

		FOR BHF USE					

LL1

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.

I. IDPH License ID Number: 0054841

Facility Name: Briar Place Nursing

Address: 6800 West Joliet Indian Head Park 60525
Number City Zip Code

County: Cook

Telephone Number: 708-246-8500 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2018

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mendel Schneider Telephone Number: (847)933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)		
	(Title)		
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	See Accountant's Report Attached	
	(Firm Name & Address)	Mendel Schneider CPA & Associates 4051 Old Orchard Road, Skokie, IL 60076	
	(Telephone)	(847)933-1274	Fax # (847)0933-1283
	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		

#	0054841	Report Period Beginning:	01/01/2020	Ending:	12/31/2020
---	---------	--------------------------	------------	---------	------------

D. How many bed reserve days during this year were paid by the Department?

(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 02/01/2018

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/01/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number

of beds certified **88** **and days of care provided** **4,194**

Medicare Intermediary National Government Services

MODIFIED

ACCRUAL	X	CASH*		CASH*	
---------	---	-------	--	-------	--

CASH* ☐

CASH* ☐

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

Tax Year: 12/31 **Fiscal Year:** 12/31

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

B. Census-For the entire report period.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **90.18%**

Facility Name & ID Number Briar Place Nursing # 0054841 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	
	A. General Services											
1	Dietary	375,527	31,086	11,656	418,269		418,269		418,269			1
2	Food Purchase		348,433		348,433		348,433	(382)	348,051			2
3	Housekeeping	248,244	189,583	16,292	454,119		454,119		454,119			3
4	Laundry	27,223		125,312	152,535		152,535		152,535			4
5	Heat and Other Utilities			184,830	184,830		184,830		184,830			5
6	Maintenance	74,865		51,003	125,868		125,868	243	126,111			6
7	Other (specify):* Security Wages	73,299			73,299		73,299		73,299			7
8	TOTAL General Services	799,158	569,102	389,093	1,757,353		1,757,353	(139)	1,757,214			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,061,373	302,246	235,510	3,599,129		3,599,129	(92,228)	3,506,901			10
10a	Therapy											10a
11	Activities	108,580	7,647		116,227		116,227		116,227			11
12	Social Services	397,232		448	397,680		397,680		397,680			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,706	9,706			15
16	TOTAL Health Care and Programs	3,567,185	309,893	259,958	4,137,036		4,137,036	(82,522)	4,054,514			16
	C. General Administration											
17	Administrative	249,790		926,127	1,175,917		1,175,917	(818,521)	357,396			17
18	Directors Fees											18
19	Professional Services			27,351	27,351		27,351	12,896	40,247			19
20	Dues, Fees, Subscriptions & Promotions			83,536	83,536		83,536	77	83,613			20
21	Clerical & General Office Expenses	128,361	36,315	341,041	505,717		505,717	193,663	699,380			21
22	Employee Benefits & Payroll Taxes			623,466	623,466		623,466		623,466			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,540	4,540		4,540		4,540			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			324,671	324,671		324,671		324,671			26
27	Other (specify):*							34,563	34,563			27
28	TOTAL General Administration	378,151	36,315	2,330,732	2,745,198		2,745,198	(577,322)	2,167,876			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,744,494	915,310	2,979,783	8,639,587		8,639,587	(659,983)	7,979,604			29

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

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			2,326	2,326		2,326	857,879	860,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,479	2,479		2,479	(2,479)				32
33	Real Estate Taxes			451,112	451,112		451,112		451,112			33
34	Rent-Facility & Grounds			1,335,117	1,335,117		1,335,117	8,816	1,343,933			34
35	Rent-Equipment & Vehicles			963	963		963		963			35
36	Other (specify):*											36
37	TOTAL Ownership			1,791,997	1,791,997		1,791,997	864,216	2,656,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,859	497,649	567,508		567,508		567,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			563,899	563,899		563,899		563,899			42
43	Other (specify):* Bad Debt Expense			155,772	155,772		155,772	(155,772)				43
44	TOTAL Special Cost Centers		69,859	1,217,320	1,287,179		1,287,179	(155,772)	1,131,407			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,744,494	985,169	5,989,100	11,718,763		11,718,763	48,461	11,767,224			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(3,172,049)	30		9
10	Interest and Other Investment Income	(9,672)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(382)	2		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				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	(155,772)	43		24
25	Fund Raising, Advertising and Promotional	(7,952)	19		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(55,130)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,400,957)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,449,418		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,449,418		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 48,461		37

