

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0038232</u></p> <p><b>Facility Name:</b> <u>Briarbrook Place</u></p> <p><b>Address:</b> <u>228 Briarbrook Drive</u> <u>East Peoria</u> <u>61611</u> Number City Zip Code</p> <p><b>County:</b> <u>Tazewell</u></p> <p><b>Telephone Number:</b> <u>(309) 698-9200</u> <b>Fax #</b> <u>(309) 698-9213</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/1992</u></p> <p><b>Type of Ownership:</b></p> <table border="0" style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 C (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>630-361-2868</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 C (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2019</u> to <u>6/30/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Lawrence A. Manson</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lawrence A. Manson</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Briarbrook Place

# 0038232 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

**B. Census-For the entire report period.**

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,906			4,906	13
14	TOTALS	4,906			4,906	14

**C. Percent Occupancy.** (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.78%

**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  Non-allowable costs have been eliminated in Schedule V, Column 7

**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 08/01/1992

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 03/08/1999 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	23,762	921	2,324	27,007		27,007		27,007		1
2	Food Purchase		32,186		32,186		32,186		32,186		2
3	Housekeeping		2,776		2,776		2,776	13	2,789		3
4	Laundry		957		957		957		957		4
5	Heat and Other Utilities			15,202	15,202		15,202		15,202		5
6	Maintenance	13,579	2,496	15,516	31,591		31,591	1,316	32,907		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>37,341</b>	<b>39,336</b>	<b>33,042</b>	<b>109,719</b>		<b>109,719</b>	<b>1,329</b>	<b>111,048</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			660	660		660		660		9
10	Nursing and Medical Records	184,618	4,749	592	189,959		189,959		189,959		10
10a	Therapy										10a
11	Activities		2,072	13	2,085		2,085		2,085		11
12	Social Services			608	608		608		608		12
13	CNA Training	12,042			12,042		12,042		12,042		13
14	Program Transportation			3,602	3,602		3,602		3,602		14
15	Other (specify):*			221	221		221		221		15
16	<b>TOTAL Health Care and Programs</b>	<b>196,660</b>	<b>6,821</b>	<b>5,696</b>	<b>209,177</b>		<b>209,177</b>		<b>209,177</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	48,190		114,711	162,901		162,901	(114,711)	48,190		17
18	Directors Fees							4,375	4,375		18
19	Professional Services			8,503	8,503		8,503	7,191	15,694		19
20	Dues, Fees, Subscriptions & Promotions			1,516	1,516		1,516	2,500	4,016		20
21	Clerical & General Office Expenses	8,522	2,576	7,671	18,769		18,769	72,839	91,608		21
22	Employee Benefits & Payroll Taxes			68,063	68,063		68,063	11,402	79,465		22
23	Inservice Training & Education			1,880	1,880		1,880		1,880		23
24	Travel and Seminar			610	610		610	2,305	2,915		24
25	Other Admin. Staff Transportation			1,609	1,609		1,609	1,150	2,759		25
26	Insurance-Prop.Liab.Malpractice			9,387	9,387		9,387	464	9,851		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>56,712</b>	<b>2,576</b>	<b>213,950</b>	<b>273,238</b>		<b>273,238</b>	<b>(12,485)</b>	<b>260,753</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>290,713</b>	<b>48,733</b>	<b>252,688</b>	<b>592,134</b>		<b>592,134</b>	<b>(11,156)</b>	<b>580,978</b>		<b>29</b>

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Briarbrook Place

#0038232

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

## 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	
	<b>D. Ownership</b>											
30	Depreciation			5,341	5,341		5,341	25,775	31,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			817	817		817	(817)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							7,015	7,015			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			6,158	6,158		6,158	31,973	38,131			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,180		1,180		1,180		1,180			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,605	40,605		40,605		40,605			42
43	Other (specify):* <b>Disallowed Costs</b>											43
44	<b>TOTAL Special Cost Centers</b>		1,180	40,605	41,785		41,785		41,785			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	290,713	49,913	299,451	640,077		640,077	20,817	660,894			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	23,511	30		9
10	Interest and Other Investment Income	(817)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(46)	20		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	(28)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 See Page 5A	(1,803)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 20,817		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 20,817		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Briarbrook Place

