

		FOR BHF USE				

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**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0054841</u></p> <p>Facility Name: <u>BRIAR PLACE NURSING</u></p> <p>Address: <u>6800 Joliet Road</u> <u>Indian Head Park</u> <u>60525</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>708-246-8500</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/01/2018</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mendel Schneider</u> Telephone Number: <u>847-933-1274</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/2018</u> to <u>12/31/2018</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%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>See Accountant's reprt Attached</u> (Firm Name & Address) <u>Mendel S Schneider CPA & Associates</u> <u>4051 Old Orchard Road, Skokie, IL 60076</u> (Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>See Accountant's reprt Attached</u> (Firm Name & Address) <u>Mendel S Schneider CPA & Associates</u> <u>4051 Old Orchard Road, Skokie, IL 60076</u> (Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>See Accountant's reprt Attached</u> (Firm Name & Address) <u>Mendel S Schneider CPA & Associates</u> <u>4051 Old Orchard Road, Skokie, IL 60076</u> (Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>							

Facility Name & ID Number **BRIAR PLACE NURSING**

0054841 Report Period Beginning: **02/01/2018** Ending: **12/31/2018**

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	29,392	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	48,096	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	77,488	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,328		2,651	19,979	8
9	SNF/PED					9
10	ICF	45,899	179	2,018	48,096	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,227	179	4,669	68,075	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.85%

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 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 2,651

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED 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.

Facility Name & ID Number

BRIAR PLACE NURSING

0054841

Report Period Beginning:

02/01/2018

Ending:

12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	344,924	18,310	13,581	376,815		376,815		376,815		1
2	Food Purchase		343,912		343,912		343,912	(417)	343,495		2
3	Housekeeping	173,695	22,292		195,987		195,987		195,987		3
4	Laundry	29,991		111,514	141,505		141,505		141,505		4
5	Heat and Other Utilities			168,998	168,998		168,998		168,998		5
6	Maintenance	62,289		52,105	114,394		114,394	1,790	116,184		6
7	Other (specify):* Security	85,927			85,927		85,927		85,927		7
8	TOTAL General Services	696,826	384,514	346,198	1,427,538		1,427,538	1,373	1,428,911		8
	B. Health Care and Programs										
9	Medical Director			18,700	18,700		18,700		18,700		9
10	Nursing and Medical Records	2,450,995	103,094	140,310	2,694,399		2,694,399	11,969	2,706,368		10
10a	Therapy										10a
11	Activities	88,783	5,039		93,822		93,822		93,822		11
12	Social Services	242,979		2,560	245,539		245,539		245,539		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Allocated benefets							3,051	3,051		15
16	TOTAL Health Care and Programs	2,782,757	108,133	161,570	3,052,460		3,052,460	15,020	3,067,480		16
	C. General Administration										
17	Administrative	155,341		597,554	752,895		752,895	(393,061)	359,834		17
18	Directors Fees										18
19	Professional Services			39,731	39,731		39,731	1,048	40,779		19
20	Dues, Fees, Subscriptions & Promotions			51,128	51,128		51,128	(1,097)	50,031		20
21	Clerical & General Office Expenses	125,931	12,398	207,722	346,051		346,051	198,892	544,943		21
22	Employee Benefits & Payroll Taxes			528,076	528,076		528,076		528,076		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,390	6,390		6,390	7,680	14,070		24
25	Other Admin. Staff Transportation			3,633	3,633		3,633	3,134	6,767		25
26	Insurance-Prop.Liab.Malpractice			314,166	314,166		314,166	808	314,974		26
27	Other (specify):* Allocated benefets							41,879	41,879		27
28	TOTAL General Administration	281,272	12,398	1,748,400	2,042,070		2,042,070	(140,717)	1,901,353		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,760,855	505,045	2,256,168	6,522,068		6,522,068	(124,324)	6,397,744		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.

Facility Name & ID Number

BRIAR PLACE NURSING

#0054841

Report Period Beginning:

02/01/2018

Ending:

12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,837	44,837		44,837	(3,921)	40,916			32
33	Real Estate Taxes			394,271	394,271		394,271		394,271			33
34	Rent-Facility & Grounds			1,164,350	1,164,350		1,164,350	17,022	1,181,372			34
35	Rent-Equipment & Vehicles			2,959	2,959		2,959		2,959			35
36	Other (specify):*											36
37	TOTAL Ownership			1,606,417	1,606,417		1,606,417	13,101	1,619,518			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,285	485,380	528,665		528,665		528,665			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			508,346	508,346		508,346		508,346			42
43	Other (specify):* Bad Debt			66,000	66,000		66,000	(66,000)				43
44	TOTAL Special Cost Centers		43,285	1,059,726	1,103,011		1,103,011	(66,000)	1,037,011			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,760,855	548,330	4,922,311	9,231,496		9,231,496	(177,223)	9,054,273			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.)

