		FOR BHF USE					

LL1

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.

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

I. IDPH License ID Number: 0048629

Facility Name: Bryan Manor

Address: 2150 E McCord Bx 568 (Number) Centralia (City) 62801 (Zip Code)

County: Marion

Telephone Number: 618-918-3770 Fax # 618-532-0125

HFS ID Number:

Date of Initial License for Current Owners: 02/12/88

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code 501c3
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

In the event there are further questions about this report, please contact:
Name: Emily Masching Telephone Number: 618-533-9633 x 6
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2019 to 06/30/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) ____________ (Date)
(Type or Print Name) James Veach
(Title) Administrator

Paid Preparer
(Signed) ____________ (Date)
(Print Name and Title) Emily Masching, CFO
(Firm Name & Address) CSI, PO Box 1946, Centralia, IL 62801
(Telephone) 618-533-9633 x 6 Fax # 618-533-6345

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	34,634			34,634	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,634			34,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.89%

D. How many bed reserve days during this year were paid by the Department?
24pd, 451 unpd (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/14/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/14/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ______ and days of care provided ______

Medicare Intermediary ______

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/19-6/30/20 Fiscal Year: 7/1/19-6/30/20

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

Facility Name & ID Number Bryan Manor # 0048629 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	605,926	32,522	31,019	669,467		669,467		669,467			1
2	Food Purchase		310,801		310,801		310,801		310,801			2
3	Housekeeping	469,735	107,238		576,973		576,973		576,973			3
4	Laundry	230,870	26,650	205,805	463,325		463,325		463,325			4
5	Heat and Other Utilities			179,819	179,819		179,819		179,819			5
6	Maintenance	264,129	52,298	23,587	340,014		340,014		340,014			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,570,660	529,509	440,230	2,540,399		2,540,399		2,540,399			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	7,082,012	743,619	180,231	8,005,862		8,005,862		8,005,862			10
10a	Therapy			8,757	8,757		8,757		8,757			10a
11	Activities	425,578	27,066		452,644		452,644		452,644			11
12	Social Services	61,984			61,984		61,984		61,984			12
13	CNA Training											13
14	Program Transportation			25,407	25,407	(14,888)	10,519		10,519			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,569,574	770,685	229,395	8,569,654	(14,888)	8,554,766		8,554,766			16
	C. General Administration											
17	Administrative	579,504			579,504		579,504		579,504			17
18	Directors Fees											18
19	Professional Services			506,262	506,262		506,262		506,262			19
20	Dues, Fees, Subscriptions & Promotions			432,395	432,395		432,395		432,395			20
21	Clerical & General Office Expenses	172,676	77,244	26,582	276,502		276,502		276,502			21
22	Employee Benefits & Payroll Taxes			2,560,454	2,560,454		2,560,454		2,560,454			22
23	Inservice Training & Education			25,964	25,964		25,964		25,964			23
24	Travel and Seminar			10,861	10,861		10,861		10,861			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,717	57,717		57,717		57,717			26
27	Other (specify):*											27
28	**TOTAL General Administration**	752,180	77,244	3,620,235	4,449,659		4,449,659		4,449,659			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	9,892,414	1,377,438	4,289,860	15,559,712	(14,888)	15,544,824		15,544,824			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.

C. General and Admin
Inservice Training & Education

Vendor	Cost	Description
Crisis Prevention Institute	$6,234.00	Instructor Certification and Workbooks
Francis Dietl	$4,134.62	CPR/First Aid Training
KLA Consulting	$1,600.00	Administrative Training
Kaskaskia Workshop	$2,850.00	Fixed Asset Software/Training
Amazon	$ 215.44	Administrative Training Books
Walmart	$ 150.35	Refreshments at Trainings
Allied 100 LLC	$6,758.50	AED Training
Executive Business	$3,541.44	Printing Training Materials
ProProfs	$ 479.64	DSP Training Quiz Maker

Facility Name & ID Number Bryan Manor #0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			106,824	106,824		106,824	192,178	299,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							197,590	197,590			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			432,447	432,447		432,447	(432,447)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt & Fines			20,790	20,790		20,790		20,790			36
37	TOTAL Ownership			560,061	560,061		560,061	(42,679)	517,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					14,888	14,888		14,888			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			862,184	862,184		862,184		862,184			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			862,184	862,184	14,888	877,072		877,072			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,892,414	1,377,438	5,712,105	16,981,957		16,981,957	(42,679)	16,939,278			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 Bryan Manor # 0048629 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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				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	20,790	36-3		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 20,790		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42,679)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (42,679)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (21,889)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$ 14,888	14-5	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)**			$ 14,888		47

Page 3-4
Schedule V Reclassification

All transportation costs go into program transportation. $14,888 was reclassified as medically necessary based on the mileage driven for those trips.