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

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

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

Briar Place Nursing

ID# 0054841

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place Nursing

0054841

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	(382)	0	0	0	0	0	0	0	0	0	0	(382)	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	243	0	0	0	0	0	0	0	0	0	243	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(382)	243	0	0	0	0	0	0	0	0	0	(139)	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	126,872	(219,100)	0	0	0	0	0	0	0	0	(92,228)	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	9,706	0	0	0	0	0	0	0	0	0	9,706	15
16	TOTAL Health Care and Programs	0	136,578	(219,100)	0	0	0	0	0	0	0	0	(82,522)	16
	C. General Administration													
17	Administrative	0	107,606	(926,127)	0	0	0	0	0	0	0	0	(818,521)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,952)	20,848	0	0	0	0	0	0	0	0	0	12,896	19
20	Fees, Subscriptions & Promotions	0	77	0	0	0	0	0	0	0	0	0	77	20
21	Clerical & General Office Expenses	(55,130)	248,793	0	0	0	0	0	0	0	0	0	193,663	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	34,563	0	0	0	0	0	0	0	0	0	34,563	27
28	TOTAL General Administration	(63,082)	411,887	(926,127)	0	0	0	0	0	0	0	0	(577,322)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,464)	548,708	(1,145,227)	0	0	0	0	0	0	0	0	(659,983)	29

Facility Name & ID Number Briar Place Nursing # 0054841 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
Aaron Singer	33.34	Arista Healthcare	Naperville	Saba Healthcare	Skokie	Management
Moishe Blonder	33.33	Forest City Nursing & Rehab	Rockford	Saba Financial	Skokie	Management
Atied Corporation	33.33	Rock River Healthcare	Rockford			
		Pearl Pavillion	Freeport			
		Parc Of Joliet	Joliet			
		Spring Creek SNF	Joliet			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical Salaries	\$	Saba Healthcare		\$ 211,909	\$ 211,909	1
2	V	27	Payroll Taxes		Saba Healthcare		14,480	14,480	2
3	V	27	Employee Benifets		Saba Healthcare		20,083	20,083	3
4	V	10	Nursing salary		Saba Healthcare		126,872	126,872	4
5	V	20	Dues & Subs		Saba Healthcare		77	77	5
6	V	19	Professional Fees		Saba Healthcare		20,848	20,848	6
7	V	34	Rent		Saba Healthcare		16,009	16,009	7
8	V	6	Repairs & Maintenance		Saba Healthcare		243	243	8
9	V	21	Telephone		Saba Healthcare		1,697	1,697	9
10	V	17	Salary Blonder		Saba Healthcare		53,803	53,803	10
11	V	17	Salary Singer		Saba Healthcare		53,803	53,803	11
12	V	21	Admin & General Expenses		Saba Healthcare		35,187	35,187	12
13	V	15	Nursing Benifets		Saba Healthcare		9,706	9,706	13
14	Total			\$			\$ 564,717	\$ *	564,717 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$ 926,127	SABA HEALTHCARE		\$	\$ (926,127)	15
16	V	10	RN CONSULTANT	219,100	SABA HEALTHCARE			(219,100)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,145,227			\$ 0	\$ * (1,145,227)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Briar Realty		\$ 4,029,928	\$ 4,029,928	15
16	V	34	Rent	7,193	Briar Realty			(7,193)	16
17	V	32	Interest		Briar Realty		7,193	7,193	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,193			\$ 4,037,121	\$ * 4,029,928	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

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

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	Aaron Singer	Owner	Administrative	33.34	196,197	6.66	16.67	Mgmt Fee	\$ 53,803	17-7	1
2	Moshe Blonder	Owner	Administrative	33.33	196,197	6.66	16.67	Mgmt Fee	53,803	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 107,606		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.