		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				9
10	Interest and Other Investment Income	(3,921)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(417)	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	(66,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,097)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,435)		\$	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	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)	(105,788)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (105,788)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (177,223)		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.			\$		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: 02/01/2018

Ending: 12/31/2018

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
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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:

02/01/2018

Ending:

12/31/2018**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(417)	0	0	0	0	0	0	0	0	0	0	(417)	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	1,790	0	0	0	0	0	0	0	0	0	1,790	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(417)	1,790	0	0	0	0	0	0	0	0	0	1,373	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	11,969	0	0	0	0	0	0	0	0	11,969	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	3,051	0	0	0	0	0	0	0	0	3,051	15
16	TOTAL Health Care and Programs	0	0	15,020	0	0	0	0	0	0	0	0	15,020	16
	C. General Administration													
17	Administrative	0	(298,777)	(94,284)	0	0	0	0	0	0	0	0	(393,061)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	470	578	0	0	0	0	0	0	0	0	1,048	19
20	Fees, Subscriptions & Promotions	(1,097)	0	0	0	0	0	0	0	0	0	0	(1,097)	20
21	Clerical & General Office Expenses	0	154,914	43,978	0	0	0	0	0	0	0	0	198,892	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	873	6,807	0	0	0	0	0	0	0	0	7,680	24
25	Other Admin. Staff Transportation	0	0	3,134	0	0	0	0	0	0	0	0	3,134	25
26	Insurance-Prop.Liab.Malpractice	0	808	0	0	0	0	0	0	0	0	0	808	26
27	Other (specify):*	0	13,995	27,884	0	0	0	0	0	0	0	0	41,879	27
28	TOTAL General Administration	(1,097)	(127,717)	(11,903)	0	0	0	0	0	0	0	0	(140,717)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,514)	(125,927)	3,117	0	0	0	0	0	0	0	0	(124,324)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIAR PLACE NURSING

0054841

Report Period Beginning:

02/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,921)	0	0	0	0	0	0	0	0	0	0	(3,921)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	17,022	0	0	0	0	0	0	0	0	0	17,022	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,921)	17,022	0	0	0	0	0	0	0	0	0	13,101	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(66,000)	0	0	0	0	0	0	0	0	0	0	(66,000)	43
44	TOTAL Special Cost Centers	(66,000)	0	0	0	0	0	0	0	0	0	0	(66,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(71,435)	(108,905)	3,117	0	0	0	0	0	0	0	0	(177,223)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Aaron Singer	33.34	Arista Healthcare	Naperville	Saba Financial	Skokie	Management
Moshe Blonder	33.33	Forest City Nursing & Rehab	Rockford	Saba Healthcare	Skokie	Management
Atied Corporation	33.33	Rock River Healthcare	Rockford			
		Pearl Pavilion	Freeport			

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	17 Management Fees	\$ 298,777	Saba Financial	100.00%	\$	\$ (298,777)	1
2	V	21 Clerical Wages		Saba Financial		108,552	108,552	2
3	V	6 Repairs & maintenance		Saba Financial		1,790	1,790	3
4	V	34 Rent		Saba Financial		17,022	17,022	4
5	V	27 Employee Benifets & Pr Taxes		Saba Financial		13,995	13,995	5
6	V	21 Bank Charges		Saba Financial		3,312	3,312	6
7	V	21 Computer services		Saba Financial		21,974	21,974	7
8	V	26 Insurance		Saba Financial		808	808	8
9	V	19 Professional fees		Saba Financial		470	470	9
10	V	21 Office		Saba Financial		19,145	19,145	10
11	V	21 Telephone		Saba Financial		1,931	1,931	11
12	V	24 Seminars		Saba Financial		873	873	12
13	V							13
14	Total		\$ 298,777			\$ 189,872	\$ * (108,905)	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	\$ 298,777	Saba Healthcare	100.00%	\$	\$ (298,777)
16	V	10 Nursing Salary		Saba Healthcare		11,969	11,969
17	V	15 Nursing employee Benifets		Saba Healthcare		3,051	3,051
18	V	17 Admin Salary-Related		Saba Healthcare		168,587	168,587
19	V	17 Admin- Salary Non Related		Saba Healthcare		35,906	35,906
20	V	19 Professional fees		Saba Healthcare		578	578
21	V	21 Admin & General Expenses		Saba Healthcare		2,295	2,295
22	V	21 Admin & General Salary		Saba Healthcare		41,683	41,683
23	V	24 Seminars & education		Saba Healthcare		6,807	6,807
24	V	25 Auto & Travel		Saba Healthcare		3,134	3,134
25	V	27 Employee Benifets-Admin		Saba Healthcare		27,884	27,884
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 298,777			\$ 301,894	\$ * 3,117