STATE OF ILLINOIS

Bryan Manor

ID# 0048629

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

	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
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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 Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	192,178	0	0	0	0	0	0	0	0	0	192,178	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	197,590	0	0	0	0	0	0	0	0	0	197,590	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(432,447)	0	0	0	0	0	0	0	0	0	(432,447)	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	0	(42,679)	0	0	0	0	0	0	0	0	0	(42,679)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	(42,679)	0	0	0	0	0	0	0	0	0	(42,679)	45

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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)	
1	V	34	Building Lease	$ 432,447	Adult Comprehensive Human Services, Inc		$	$ (432,447)	1
2	V	30	Depreciation		Adult Comprehensive Human Services, Inc		192,178	192,178	2
3	V	32	Interest		Adult Comprehensive Human Services, Inc		197,590	197,590	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 432,447			$ 389,768	$ * (42,679)	14

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	Pat Bronson	BOD						1
2	Sue Castleman	BOD						2
3	Shelly Heimann	BOD						3
4	Linda O'Rourke	BOD						4
5	Karisa Neudecker	BOD						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 Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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								TOTAL	$		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 Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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				
	A. Directly Facility Related											
	Long-Term											
1	PNB/SEIDA		X	Mortgage/Bonds	$36,037.25	12/26/06	$ 6,120,000	$ 3,761,158	12/22/2031		$ 197,590	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$36,037.25		$ 6,120,000	$ 3,761,158			$ 197,590	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,120,000	$ 3,761,158			$ 197,590	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.)

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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.

Item	Amount	Line
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. **(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.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2015		8
2016		9
2017		10
2018		11
2019		12

Line	FOR BHF USE ONLY	Amount	Line
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 Bryan Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0048629

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)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,427 B. General Construction Type: Exterior Brick/Siding Frame Wood/Block Number of Stories 1

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building	914,760	2007	$ 300,307	1
2					2
3	TOTALS	914,760		$ 300,307	3

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		2008	2008	$ 7,667,922	$ 191,698	40	$ 191,698	$	$ 2,268,427	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Sidewalk & Driveway			2009	7,198	480	15	480		5,398	10
11	Training Room Flooring			2013	3,553	355	10	355		2,369	11
12	Painting & Wall Repairs room 101-113, 201-203, 205			2014	19,096	955	20	955		5,729	12
13	207, 301-312, 402-413 & 4 parker tub rooms										13
14	Painting & Wall Repairs room 100 wing hallway, family room &			2015	31,187	1,559	20	1,559		7,797	14
15	offices in main corridor										15
16	Painting & Wall Repairs 400 wing rooms, center hub restroom,			2016	56,104	2,805	20	2,805		11,221	16
17	housekeeping offices, offices in main corridor, 300 wing, dining										17
18	room, breakroom, and 100 wing										18
19	2016 Addition			2016	367,197	14,688	25	14,688		63,648	19
20	Painting and Wall Repairs in main office, family room, north			2017	25,509	1,275	20	1,275		3,826	20
21	and south halls, 100 wing, 200 wing, 5 bathrooms, and exterior										21
22	sign										22
23	Carpet/Flooring in main building			2017	15,374	769	20	769		2,114	23
24	Painting to exterior doors on main bldg & maintenance bldg;			2017	3,103	621	5	621		1,707	24
25	paint QMRP offices in 200 and 400 wing										25
26	Light Poles			2018	9,396	470	20	470		1,057	26
27	Carpeting in main building			2018	5,200	260	20	260		498	27
28	Painting and Wall Repairs in family area, kitchen hall, 100 and 300										28
29	wings, and nurses station			2019	4,672	234	20	234		292	29
30	Countertops at Nurses Station			2019	4,951	223	20	223		223	30
31	Water Heater			2020	8,500						31
32	Painting & Wall Repairs main entrance, rooms 202-204, rooms 407			2020	30,034	375	20	375		375	32
33	and 413, family area, 100, 200, &300 wing, bathrooms in 100. 200, &										33
34	300 wings, laundry room										34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		$ 8,258,996	$ 216,767		$ 216,767	$	$ 2,374,681	70

