	<u>51,232</u>	<u>9</u>	
	2017	<u>51,504</u>	<u>10</u>	
	2018	<u>52,900</u>	<u>11</u>	
	2019	<u>48,478</u>	<u>12</u>	
<b>The accrual used on line 4 was based on the 2020 tax year.</b>				
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2019	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Breese Nursing Home COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036012

CONTACT PERSON REGARDING THIS REPORT Cindy Tefteller

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>06-06-22-252-008</u>	<u>Sec 22 Twp 2N Rng 4W PT W 1/2 N</u>	\$ <u>48,477.84</u>	\$ <u>48,477.84</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>48,477.84</u></u>	\$ <u><u>48,477.84</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**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:

01/01/2020 Ending:

12/31/2020

**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

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

If so, please complete the following:

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

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	\$	\$ 1,711,322	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Beg. Balance		1990		10,000	317	31.5	317		9,774	9
10											10
11	Interior Renovation		1990		1,292	41	31.5	41		1,231	11
12	Air Conditioner Pad		1990		2,645		15			2,645	12
13	Handrails		1991		4,884	155	31.5	155		4,581	13
14	Soffits & Siding		1991		11,204	356	31.5	356		10,563	14
15	Plastering		1992		1,952	62	31.5	62		1,719	15
16	Laundry Improvements		1994		1,162	30	27	43	13	1,155	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	13,072	30
31	Window Screens		1996		914		25			914	31
32	Remodel Nurses Stations		1996		1,077		25	43	43	1,055	32
33	Reception Room Addition		1996		3,721		25	149	149	3,646	33
34	Doors - Alzheimer Unit		1996		1,030		25	41	41	1,010	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 &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

**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	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		(188)	7,350	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 Sprayout Room	2002	2,481	64	15		(64)	2,481	47
48	Drainage	2002	1,500		15			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		6,651	52
53	Fire Alarm	2011	18,582	1,858	10	1,858		17,033	53
54	Roof Repair	2011	35,195	3,520	10	902	(2,618)	8,122	54
55	Sprinkler	2011	78,346	3,134	25	3,134		28,727	55
56	Water Softener	2011	8,960	896	10	896		8,213	56
57	Roof Repair	2012	137,503	13,750	10	13,750		110,002	57
58	Sprinkler	2012	52,000	2,080	25	2,080		18,200	58
59	Door Knobs	2012	250	25	10	25		225	59
60	Water Heater	2013	5,295	530	10	530		4,148	60
61	3 Ton Air Handler	2013	1,945	195	10	195		1,524	61
62	Roof Repairs	2013	12,999	1,300	10	1,300		10,074	62
63	2 Water Heaters	2013	10,590	1,059	10	1,059		8,207	63
64	Rooftop Unit with Heat Pump	2014	6,780	678	10	678		4,577	64
65	Water Heater	2014	5,295	530	10	530		3,486	65
66	American Standard A/C Economizer	2016	12,090	1,209	10	1,209		5,441	66
67	HVAC System	2017	9,875	658	15	658		2,359	67
68	Water Heater	2017	5,295	530	10	530		2,074	68
69	Prepped & Painted All Hallways & Doorjamb	2018	6,200	1,240	5	1,240		2,790	69
70	TOTAL (lines 4 thru 69)		\$ 2,513,356	\$ 93,495		\$ 88,357	\$ (5,138)	\$ 2,299,821	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		\$ 2,513,356	\$ 93,495		\$ 88,357	\$ (5,138)	\$ 2,299,821	1
2	Replaced Sewer Line at West Side Nurses Station	2018	5,126	342	15	342		997	2
3	Wiring of Wall Heaters throughout Building	2018	5,575	372	15	372		1,084	3
4	Replace all Bathroom Faucets	2019	13,225	661	20	661		1,212	4
5	100 Gal. Commercial Water Heater	2020	5,625	141	10	141		141	5
6	Digital Mixing Valve Install Water Distrib	2020	4,395	36	10	36		37	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)		\$ 2,547,302	\$ 95,047		\$ 89,909	\$ (5,138)	\$ 2,303,292	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	\$ 112,158	\$ 11,468	\$ 12,187	\$ 719	5-20 yrs	\$ 69,898	71
72	Current Year Purchases					5-20 yrs		72
73	Fully Depreciated Assets	420,622					420,622	73
74								74
75	TOTALS	\$ 532,780	\$ 11,468	\$ 12,187	\$ 719		\$ 490,520	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	4,797	77
78										78
79										79
80	TOTALS			\$ 16,194	\$ 1,338	\$ 1,338	\$		\$ 14,297	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)	\$ 3,111,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,853	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,434	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,419)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,808,109	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

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 3,412

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	<b>TOTAL</b>		\$	\$	21

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

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

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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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				21,464		21,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab, X-Ray, Therapy	39, 3				94,760			94,760	13
14	TOTAL			\$		\$ 94,760	\$ 21,464		\$ 116,224	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

Facility Name & ID Number Breese Nursing Home  
 XV. BALANCE SHEET - Unrestricted Operating Fund.