ID# 0038232

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (1,967)	43	1
2	Expense Fixed Asset Additions under \$2,500	1,110	6	2
3	Miscellaneous Income Offset	(5)	21	3
4	Rental Income Offset	(941)	34	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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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,803)		49

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Progressive Housing, Inc</u>	<u>100</u>	<u>See Pg 6-Supp</u>		<u>See Pg 6-Supp</u>		

**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	<u>3 Housekeeping</u>	\$	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	\$ <u>13</u>	\$	<u>13</u>   1
2	V	<u>6 Maintenance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>206</u>		<u>206</u>   2
3	V	<u>18 Director Fees</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>4,375</u>		<u>4,375</u>   3
4	V	<u>19 Professional Services</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>7,219</u>		<u>7,219</u>   4
5	V	<u>20 Dues, Fees, Subs and Promotions</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,546</u>		<u>2,546</u>   5
6	V	<u>21 Clerical and General Office</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>72,844</u>		<u>72,844</u>   6
7	V	<u>22 Employee Benefits</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>11,402</u>		<u>11,402</u>   7
8	V	<u>24 Travel and Seminar</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,305</u>		<u>2,305</u>   8
9	V	<u>25 Auto Expense</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,150</u>		<u>1,150</u>   9
10	V	<u>26 Insurance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>464</u>		<u>464</u>   10
11	V	<u>30 Depreciation</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,264</u>		<u>2,264</u>   11
12	V	<u>34 Rent</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>941</u>		<u>941</u>   12
13	V	<u>35 Equipment Rental</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>7,015</u>		<u>7,015</u>   13
14	Total		\$			\$ <u>112,744</u>	\$ *	<u>112,744</u>   14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	\$ 1,967	\$ 1,967
16	V	17 Administrative	114,711	Progressive Housing, Inc.	100.00%		(114,711)
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		\$ 114,711			\$ 1,967	\$ * (112,744)

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name &amp; ID Number

Briarbrook Place

# 0038232

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

## 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			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace -closed	Evansville	Progressive Careers			3
4			Aviston Terrace	Aviston	& Housing	Flossmoor	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop-closed	6
7			Park Place	Pana	Progressive Careers			7
8			Cardinal	Woodlawn	& Housing	Mt Vernon	Workshop-closed	8
9			Western Gardens	MT. Vernon	Perfection			9
10			Galaxy	Woodlawn	Cleaning	Olympia Fields	Housekeeping	10
11			Bill Goat Hill	MT. Vernon				11
12			Country Club Hill	Country Club Hills				12
13			Lee street	Country Club Hills				13
14			Baker Street	Country Club Hills				14
15			182nd Street	Country Club Hills				15
16			Osage	Park Forest				16
17			Oakwood	Park Forest				17
18			Blair	Park Forest				18
19			Lowell	Hazelcrest				19
20			Marquette	Park Forest				20
21			Cherry	Park Forest				21
22			Luella	Sauk Village				22
23			Olivia	Sauk Village				23
24			Huron	Park Forest				24
25			Wilshire	Park Forest				25
26			Constance - closed	Sauk Village				26
27			175th Place	Country Club Hills				27
28			Sauganash	Park Forest				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Briarbrook Place

# 0038232

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

## 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	Edward Childers	Chairman	Board Member	None	8,230	3Hrs/MTG	1.00	Dir. Fees	\$ 570	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,229	3Hrs/MTG	1.00	Dir. Fees	571	L18,C8	3
4	Hal Brown	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	6
7	Eileen Mullin	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	7
8	Julie Lilie	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	8
9	Shawn Jeffers	Director-Partial yr	Board Member	None	1,496	3Hrs/MTG	1.00	Dir. Fees	104	L18,C8	9
10											10
11					Misc Expenses				20		11
12											12
13								TOTAL	\$ 4,375		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Briarbrook Place