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$ 199,046	$ 22,379	$ 22,379	$	5-10 years	$ 74,869	71
72	Current Year Purchases	97,630	7,676	7,676		5-10 years	7,676	72
73	Fully Depreciated Assets	771,631				5-10 years	771,631	73
74								74
75	TOTALS	$ 1,068,307	$ 30,055	$ 30,055	$		$ 854,176	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	Patient/Admin	2017 Ford Transit	2017	$ 45,757	$ 9,151	$ 9,151	$	5	$ 27,454	76
77	Patient/Admin	2017 E350 Braun Van	2017	25,198	5,040	5,040		5	14,279	77
78	Patient/Admin	Vans/Buses	various	271,099	37,989	37,989		5	143,745	78
79										79
80	TOTALS			$ 342,054	$ 52,180	$ 52,180	$		$ 185,478	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)	$ 9,969,664	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 299,002	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 299,002	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,414,335	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	Improvements	$ 393,735	$	$ 393,735	86
87	06 Mazda	11,176		11,176	87
88	08 Chevy Colorado	14,543		14,543	88
89					89
90					90
91	TOTALS	$ 419,454	$	$ 419,454	91

G. Construction-in-Progress

	Description	Cost	
92	Cafeteria Cabinets & Sinks	$ 6,097	92
93			93
94			94
95		$ 6,097	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:
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	TOTAL				$ **			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: *

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	$

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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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		# of prescrpts							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			$		$	$		$	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.

STATE OF ILLINOIS

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,809,177	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,334,229		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,071		6
7	Other Prepaid Expenses	10,212		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,203,689	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	367,197		14
15	Leasehold Improvements, at Historical Cost	616,510		15
16	Equipment, at Historical Cost	1,318,344		16
17	Accumulated Depreciation (book methods)	(1,332,132)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	148,956		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,118,875	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,322,564	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,158	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	431,960		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,658		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	1,086,535		35
	Other Current Liabilities(specify):			
36	Day Training Payable	386,363		36
37	Unclaimed Funds	3,055		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,015,729	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,015,729	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,306,835	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,322,564	$	48

*(See instructions.)

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,322,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,322,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	984,312	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 984,312	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)**	$ 4,306,835	24 *

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,659,984	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,659,984	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	230,618	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)**	$ 230,618	23
	D. Non-Operating Revenue		
24	Contributions	2,012,174	24
25	Interest and Other Investment Income***	29,198	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,041,372	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation	8,446	28
28a	Miscellaneous	25,849	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34,295	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,966,269	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,540,399	31
32	Health Care	8,584,216	32
33	General Administration	4,435,097	33
	B. Capital Expense		
34	Ownership	560,061	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	862,184	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,981,957	40
41	**Income before Income Taxes (line 30 minus line 40)****	984,312	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 984,312	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 14,866,551	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Hospice	13,704	47
48	Other-(specify) Social Security	779,729	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,659,984	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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.

Section I Revenue
Other Revenue

Gain on Sale of Assets	$ 9,958.10
Miscellaneous Income	$15,890.58
	$25,848.68

STATE OF ILLINOIS

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	3,279	3,599	$ 145,439	$ 40.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,847	20,292	945,061	46.57	3
4	Licensed Practical Nurses	24,747	25,998	1,077,629	41.45	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	24,531	26,283	756,144	28.77	8
9	Activity Director	2,040	2,238	72,180	32.25	9
10	Activity Assistants	12,719	13,874	353,398	25.47	10
11	Social Service Workers	1,850	2,104	61,984	29.46	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,236	62,504	27.95	13
14	Head Cook	11,642	12,309	241,038	19.58	14
15	Cook Helpers/Assistants	14,586	15,081	302,384	20.05	15
16	Dishwashers					16
17	Maintenance Workers	8,756	9,452	264,129	27.94	17
18	Housekeepers	23,450	24,923	469,735	18.85	18
19	Laundry	11,238	12,297	230,870	18.77	19
20	Administrator	1,774	2,000	179,907	89.95	20
21	Assistant Administrator					21
22	Other Administrative	9,277	9,912	399,597	40.31	22
23	Office Manager					23
24	Clerical	6,186	7,397	172,676	23.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	12,117	12,909	349,481	27.07	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	173,603	181,326	3,808,258	21.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	362,604	384,230	$ 9,892,414 *	$ 25.75	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	477	$ 31,019	1-3	35
36	Medical Director	150	15,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	35	3,474	10-3	39
40	Physical Therapy Consultant	79	5,911	10a-3	40
41	Occupational Therapy Consultant	0	25	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	37	2,821	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental, Vision, Podiatry		6,294	10-3	46
47	Psychologist		0		47
48					48
49	TOTAL (lines 35 - 48)	778	$ 64,544		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		170,463	10-3	52
53	TOTAL (lines 50 - 52)		$ 170,463		53

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
C. Hiestand	Service Coord/Training		$ 103,399
P. McKay	HR Director		66,324
G. Miller	Admin		183,056
C. Bixler	Asst Admin		44,035
J. Pontious	Asst Admin		45,431
J. Veach	Admin		91,968
D. Zvonar	HR Director		45,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 579,504