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

Facility Name & ID Number

BRIAR PLACE NURSING

0054841

Report Period Beginning:

02/01/2018

Ending:

12/31/2018

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

Facility Name & ID Number **BRIAR PLACE NURSING** # **0054841** Report Period Beginning: **02/01/2018** Ending: **12/31/2018**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aaron Singer	Manager	Management	33.34	132,000	40	40.00	Management Fee	\$ 68,000	17	1
2	Moishe Blonder	Manager	Management	33.33	132,000	40	40.00	Management Fee	68,000	17	2
3	Jake Singer	Manager	Management		61,380	40	40.00	Salary	31,620	17	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 167,620		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:

02/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Saba Financial
 Street Address 3515 Howard st, Ste 1001
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847-383-9104
 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	21	Clerical Salaries	Number of Beds	385	\$ 180,141	\$ 180,141	232	\$ 108,552	1
2	6	Repairs & Maintenance	Number of Beds	385	2,970		232	1,790	2
3	34	Rent	Number of Beds	385	28,248		232	17,022	3
4	27	Employee Benifets & Pr Taxes	Number of Beds	385	23,225		232	13,995	4
5	21	Bank charges	Number of Beds	385	5,496		232	3,312	5
6	21	Computer services	Number of Beds	385	36,466		232	21,974	6
7	26	Insurance	Number of Beds	385	1,341		232	808	7
8	19	Professional Fees	Number of Beds	385	780		232	470	8
9	21	Office	Number of Beds	385	31,770		232	19,145	9
10	21	Telephone	Number of Beds	385	3,204		232	1,931	10
11	24	Seminars	Number of Beds	385	1,448		232	873	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				\$ 315,089	\$ 180,141		\$ 189,872	25

Facility Name & ID Number BRIAR PLACE NURSING

0054841

Report Period Beginning:

02/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Saba Healthcare
 Street Address 3515 Howard St, Ste 1001
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847-383-9104
 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	10	Nursing Salary	Resident Days	199,072	5	\$ 35,000	\$ 35,000	68,075	\$ 11,969	1
2	15	Nursing Employee Benifets	Resident Days	199,072	5	8,921		68,075	3,051	2
3	17	Admin Salary-Related	Resident Days	199,072	5	493,000	93,000	68,075	168,587	3
4	17	Admin Salary-Non Related	Resident Days	199,072	5	105,000	105,000	68,075	35,906	4
5	19	Professional Fees	Resident Days	199,072	5	1,689		68,075	578	5
6	21	Admin & General expenses	Resident Days	199,072	5	6,710		68,075	2,295	6
7	21	Admin & General Salary	Resident Days	199,072	5	121,894	121,894	68,075	41,683	7
8	24	Seminar & Education	Resident Days	199,072	5	19,907		68,075	6,807	8
9	25	Auto & Travel	Resident Days	199,072	5	9,165		68,075	3,134	9
10	27	Employee Benifets- Admin	Resident Days	199,072	5	81,540		68,075	27,884	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					\$ 882,826	\$ 354,894		\$ 301,894	25

Facility Name & ID Number

BRIAR PLACE NURSING

0054841

Report Period Beginning:

02/01/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					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							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Bank Leumi		X	Working Capital		02/01/2018		605,000		5.5000	44,837	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$ 605,000			\$ 44,837	9					
	B. Non-Facility Related*																
10	Interest Income										(3,921)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (3,921)	14					
15	TOTALS (line 9+line14)						\$	\$ 605,000			\$ 40,916	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	394,271
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	394,271
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013		8
	2014		9
	2015		10
	2016		11
	2017	394,271	12
100% of 2017 bill			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIAR PLACE NURSING COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054841

CONTACT PERSON REGARDING THIS REPORT Aaron Singer

TELEPHONE 7739451000 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>Facility</u>	\$ <u>394,271.00</u>	\$ <u>394,271.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>394,271.00</u></u>	\$ <u><u>394,271.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 BRIAR PLACE NURSING

0054841

Report Period Beginning:

02/01/2018 Ending:

12/31/2018

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).

None

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

If so, please complete the following:

1. Total Amount Incurred: 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

Facility Name & ID Number **BRIAR PLACE NURSING**

0054841

Report Period Beginning:

02/01/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1	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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

Facility Name & ID Number **BRIAR PLACE NURSING**

0054841

Report Period Beginning:

02/01/2018 Ending: **12/31/2018**

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	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							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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 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)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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?