Facility Name & ID Number Briar Place Nursing# 0054841 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

SABA HEALTHCARE

Street Address

3515 w Howard

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847)383-9104

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical Salaries	Number of Beds	1,078	6	\$ 984,647	\$ 984,647	232	\$ 211,909	1
2	27	Payroll Taxes	Number of Beds	1,078	6	67,280		232	14,480	2
3	27	Employee Benifets	Number of Beds	1,078	6	93,316		232	20,083	3
4	10	Nursing salary	Number of Beds	1,078	6	589,519	589,519	232	126,872	4
5	20	Dues & Subs	Number of Beds	1,078	6	356		232	77	5
6	19	Professional Fees	Number of Beds	1,078	6	96,869		232	20,848	6
7	34	Rent	Number of Beds	1,078	6	74,385		232	16,009	7
8	6	Repairs & Maintenance	Number of Beds	1,078	6	1,130		232	243	8
9	21	Telephone	Number of Beds	1,078	6	7,884		232	1,697	9
10	17	Salary Blonder	Number of Beds	1,078	6	250,000	250,000	232	53,803	10
11	17	Salary Singer	Number of Beds	1,078	6	250,000	250,000	232	53,803	11
12	21	Admin & General Expenses	Number of Beds	1,078	6	163,497		232	35,187	12
13	15	Nursing Benifets	Number of Beds	1,078	6	45,098		232	9,706	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					\$ 2,623,981	\$ 2,074,166		\$ 564,717	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Sellers note		X	Mortgage			\$	19,000,000			\$ 7,193	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST MIDWEST		X	Working Capital							2,479	6
7												7
8												8
9	TOTAL Facility Related						\$	19,000,000			\$ 9,672	9
	B. Non-Facility Related*											
10	Interest Income										(9,672)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (9,672)	14
15	TOTALS (line 9+line14)						\$	19,000,000			\$	15

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054841

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-20-102-035-0000</u>	<u>Nursing Home</u>	\$ <u>385,637.05</u>	\$ <u>385,637.05</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>385,637.05</u></u>	\$ <u><u>385,637.05</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 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,200

B. General Construction Type: Exterior Brick Frame

Number of Stories 5

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).

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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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	Facility	62,500	2020	\$ 1,900,000	1
2					2
3	TOTALS	62,500		\$ 1,900,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	232		2020		\$ 13,394,871	\$ 324,798	27.5	\$ 487,086	\$ 162,288	\$ 487,086	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Boiler		2019		24,800	1,240	20	1,240		1,343	9
10	Repiping Sewer in Kitchen		2020		7,100	225	20	225		225	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

*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

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,426,771	\$ 326,263		\$ 488,551	\$ 162,288	\$ 488,654	70

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	3,716,543	3,705,991	371,654	(3,334,337)		371,654	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,716,543	\$ 3,705,991	\$ 371,654	\$ (3,334,337)		\$ 371,654	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 19,043,314	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,032,254	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 860,205	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,172,049)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 860,308	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GWH Limited Partnership
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

X

NO
- If NO, see instructions.

		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:	1976	232	02/01/2018	\$ 1,327,924			3
4	Additions							4
5	Allocated from Saba				8,816			5
6								6
7	TOTAL		232		\$ 1,336,740			7

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

9. Option to Buy:

YES

NO

 Terms: *

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: \$ 963 Description: Medical Equipment rental
- (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			\$	\$	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.

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	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 232,005	\$		\$ 232,005	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			62,585			62,585	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			203,059			203,059	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				54,173		54,173	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab&Xray	39-2					15,686		15,686	12
13	Other (specify):									13
14	TOTAL			\$		\$ 497,649	\$ 69,859		\$ 567,508	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.

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	\$ 3,520,958	\$ 3,520,958	1
2	Cash-Patient Deposits	212,288	212,288	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,256,389	2,256,389	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,022	72,022	6
7	Other Prepaid Expenses	152,365	152,365	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Parties	179,258	179,258	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,393,280	\$ 6,393,280	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,900,000	13
14	Buildings, at Historical Cost		13,394,871	14
15	Leasehold Improvements, at Historical Cost	31,900	31,900	15
16	Equipment, at Historical Cost	11,414	3,716,543	16
17	Accumulated Depreciation (book methods)	(2,430)	(4,032,357)	17
18	Deferred Charges			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)	\$ 40,884	\$ 15,010,957	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,434,164	\$ 21,404,237	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,695	\$ 213,695	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	208,288	208,288	28
29	Short-Term Notes Payable	1,176,043	1,176,043	29
30	Accrued Salaries Payable	309,733	309,733	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,091	14,091	31
32	Accrued Real Estate Taxes(Sch.IX-B)	471,036	471,036	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	213,754	213,754	35
	Other Current Liabilities(specify):			
36	Deferred Provider Relief Funds	886,654	886,654	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,493,294	\$ 3,493,294	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		19,000,000	39
40	Mortgage Payable			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)	\$	\$ 19,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,493,294	\$ 22,493,294	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,940,870	\$ (1,089,057)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,434,164	\$ 21,404,237	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,462,462	1
2	Restatements (describe):		2
3	Prior Period Adjustment	28,785	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,491,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,289,623	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	(2,840,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,449,623	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)	\$ 2,940,870	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Briar Place Nursing