# 0038232

Report Period Beginning:

7/1/2019

Ending: 5/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Progressive Housing, Inc.  
 Street Address 20180 Governors Dr., Suite 300  
 City / State / Zip Code Olympia Fields, IL 60461  
 Phone Number (708) 283-1530  
 Fax Number (708) 283-2470

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	3	Housekeeping	Bed Capacity/Specific Alloc.	252	28	\$ 523	16	\$ 13	1	
2	6	Maintenance	Bed Capacity/Specific Alloc.	252	28	4,326	16	206	2	
3	18	Director Fees	Bed Capacity/Specific Alloc.	252	28	67,510	16	4,375	3	
4	19	Professional Services	Bed Capacity/Specific Alloc.	252	28	109,179	16	7,219	4	
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	252	28	42,077	16	2,546	5	
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	252	28	1,118,951	935,187	16	72,844	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	252	28	195,610	16	11,402	7	
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	252	28	33,408	16	2,305	8	
9	25	Auto Expense	Bed Capacity/Specific Alloc.	252	28	18,416	16	1,150	9	
10	26	Insurance	Bed Capacity/Specific Alloc.	252	28	7,288	16	464	10	
11	30	Depreciation	Bed Capacity/Specific Alloc.	252	28	34,937	16	2,264	11	
12	34	Rent	Bed Capacity/Specific Alloc.	252	28	14,823	16	941	12	
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	252	28	45,991	16	7,015	13	
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	252	28	43,564	16	1,967	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,736,603	\$ 935,187	\$ 114,711	25	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Briarbrook Place

# 0038232

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	Enterprise	X	Vehicle	\$390.20	10/2018	18,975	12,630	9/2023	0.0588	817										
7	Peoples Bank	X	PPP Loan		4/14/20	116,788	116,788													
8																				
9	<b>TOTAL Facility Related</b>			\$390.20		\$ 135,763	\$ 129,418			\$ 817										
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12							Interest Income Offset			(817)										
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (817)										
15	<b>TOTALS (line 9+line14)</b>					\$ 135,763	\$ 129,418			\$										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$   N/A        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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2019 report.		\$	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 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	N/A	8
	2016	N/A	9
	2017	N/A	10
	2018	N/A	11
	2019	N/A	12

N/A - Not for profit entity

**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.**

SEE ACCOUNTANTS' PREPARATION REPORT

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

FACILITY NAME Briarbrook Place COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0038232

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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>          </u>	\$ <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 Briarbrook Place

# 0038232

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (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? [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 for index. Rows include Facility (47,250 sq ft, 1999, \$20,000), Allocated from Home Office (7,369), and TOTALS (47,250, \$27,369).