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
CSI	Mgmt	$ 321,182
Crain, Miller, & Wernsman	Legal	33,806
Creative Systems, Inc	IT	50,242
Glass & Shuffett, LTD	Audit	9,000
Ascensus	Acctg	2,956
KLA Consulting	Admin	55,501
Mueller Prost	P/S Audit	17,000
CSI	Admin	16,575
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 506,262

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,252
Unemployment Compensation Insurance	0
FICA Taxes	745,996
Employee Health Insurance	643,531
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Physicals, Vaccines, Retirement, etc	994,675
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,560,454

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,667
Health Care Worker Background Check	
(Indicate # of checks performed 100)	2,293
Patient Background Checks 2	36
Dues	20,424
License & Fees	4,975
Promotions	400,000
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 432,395

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage Reimbursement for Seminars	829
Lodging for Seminars	4,680
Seminar Expense	5,352
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,861

**See instructions.

Invoice Date	Law Firm	Allowable Amount	Non-Allowable Amount	Description of Services
8/2/2019	Crain, Miller, & Wernsman	$ 80.00		Guardianships
9/4/2019	Crain, Miller, & Wernsman	$ 351.00		Discrimination Charge
9/4/2019	Crain, Miller, & Wernsman	$ 20.00		Guardianships
10/3/2019	Crain, Miller, & Wernsman	$ 644.30		Guardianships
10/3/2019	Crain, Miller, & Wernsman	$ 436.80		Discrimination Charges
11/5/2019	Crain, Miller, & Wernsman	$1,944.97		Guardianships
11/5/2019	Crain, Miller, & Wernsman	$ 141.25		General Corporate Matters
11/5/2019	Crain, Miller, & Wernsman	$ 40.00		IDPH Investigations
11/27/2019	Crain, Miller, & Wernsman	$1,585.36		Guardianships
11/27/2019	Crain, Miller, & Wernsman	$ 410.00		Discrimination Charges
11/27/2019	Crain, Miller, & Wernsman	$5,739.17		Discrimination Charges
1/7/2020	Crain, Miller, & Wernsman	$4,736.15		Discrimination Charges
1/7/2020	Crain, Miller, & Wernsman	$ 67.74		Discrimination Charges
1/7/2020	Crain, Miller, & Wernsman	$ 645.67		Guardianships
2/4/2020	Crain, Miller, & Wernsman	$ 387.50		Guardianships
2/4/2020	Crain, Miller, & Wernsman	$ 200.00		General Corporate Matters
3/2/2020	Crain, Miller, & Wernsman	$ 572.92		Discrimination Charges
3/2/2020	Crain, Miller, & Wernsman	$ 78.65		Discrimination Charges
8/3/2020	Crain, Miller, & Wernsman	$ 598.97		Guardianships
4/2/2020	Crain, Miller, & Wernsman	$ 873.67		Guardianships
5/1/2020	Crain, Miller, & Wernsman	$ 281.50		Discrimination Charges
5/1/2020	Crain, Miller, & Wernsman	$1,258.93		Guardianships
5/1/2020	Crain, Miller, & Wernsman	$ 240.00		Discrimination Charges
5/1/2020	Crain, Miller, & Wernsman	$7,097.00		General Corporate Matters
6/3/2020	Crain, Miller, & Wernsman	$ 630.50		Discrimination Charges
6/3/2020	Crain, Miller, & Wernsman	$ 320.00		Discrimination Charges
6/3/2020	Crain, Miller, & Wernsman	$ 793.39		Guardianships
7/7/20 - For June Servic	Crain, Miller, & Wernsman	$1,860.50		Discrimination Charges
7/7/20 - For June Servic	Crain, Miller, & Wernsman	$1,310.00		Discrimination Charges
8/10/20 - For June Servi	Crain, Miller, & Wernsman	$ 460.00		Discimination Charges

Date	Seminar	Cost	Staff Attended
7/13/2019	Food Sanitation	$ 675.00	C. Krieger C. Clifton S. Aldrich C. Morales L. Washington
9/4/2019 - 9/6/2019	IARF Conference	$1,989.30	G. Miller M. Swagler T. Lindsey J. Pontious C. Bixler G. Helton
8/14/2019 - 8/15/2019	INHAA Conference	$ 200.00	G. Miller
8/28/2019 - 8/30/2019	NHA License Review Course	$ 645.00	T. Lindsey
5/18/2020 - 5/19/2020 5/21/2020, 5/26/2020	Benefits Conference	$1,843.46	H. Queen

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. **IL Assn of Rehabilitation Facilities $20,424**

(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? **5-7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **93,210** Line **10-f**

(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. $ **862,184**
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. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **8,446**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Glass & Shuffett**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.