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:	1976	232	02/01/2018	\$ 1,164,350			3
4	Additions							4
5	Allocated from Saba Financial				17,022			5
6								6
7	TOTAL		232		\$ 1,181,372			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2019 \$ _____
 13. _____ /2020 \$ _____
 14. _____ /2021 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **2,959** Description: _____

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 198,357	\$		\$ 198,357	1
2	Licensed Speech and Language Development Therapist		hrs			51,487			51,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			235,536			235,536	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				43,285		43,285	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 485,380	\$ 43,285		\$ 528,665	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 50,779	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,397,527		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,807		6
7	Other Prepaid Expenses	32,485		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Tax Escrow	294,525		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,786,123	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,786,123	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 430,587	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	605,000		29
30	Accrued Salaries Payable	99,007		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,959		31
32	Accrued Real Estate Taxes(Sch.IX-B)	394,271		32
33	Accrued Interest Payable	1,729		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Partners	501,000		36
37	Due to Prior Owner	12,533		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,053,086	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,053,086	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 733,037	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,786,123	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	733,037	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 733,037	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)	\$ 733,037	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIAR PLACE NURSING

0054841

Report Period Beginning: 02/01/2018

Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,960,612	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,960,612	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***	3,921	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,921	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,964,533	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,427,538	31
32	Health Care	3,052,460	32
33	General Administration	2,042,070	33
B. Capital Expense			
34	Ownership	1,606,417	34
C. Ancillary Expense			
35	Special Cost Centers	594,665	35
36	Provider Participation Fee	508,346	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,231,496	40
41	Income before Income Taxes (line 30 minus line 40)**	733,037	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 733,037	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,854,225	44
45	Private Pay - Net Inpatient Revenue	35,263	45
46	Medicare - Net Inpatient Revenue	1,396,927	46
47	Other-(specify) Hospice	102,862	47
48	Other-(specify) VA, Med B	571,335	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,960,612	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.

Facility Name & ID Number **BRIAR PLACE NURSING**

0054841

Report Period Beginning: 02/01/2018

Ending:

12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,853	4,274	\$ 170,688	\$ 39.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,783	11,239	430,594	38.31	3
4	Licensed Practical Nurses	32,204	33,505	1,012,689	30.23	4
5	CNAs & Orderlies	53,465	55,388	807,910	14.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,905	1,937	27,111	14.00	9
10	Activity Assistants	6,238	6,313	61,672	9.77	10
11	Social Service Workers	11,596	11,940	242,979	20.35	11
12	Dietician					12
13	Food Service Supervisor	1,768	1,928	59,078	30.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,496	21,175	285,846	13.50	15
16	Dishwashers					16
17	Maintenance Workers	5,148	5,241	62,289	11.88	17
18	Housekeepers	13,006	13,700	173,695	12.68	18
19	Laundry	1,658	1,815	29,991	16.52	19
20	Administrator	3,420	3,513	155,341	44.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,222	7,694	125,931	16.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,587	1,755	29,114	16.59	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	6,550	6,880	85,927	12.49	33
34	TOTAL (lines 1 - 33)	179,899	188,297	\$ 3,760,855 *	\$ 19.97	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	272	\$ 13,581	1-3	35
36	Medical Director	monthly	18,700	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,837	91,864	10-3	38
39	Pharmacist Consultant	195	14,598	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	64	2,560	12-3	45
46	Other(specify)				46
47	<u>MDS consultant</u>	72	3,240	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,440	\$ 144,543		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	380	11,272	10-3	52
53	TOTAL (lines 50 - 52)	380	\$ 11,272		53

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		
Lawanda Bradley	Administrator		\$ 89,302	Workers' Compensation Insurance	\$ 97,729	IDPH License Fee	\$ 3,719		
Addison Wilczak	Administrator		66,039	Unemployment Compensation Insurance	28,179	Advertising: Employee Recruitment			
				FICA Taxes	287,705	Health Care Worker Background Check			
				Employee Health Insurance	114,463	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois council On Long Term Care	19,900		
						Village indian Head park	26,412		
						Advertising	1,097		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 155,341						
B. Administrative - Other									
Description			Amount						
Management Fee			\$ 597,554			Less: Public Relations Expense	()		
						Non-allowable advertising	(1,097)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 597,554	TOTAL (agree to Schedule V, line 22, col.8)	\$ 528,076	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 50,031		
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	
Gutnicki LLP	Legal		\$ 13,061				Out-of-State Travel	\$	
Polsinelli	Legal		2,640						
Michael Margolies	Legal		1,035						
Mendel Schneider CPA	Accounting		9,350				In-State Travel		
Bank Leumi	Legal		9,950						
Indeed	Job search		1,670						
Meyer Magence	Legal		750				Seminar Expense		
Personnel Planners	UC Consultant		1,275				Allocated from Saba	7,680	
							Spectrum	4,800	
							Misc seminars	1,590	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 39,731	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 14,070	

* Attach copy of IMRF notifications

**See instructions.

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. Illinois council on long term care \$19,900
- (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? N/A
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,000 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. \$ 508,346
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? N/A
- (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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A 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? 0
 - 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. \$ N/A
- (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