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Briarbrook Place

# 0038232

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

**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	16		1999	1991	\$ 730,000	\$	40	\$ 18,250	\$ 18,250	\$ 389,383	4
5				2013	(11,953)			(299)	(299)	(5,903)	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Landscaping		1994	1,593		15			1,593	9
10		Electrical Wiring		2001	552		15			552	10
11		Ceramic Tiles, Sink and Stool		2006	1,240		15	83	83	1,170	11
12		Bathroom Remodel		2007	266		15	18	18	241	12
13		Water Heater		2008	776		15	52	52	636	13
14		Bathroom Remodel		2008	950		15	63	63	772	14
15		Bathroom Remodel		2008	1,072		15	71	71	865	15
16		Bathroom Remodel		2008	194		15	13	13	158	16
17		Concrete Sidewalk		2008	2,255		15	150	150	1,688	17
18		Carpets for Bedrooms, Living Room and Activity Rooms		2010	5,970		15	398	398	4,054	18
19		Kitchen and Pantry Remodel		2010	2,214		15	148	148	1,679	19
20		Kitchen and Pantry Remodel- Paint and Materials for project		2010	1,049		15	70	70	735	20
21		Kitchen and Pantry Remodel - Counter Top, Sink, Plumbing		2010	600		15	40	40	417	21
22		Kitchen and Pantry Remodel - Steel Door		2010	265		15	18	18	186	22
23		AC Installation		2010	2,927		15	195	195	1,950	23
24		Replace water valve		2010	952		15	64	64	624	24
25		Kitchen fire repair		2011	574		15	38	38	358	25
26		Replace condensor fan and capacitor		2011	700		15	47	47	427	26
27		Replace 2 Furnaces		2011	3,470		15	231	231	2,022	27
28		Replace Condenser Coil		2012	1,387		15	92	92	721	28
29		Replace Washer Fill Box		2013	542		15	36	36	282	29
30		Replaced air compressor/fire sprinkler system		2013	3,640		15	243	243	1,660	30
31		Replace dry system piping w/galvanized pipe		2013	10,144		15	676	676	4,394	31
32		Roof Repair		2013	770		15	51	51	336	32
33		Water Heater (100 Gallon)		2013	6,771		10	677	677	4,457	33
34		New Roof (Gross of Write off of Old Roof-See Line 5)		2014	17,100		25	684	684	4,275	34
35		Replaced 10 smoke detectors		2015	675		15	45	45	226	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

SEE ACCOUNTANTS' PREPARATION REPORT



**XI. OWNERSHIP COSTS (continued)**

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

1	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	2016	\$ 3,310	\$	15	\$ 221	\$ 221	\$ 836	37
38								38
39								39
40								40
41			5,341			(5,341)		41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49		14,698			2,264	2,264	26,747	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		\$ 804,703	\$ 5,341		\$ 24,639	\$ 19,298	\$ 447,541	70

SEE ACCOUNTANTS' PREPARATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 18,013	\$	\$ 1,525	\$ 1,525	5-10 Yrs	\$ 13,507	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	21,795				5-10 Yrs	21,795	73
74	Allocated from Home Office	29,458						74
75	TOTALS	\$ 69,266	\$	\$ 1,525	\$ 1,525		\$ 35,302	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	Resident Transportation	2002 Ford E350	2002	\$ 28,401	\$	\$	\$	5	\$ 28,400	76
77	Resident Transportation	2004 Dodge Caravan	2004	19,918				5	19,918	77
78	Resident Transportation	Capitalized Repairs	2009-2016	3,332		487	487	5	3,332	78
79	Resident Transportation	2019 Dodge Grand Caravan	2018	22,323		4,465	4,465	5	8,018	79
80	TOTALS			\$ 73,974	\$	\$ 4,952	\$ 4,952		\$ 59,668	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)	\$ 975,312	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,341	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,116	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,775	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 542,511	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

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

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

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

N/A

N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 7,015 Description: Allocated from Home Office-Office Equipment

(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	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		12,042		12,042
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 12,042	\$	\$ 12,042
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	12,042		

**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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>6</b>

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				1,180		1,180	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			\$		\$	1,180		\$ 1,180	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Briarbrook Place

# 0038232

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 262,069	\$ 262,069	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,073 )	133,716	133,716	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,321)	(3,321)	6
7	Other Prepaid Expenses	14,857	14,857	7
8	Accounts Receivable (owners or related parties)	176,924	176,924	8
9	Other(specify): <u>Reserves/Deposits</u>	1,566	1,566	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 585,811	\$ 585,811	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,369	13
14	Buildings, at Historical Cost	36,110	804,703	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	77,898	143,240	16
17	Accumulated Depreciation (book methods)	(59,606)	(542,511)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 74,402	\$ 432,801	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 660,213	\$ 1,018,612	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 12,891	\$ 12,891	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	116,788	116,788	29
30	Accrued Salaries Payable	38,511	38,511	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,195	2,195	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	39,479	39,479	36
37	<u>Advances from DHS</u>	18,829	18,829	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 228,693	\$ 228,693	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	12,630	12,630	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 12,630	\$ 12,630	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 241,323	\$ 241,323	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 418,890	\$ 777,289	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 660,213	\$ 1,018,612	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 246,330	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 246,330	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	172,560	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 172,560	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 418,890	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Briarbrook Place

