

		FOR BHF USE					

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2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2019)

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

<p>I. IDPH License ID Number: <u>0052035</u></p> <p>Facility Name: <u>BRIA OF FOREST EDGE</u></p> <p>Address: <u>8001 S. WESTERN AVE.</u> <u>CHICAGO</u> <u>60620</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/1/12</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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>IRS Exemption Code _____</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 checked="" 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>In the event there are further questions about this report, please contact: Name: <u>KATHLEEN MCNAMARA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2019</u> to <u>12/31/2019</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>AVRUM WEINFELD</u></td> </tr> <tr> <td></td> <td>(Title) <u>CEO</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>AVRUM WEINFELD</u>		(Title) <u>CEO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____		(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u>		(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number BRIA OF FOREST EDGE

0052035 Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	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			4,209	4,209	8
9	SNF/PED					9
10	ICF	90,192	13		90,205	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	90,192	13	4,209	94,414	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.86%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 11/1/12

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/12 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 112 and days of care provided 4,209

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2019 Fiscal Year: 12/31/2019

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

Facility Name & ID Number **BRIA OF FOREST EDGE** # **0052035** Report Period Beginning: **1/1/2019** Ending: **12/31/2019**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary			1,378,753	1,378,753		1,378,753		1,378,753		1
2	Food Purchase		13,888		13,888		13,888	(649)	13,239		2
3	Housekeeping		3,685	639,247	642,932		642,932		642,932		3
4	Laundry		35,500	427,414	462,914		462,914		462,914		4
5	Heat and Other Utilities			443,338	443,338		443,338	158	443,496		5
6	Maintenance	143,181	59,886	178,078	381,145		381,145	2,184	383,329		6
7	Other (specify):*	385,576		65,646	451,222		451,222	341	451,563		7
8	TOTAL General Services	528,757	112,959	3,132,476	3,774,192		3,774,192	2,034	3,776,226		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	5,122,876	187,077	26,033	5,335,986		5,335,986	73,798	5,409,784		10
10a	Therapy			76,489	76,489		76,489		76,489		10a
11	Activities	241,449	3,473	352	245,274		245,274		245,274		11
12	Social Services	409,965	4,946	512	415,423		415,423		415,423		12
13	CNA Training										13
14	Program Transportation			9,475	9,475		9,475		9,475		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,774,290	195,496	142,861	6,112,647		6,112,647	73,798	6,186,445		16
	C. General Administration										
17	Administrative	194,612		860,500	1,055,112		1,055,112	(849,500)	205,612		17
18	Directors Fees										18
19	Professional Services			534,318	534,318		534,318	20,014	554,332		19
20	Dues, Fees, Subscriptions & Promotions			85,748	85,748		85,748	(31,456)	54,292		20
21	Clerical & General Office Expenses	402,964	30,496	275,938	709,398		709,398	(47,312)	662,086		21
22	Employee Benefits & Payroll Taxes			1,004,066	1,004,066		1,004,066		1,004,066		22
23	Inservice Training & Education			26,093	26,093		26,093	2,308	28,401		23
24	Travel and Seminar			11,236	11,236		11,236	9,573	20,809		24
25	Other Admin. Staff Transportation							(1,963)	(1,963)		25
26	Insurance-Prop.Liab.Malpractice			357,212	357,212		357,212	51,149	408,361		26
27	Other (specify):*			268,215	268,215		268,215	(221,695)	46,520		27
28	TOTAL General Administration	597,576	30,496	3,423,326	4,051,398		4,051,398	(1,068,882)	2,982,516		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,900,623	338,951	6,698,663	13,938,237		13,938,237	(993,050)	12,945,187		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	0
	CONTRACTED DIETARY SERVICES	1,378,753
		1,378,753
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICES	639,247
		639,247
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,249
	CONTRACTED LAUNDRY SERVICES	426,165
		427,414
5	HEAT & OTHER UTILITIES	
	GAS HEAT	98,023
	ELECTRICITY	158,577
	WATER	185,026
	CABLE TV - LOBBY	1,712
		443,338
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,643
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,379
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	126,754
	EXTERMINATING SERVICE	0
	FIRE SERVICE	41,302
		178,078
7	OTHER	
	SCAVENGER	65,646
	SECURITY SERVICE	0
		65,646
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	30,000
		30,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	6,000
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	20,033
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		26,033
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	29,240
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	33,823
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	6,054
	SPEECH THERAPY CONSULTANT XVIII B 43-2	7,372
		76,489
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	352
		352
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	512
	SOCIAL WORKER XVIII B 45-2	0
		512
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	9,475
		9,475
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	860,500
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,551
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	514,767
	BOOKKEEPING/ADMINISTRATIVE SERVICES	
		534,318
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,959
	EMPLOYEE WANT ADS XIX F	21,216
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	22,766
	LICENSES & PERMITS XIX F	2,972
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	24,420
	HEALTH CARE WORKER BACKGROUND CHECK XIX F	1,920
	PATIENT BACKGROUND CHECKS XIX F	4,495
		85,748
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,539
	EQUIPMENT REPAIR & MAINTENANCE	155,542
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	80,490
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	27,641
	MESSENGER SERVICE	3,726
		275,938