# 0036012  
 As of 12/31/2020

Report Period Beginning: 01/01/2020  
 (last day of reporting year)

Ending: 12/31/2020

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 303,949	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 42,201 )	492,337		3
4	Supply Inventory (priced at )	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,818		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 838,604	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,400		13
14	Buildings, at Historical Cost	2,529,690		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	549,403		16
17	Accumulated Depreciation (book methods)	(2,751,340)		17
18	Deferred Charges	35,072		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	487,693		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 865,918	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,704,522	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 302,172	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,841		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,046		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
	<b>Other Current Liabilities(specify):</b>			
36	Shareholder Loan	89,203		36
37	PPP Loan	471,400		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,013,662	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,748,055		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,748,055	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,761,717	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,057,195)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,704,522	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(931,516)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Audit adjustments made after cost report issued</b>	<b>(51,685)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(983,201)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(73,994)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(73,994)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,057,195)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,772,677	1
2	Discounts and Allowances for all Levels	(137,724)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,634,953	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	40,365	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 40,365	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,391	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,391	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>CARES Funds</b>	660,769	28
28a	<b>Miscellaneous</b>	2,546	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 663,315	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,340,024	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	622,319	31
32	Health Care	1,599,830	32
33	General Administration	648,074	33
<b>B. Capital Expense</b>			
34	Ownership	266,795	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	116,224	35
36	Provider Participation Fee	160,776	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,414,018	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(73,994)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (73,994)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 701,443	44
45	Private Pay - Net Inpatient Revenue	1,567,133	45
46	Medicare - Net Inpatient Revenue	350,350	46
47	Other-(specify) <u>Insurance</u>	16,027	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,634,953	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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: 01/01/2020

Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,770	1,905	\$ 64,814	\$ 34.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,588	10,448	323,759	30.99	3
4	Licensed Practical Nurses	13,170	14,735	390,272	26.49	4
5	CNAs & Orderlies	33,550	36,665	612,224	16.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,054	2,216	34,292	15.47	10
11	Social Service Workers	53	75	1,233	16.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,113	10,117	141,748	14.01	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	7,823	8,532	101,280	11.87	18
19	Laundry	3,989	4,456	62,298	13.98	19
20	Administrator	2,097	2,097	65,406	31.19	20
21	Assistant Administrator					21
22	Other Administrative	1,726	1,726	51,043	29.57	22
23	Office Manager					23
24	Clerical	1,888	2,094	35,762	17.08	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	271	271	2,629	9.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Van Driver</u>	374	376	5,369	14.28	33
34	TOTAL (lines 1 - 33)	87,466	95,713	\$ 1,892,129 *	\$ 19.77	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	\$ 5,167	1, 3	35
36	Medical Director	Contract 7,110	9, 3	36
37	Medical Records Consultant	326	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Contract 1,509	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 1,557	11, 3	44
45	Social Service Consultant	Contract 1,557	12, 3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,226		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: 01/01/2020

Ending: 12/31/2020

**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	\$ 22,615	Workers' Compensation Insurance	\$ 63,446	IDPH License Fee	\$ 1,990				
Steve Macaluso	Owner	25	28,427	Unemployment Compensation Insurance	7,314	Advertising: Employee Recruitment					
Martha Jackson	Administrator	0	65,407	FICA Taxes	139,622	Health Care Worker Background Check	300				
				Employee Health Insurance	50,053	(Indicate # of checks performed )					
				Employee Meals		Patient Background Checks					
				Illinois Municipal Retirement Fund (IMRF)*		Dues, Subscriptions, & Licenses	1,375				
				Employee Appreciation	3,600						
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 116,449								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				TOTAL (agree to Sch. V, line 20, col. 8)			
Description		Amount		Description		Amount		Less: Public Relations Expense		( )	
Section N/A		\$		Section N/A		\$		Non-allowable advertising		( )	
								Yellow page advertising		( )	
TOTAL (agree to Schedule V, line 17, col. 3)		\$									
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount		Description		Amount	
Archford Accounting	Accounting	\$ 60		Section N/A		\$		Out-of-State Travel		\$	
C.J. Schlosser & Company, LLC	Accounting	34,233						Section N/A			
Paychex	Payroll Services	15,971									
Giffin, Winning, Bodewes	Legal Fees	988						In-State Travel			
								Seminar Expense			
								Entertainment Expense		( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		(agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)			\$ 51,252					TOTAL		\$	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

**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. \$ 0 Line N/A
- (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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 160,776  
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? No Indicate the amount. \$ N/A
- (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, LLC
- (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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' PREPARATION REPORT**