0054841

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,258,713	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,258,713	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,949	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,949	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gov Stimulus Income</u>	731,724	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 731,724	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,008,386	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,757,353	31
32	Health Care	4,137,036	32
33	General Administration	2,745,198	33
	B. Capital Expense		
34	Ownership	1,791,997	34
	C. Ancillary Expense		
35	Special Cost Centers	723,280	35
36	Provider Participation Fee	563,899	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,718,763	40
41	Income before Income Taxes (line 30 minus line 40)**	4,289,623	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,289,623	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 12,297,997	44
45	Private Pay - Net Inpatient Revenue	79,464	45
46	Medicare - Net Inpatient Revenue	2,468,952	46
47	Other-(specify) <u>Medicare B</u>	173,755	47
48	Other-(specify) <u>Veterans</u>	238,545	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,258,713	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, cash basis 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.

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	4,637	4,857	\$ 199,807	\$ 41.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,460	15,046	587,667	39.06	3
4	Licensed Practical Nurses	34,050	35,861	1,126,857	31.42	4
5	CNAs & Orderlies	60,084	63,045	1,110,848	17.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,121	1,142	19,764	17.31	8
9	Activity Director	2,046	2,246	35,999	16.03	9
10	Activity Assistants	6,123	6,330	72,581	11.47	10
11	Social Service Workers	19,108	19,904	397,232	19.96	11
12	Dietician					12
13	Food Service Supervisor	2,019	2,123	68,477	32.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,557	21,222	307,050	14.47	15
16	Dishwashers					16
17	Maintenance Workers	3,772	4,050	74,865	18.49	17
18	Housekeepers	17,766	19,010	248,244	13.06	18
19	Laundry	1,213	1,474	27,223	18.47	19
20	Administrator	4,808	5,192	249,790	48.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,624	4,848	128,361	26.48	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	939	947	16,430	17.35	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	4,537	4,754	73,299	15.42	33
34	TOTAL (lines 1 - 33)	200,864	212,051	\$ 4,744,494 *	\$ 22.37	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	Monthly	\$ 11,656	1-3	35
36	Medical Director	Monthly	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	219,100	10-3	38
39	Pharmacist Consultant	Monthly	16,410	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				44
45	Social Service Consultant	10	448	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	10	\$ 271,614		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

0054841

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

Facility Name & ID Number

Briar Place Nursing

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lawanda Bradley	Administrative		\$ 147,415
Nesanel Cohen	Administrative		32,097
Beatriz Mora	Administrative		70,278
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 249,790

B. Administrative - Other

Description	Amount
Saba Healthcare	\$ 926,127
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 926,127

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	\$ 9,500
M&Y Reporting	Insurance reporting	1,167
Gulko Schwed	Legal	676
O'Hagon Meyer	Legal	2,500
Line of Credit Legal	Legal	881
Personnel Planners	Ui Tax Consultant	1,475
Abbey Road	Legal	5,421
Vcorp	Incorporation	115
Mcabe Kirshner	Legal	4,375
Zimmet	PDPM Consulting	1,241
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 27,351

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 83,583
Unemployment Compensation Insurance	25,625
FICA Taxes	353,475
Employee Health Insurance	160,783
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 623,466

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

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	1,963
Health Care Worker Background Check (Indicate # of checks performed)	2,571
Patient Background Checks	1,155
Village of Indian Head Park	28,090
Health Care Council Of Illinois	36,146
Advertising	7,952
Misc License	9,708
Less: Public Relations Expense	()
Non-allowable advertising	(7,952)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 83,613

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,540
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,540

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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? Yes
If YES, give association name and amount. Health Care Council Of Illinois 36,146
- (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? _____
- (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? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,913 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 563,899
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? Yes
- (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. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.