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	523,658
	UNEMPLOYMENT COMPENSATION XIX D	55,250
	WORKERS COMPENSATION INSURANCE XIX D	135,132
	HOSPITALIZATION INSURANCE XIX D	272,994
	EMPLOYEE BENEFITS - OTHER XIX D	17,032
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
		1,004,066
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	26,093
		26,093
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	11,236
		11,236
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	357,212
		357,212
27	OTHER	
	BAD DEBTS VI 24	268,215
		268,215

GRAND TOTAL COLUMN 3 OTHER

6,698,663

**BRIA OF FOREST EDGE
SCHEDULES
12/31/2019**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	13,888
LESS SALES TAX	<u>(649)</u>
NET FOOD	13,239
TOTAL PATIENT CENSUS	94,414
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	283,242
ADD # EMPLOYEE MEALS/DAY TIMES # DAYS	<u>79,570</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	283,242
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	0
NET FOOD	13,239
DIVIDE TOTAL MEALS/YEAR	<u>0</u>
COST PER MEAL	#DIV/0!
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>#DIV/0!</u></u>

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			26,776	26,776		26,776	881,561	908,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			81,002	81,002		81,002	665,228	746,230			32
33	Real Estate Taxes							538,413	538,413			33
34	Rent-Facility & Grounds			2,299,400	2,299,400		2,299,400	(2,299,400)				34
35	Rent-Equipment & Vehicles			23,534	23,534		23,534	5,216	28,750			35
36	Other (specify):* RENT OFFICE			26,400	26,400		26,400	78,428	104,828			36
37	TOTAL Ownership			2,457,112	2,457,112		2,457,112	(130,554)	2,326,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,487	768,050	851,537		851,537		851,537			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			728,119	728,119		728,119		728,119			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		83,487	1,496,169	1,579,656		1,579,656		1,579,656			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,900,623	422,438	10,651,944	17,975,005		17,975,005	(1,123,604)	16,851,401			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	19,511	30		9
10	Interest and Other Investment Income	(12,450)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(649)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(80,490)	21		18
19	Entertainment				19
20	Contributions	(24,420)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(268,215)	27		24
25	Fund Raising, Advertising and Promotional	(7,959)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(130,655)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (505,327)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(618,277)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (618,277)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,123,604)		37

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

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

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

BRIA OF FOREST EDGE

ID# 0052035

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (128,692)	21	1
2				2
3	MARKETING TRAVEL	(1,963)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(130,655)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF FOREST EDGE# 0052035