# 0038232

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

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

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 790,340	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 790,340	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	16,527	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 16,527	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	718	24
25	Interest and Other Investment Income***	965	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,683	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Allocated from Home Office-See Pg 19B</u>	4,087	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,087	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 812,637	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	109,719	31
32	Health Care	209,177	32
33	General Administration	273,238	33
<b>B. Capital Expense</b>			
34	Ownership	6,158	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,180	35
36	Provider Participation Fee	40,605	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 640,077	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	172,560	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 172,560	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 790,340	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 790,340	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT



**Briarbrook Place**  
**0038232**  
**6/30/2020**

**SCH 19A**

Schedule XVII  
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)  
and is part of a Consolidated Entity Tax Return.  
Therefore, the Income or Loss cannot be  
traced to the Federal Income Tax Return.

Briarbrook Place  
0038232  
6/30/2020

SCH 19B

**XVII. INCOME STATEMENT**

**Line 28a. Income Allocated from Home Office**

Gain/Loss on Sale of Assets	229
Miscellaneous Income	5
Rental Income	3,853
	<hr/>
<b>Total Line 28a</b>	<b><u><u>4,087</u></u></b>

Facility Name & ID Number Briarbrook Place

# 0038232

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	908	27,459	28.40	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	2,028	23,762	11.37	15
16	Dishwashers				16
17	Maintenance Workers	730	13,579	12.74	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	1,235	48,190	35.25	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	297	8,522	26.97	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,360	26,514	18.86	29
30	Habilitation Aides (DD Homes)	11,563	142,687	11.77	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	18,121	290,713 *	15.03	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	43	\$ 2,324	L1, C3	35
36	Medical Director	Monthly	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	592	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	13	L11, C3	44
45	Social Service Consultant	10	608	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	54	\$ 4,197		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

**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			
Christina Durbin	Administrator	0	\$ 14,667	Workers' Compensation Insurance	\$ 17,983	IDPH License Fee	\$			
Laura Depauw	Administrator	0	33,523	Unemployment Compensation Insurance	3,532	Advertising: Employee Recruitment				
				FICA Taxes	21,790	Health Care Worker Background Check (Indicate # of checks performed <u>2</u> )	84			
				Employee Health Insurance	12,106	Patient Background Checks				
				Employee Meals	5,003	Hiring Expense	794			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Fees	638			
				Life Insurance	36					
				Other Employee Benefits	7,613					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,190	Allocated from Home Office	11,402	Allocated from Home Office	2,546			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			Less: Public Relations Expense	(46)		
Description			Amount				Non-allowable advertising	( )		
Allocated from Progressive Housing, Inc.			\$ 114,711				Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 114,711	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,016	
C. Professional Services				Description			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
Paycor	Payroll Service		\$ 4,257			\$	Out-of-State Travel	\$		
Janet Scellato	Accounting Consultant		3,781							
Wipfli	Accounting Services		437				In-State Travel	486		
Hinshaw and Culbuertson, LLP	Legal Services		28							
							Seminar Expense	124		
							Allocated from Home Office	2,305		
							Entertainment Expense	( )		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,503	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,915

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

\*\*See instructions.

Facility Name &amp; ID Number Briarbrook Place

# 0038232

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,926 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. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,605  
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. \$ 5,003 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Heinold-Banwart, LTD
- (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.

**SEE ACCOUNTANTS' PREPARATION REPORT**