

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0054841</u></p> <p>Facility Name: <u>Briar Place Nursing</u></p> <p>Address: <u>6800 West Joliet</u> <u>Indian Head Park</u> <u>60525</u> Number City Zip Code</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>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:25%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>See Accountant's Report Attached</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) <u>Mendel Schneider CPA & Associates</u> <u>4051 Old Orchard Road, Skokie, IL 60076</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u></td> <td style="border: none;"></td> </tr> </table> <p>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) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>See Accountant's Report Attached</u>			(Firm Name & Address) <u>Mendel 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 _____																							
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Facility Name & ID Number Briar Place Nursing

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,704	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,912	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	18,091	428	5,352	23,871	8
9	SNF/PED					9
10	ICF	52,704			52,704	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,795	428	5,352	76,575	14

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

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

IV. ACCOUNTING BASIS

ACCUAL 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: 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.

Facility Name & ID Number

Briar Place Nursing

#0054841

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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			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.

Facility Name & ID Number Briar Place Nursing

0054841

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(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	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)	3,449,418		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,449,418		36
	(sum of SUBTOTALS			
37	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	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: 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

STATE OF ILLINOIS

Summary B

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

	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	(3,172,049)	0	0	4,029,928	0	0	0	0	0	0	0	857,879	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,672)	0	0	7,193	0	0	0	0	0	0	0	(2,479)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	16,009	0	(7,193)	0	0	0	0	0	0	0	8,816	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	(3,181,721)	16,009	0	4,029,928	0	0	0	0	0	0	0	864,216	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):*	(155,772)	0	0	0	0	0	0	0	0	0	0	(155,772)	43
44	TOTAL Special Cost Centers	(155,772)	0	0	0	0	0	0	0	0	0	0	(155,772)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,400,957)	564,717	(1,145,227)	4,029,928	0	0	0	0	0	0	0	48,461	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 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	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	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.

Facility Name & ID Number

Briar Place Nursing

0054841

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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)
16	V	10 RN CONSULTANT	219,100	SABA HEALTHCARE			(219,100)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
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		\$ 1,145,227			\$ 0	\$ * (1,145,227)

* 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.

Facility Name & ID Number

Briar Place Nursing

0054841

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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

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 ()

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

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	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

Facility Name & ID Number

Briar Place Nursing

0054841

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.	\$	405,561	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.)	\$	385,637	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(19,924)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	471,036	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	451,112	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	_____	8
	2016	_____	9
	2017	394,271	10
	2018	405,561	11
	2019	385,637	12

Accrual 2020=new assesed value \$1,844,216 x state equalized value 2.916 x rate.08759

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

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.**

Facility Name & ID Number Briar Place Nursing

0054841

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>62,500</u>	<u>2020</u>	<u>\$ 1,900,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	62,500		\$ 1,900,000	3

Facility Name & ID Number Briar Place Nursing

0054841

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	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 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)	\$ 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?

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: <u>1976</u>	<u>232</u>	<u>02/01/2018</u>	\$ <u>1,327,924</u>			3
4	Additions						4
5	<u>Allocated from Saba</u>			<u>8,816</u>			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

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 \$ _____

* 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.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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	

- (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	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): <u>Lab&Xray</u>	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.

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	Gov Stimulus Income	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) Medicare B	173,755	47
48	Other-(specify) Veterans	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.

Facility Name & ID Number **Briar Place Nursing**

0054841

Report Period Beginning: **01/01/2020**

Ending:

12/31/2020

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	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

XIX. SUPPORT SCHEDULES

Table A: Administrative Salaries. Columns: Name, Function, Ownership %, Amount. Rows include Lawanda Bradley (\$147,415), Nesanel Cohen (\$32,097), and Beatriz Mora (\$70,278). Total: \$249,790.

Table B: Administrative - Other. Columns: Description, Amount. Row: Saba Healthcare (\$926,127). Total: \$926,127.

Table C: Professional Services. Columns: Vendor/Payee, Type, Amount. Rows include Mendel Schneider (\$9,500), M&Y Reporting (\$1,167), Gulko Schwed (\$676), O'Hagon Meyer (\$2,500), Line of Credit Legal (\$881), Personnel Planners (\$1,475), Abbey Road (\$5,421), Vcorp (\$115), Mcabe Kirshner (\$4,375), and Zimmet (\$1,241). Total: \$27,351.

Table D: Employee Benefits and Payroll Taxes. Columns: Description, Amount. Rows include 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)*, and a Total of \$623,466.

Table E: Schedule of Non-Cash Compensation Paid to Owners or Employees. Columns: Description, Line #, Amount. Includes a Total line.

Table F: Dues, Fees, Subscriptions and Promotions. Columns: Description, Amount. Rows include IDPH License Fee (\$3,980), Advertising: Employee Recruitment (\$1,963), Health Care Worker Background Check (\$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, and a Total of \$83,613.

Table G: Schedule of Travel and Seminar**. Columns: Description, Amount. Rows include Out-of-State Travel, In-State Travel, Seminar Expense (\$4,540), and Entertainment Expense. Total: \$4,540.

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Briar Place Nursing

0054841

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 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.