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(649)	0	0	0	0	0	0	0	0	0	0	(649)	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	158	0	0	0	0	0	0	0	0	158	5
6	Maintenance	0	0	2,184	0	0	0	0	0	0	0	0	2,184	6
7	Other (specify):*	0	0	341	0	0	0	0	0	0	0	0	341	7
8	TOTAL General Services	(649)	0	2,683	0	0	0	0	0	0	0	0	2,034	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	73,798	0	0	0	0	0	0	0	0	73,798	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	73,798	0	0	0	0	0	0	0	0	73,798	16
	C. General Administration													
17	Administrative	0	0	(849,500)	0	0	0	0	0	0	0	0	(849,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,700	7,314	0	0	0	0	0	0	0	0	20,014	19
20	Fees, Subscriptions & Promotions	(32,379)	0	923	0	0	0	0	0	0	0	0	(31,456)	20
21	Clerical & General Office Expenses	(209,182)	0	161,870	0	0	0	0	0	0	0	0	(47,312)	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	2,308	0	0	0	0	0	0	0	0	2,308	23
24	Travel and Seminar	0	0	9,573	0	0	0	0	0	0	0	0	9,573	24
25	Other Admin. Staff Transportation	(1,963)	0	0	0	0	0	0	0	0	0	0	(1,963)	25
26	Insurance-Prop.Liab.Malpractice	0	47,828	3,321	0	0	0	0	0	0	0	0	51,149	26
27	Other (specify):*	(268,215)	0	46,520	0	0	0	0	0	0	0	0	(221,695)	27
28	TOTAL General Administration	(511,739)	60,528	(617,671)	0	0	0	0	0	0	0	0	(1,068,882)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(512,388)	60,528	(541,190)	0	0	0	0	0	0	0	0	(993,050)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	19,511	854,472	7,578	0	0	0	0	0	0	0	0	881,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,450)	619,508	58,170	0	0	0	0	0	0	0	0	665,228	32
33	Real Estate Taxes	0	538,413	0	0	0	0	0	0	0	0	0	538,413	33
34	Rent-Facility & Grounds	0	(2,299,400)	0	0	0	0	0	0	0	0	0	(2,299,400)	34
35	Rent-Equipment & Vehicles	0	0	5,216	0	0	0	0	0	0	0	0	5,216	35
36	Other (specify):*	0	78,428	0	0	0	0	0	0	0	0	0	78,428	36
37	TOTAL Ownership	7,061	(208,579)	70,964	0	0	0	0	0	0	0	0	(130,554)	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)	(505,327)	(148,051)	(470,226)	0	0	0	0	0	0	0	0	(1,123,604)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 - SUPPLEMENTAL						

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	34 RENT	\$ 1,699,400	BEVERLY PAVILION LLC		\$	(1,699,400)	1
2	V	19 PROFESSIONAL FEES				12,700	12,700	2
3	V	26 INSURANCE - PROPERTY				47,828	47,828	3
4	V	30 DEPRECIATION-SL				825,667	825,667	4
5	V	32 INTERST				619,508	619,508	5
6	V	33 REAL ESTATE TAXES				538,413	538,413	6
7	V	36 M.I.P. INSURANCE				78,428	78,428	7
8	V							8
9	V	34 RENT	2,299,400	PRESIDENTIAL PAVILION LLC			(2,299,400)	9
10	V	34 RENT				1,699,400	1,699,400	10
11	V	30 DEPRECIATION-SL				28,805	28,805	11
12	V							12
13	V							13
14	Total		\$ 3,998,800			\$ 3,850,749	\$ * (148,051)	14

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

Facility Name & ID Number BRIA OF FOREST EDGE# 0052035Report Period Beginning: 1/1/2019Ending: 12/31/2019

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$ 860,500	BRIA HEALTH SERVICES		\$ (860,500)	15
16	V							16
17	V	17	CFO SALARY-A.WEINFELD			11,000	11,000	17
18	V	10	SALARIES-MEDICARE/NURSING			67,236	67,236	18
19	V	10	SALARIES-REGIONAL DIR RELATED PARTIES			6,562	6,562	19
20	V	21	SALARIES-CLERICAL RELATED PARTIES			11,052	11,052	20
21	V	21	SALARIES-CLERICAL			126,061	126,061	21
22	V	5	UTILITIES			158	158	22
23	V	6	MAINTENANCE			2,184	2,184	23
24	V	7	SCAVENGER			341	341	24
25	V	19	PROFESSIONAL FEES			7,314	7,314	25
26	V	20	DUES,FEES,SUBSCRIPTIONS			923	923	26
27	V	21	OFFICE EXPENSE			24,757	24,757	27
28	V	23	SEMINARS			2,308	2,308	28
29	V	24	TRAVEL			9,573	9,573	29
30	V	26	INSURANCE			3,321	3,321	30
31	V	27	EMPLOYEE BENEFITS			46,520	46,520	31
32	V	30	DEPRECIATION			7,578	7,578	32
33	V	32	INTEREST			58,170	58,170	33
34	V	35	AUTO LEASE			3,440	3,440	34
35	V	35	EQUIPMENT RENTAL			1,776	1,776	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 860,500			\$ 390,274	\$ * (470,226)	39

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

Facility Name & ID Number

BRIA OF FOREST EDGE

0052035

Report Period Beginning:

1/1/2019

Ending: 12/31/2019

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	AVRUM WEINFELD	23.75	BRIA OF CAHOKIA	COHOKIA				1
2								2
3	DANIEL WEISS	23.75	BRIA OF RIVER OAKS	BURNHAM	IME REALTY CORP	SKOKIE	MGMT CONSULT	3
4								4
5	NATAN WEISS	23.75	BRIA OF BELLEVILLE	BELLEVILLE				5
6								6
7	FRED BERKOVITS	23.75	BRIA OF GENEVA	GENEVA	BRIA HEALTH SERVICES, LLC	SKOKIE	MANAGEMENT	7
8								8
9	DOV SEGAL	5	BRIA OF WESTMONT	WESTMONT				9
10					BEVERLY PAVILION		REAL ESTATE	10
11			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO HEIGHTS	LLC	SKOKIE		11
12								12
13								13
14			BRIA OF PALOS HEIGHTS	PALOS HILLS				14
15								15
16			LAKE PARK	WAUKEGAN				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 **BRIA OF FOREST EDGE** # **0052035** Report Period Beginning: **1/1/2019** Ending: **12/31/2019**

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	ALLOCATION FR BRIA HEALTH SERVICES								\$		1
2					SEE						2
3	AVRUM WEINFELD	CFO	ADMINISTRATIV	23.75	ATTACHED	4	10.00	SALARY	11,000	17-7	3
4					SCHEDULE						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,000		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 BRIA OF FOREST EDGE

0052035

Report Period Beginning:

1/1/2019

Ending: 2/31/2019

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 BRIA HEALTH SERVICES LLC
 Street Address 5151 CHURCH STREET
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 674 - 5795
 Fax Number (847) 674 - 5794

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	17	CFO SALARY-A.WEINFELD	wghtd avr hours	9	\$ 99,000	\$ 99,000		\$ 11,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	523,913	373,102	373,102	94,414	67,236	2
3	10	SALARIES-REGIONAL DIR RELA	wghtd avr hours	9	59,058	59,058		6,562	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours	9	98,301	98,301		11,052	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	523,913	699,523	699,523	94,414	126,061	5
6	5	UTILITIES	CENSUS DAYS	523,913	876		94,414	158	6
7	6	MAINTENANCE	CENSUS DAYS	523,913	12,122		94,414	2,184	7
8	7	SCAVENGER	CENSUS DAYS	523,913	1,890		94,414	341	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	523,913	40,586		94,414	7,314	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	523,913	5,122		94,414	923	10
11	21	OFFICE EXPENSE	CENSUS DAYS	523,913	137,380		94,414	24,757	11
12	23	SEMINARS	CENSUS DAYS	523,913	12,805		94,414	2,308	12
13	24	TRAVEL	CENSUS DAYS	523,913	53,120		94,414	9,573	13
14	26	INSURANCE	CENSUS DAYS	523,913	18,429		94,414	3,321	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	523,913	258,147		94,414	46,520	15
16	30	DEPRECIATION	CENSUS DAYS	523,913	42,051		94,414	7,578	16
17	32	INTEREST	CENSUS DAYS	523,913	322,789		94,414	58,170	17
18	35	AUTO LEASE	CENSUS DAYS	523,913	19,199		94,414	3,460	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	523,913	9,854		94,414	1,776	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,263,354	\$ 1,328,984		\$ 390,294	25

Facility Name & ID Number

BRIA OF FOREST EDGE

0052035

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	HUD - CAMBRIDGE - BEVERLY	X		MORTGAGE	\$79,003.00	6/01/12	\$ 17,721,500	\$ 15,532,581	05/01/43	0.0395	\$ 619,508	1						
2												2						
3												3						
4	S.SEGAL			WORKING CAPITAL	\$1,590.00	11/12	150,000	21,815	11/22	0.0500	3,029	4						
5	B.WEINFELD			WORKING CAPITAL	\$2,500.00	11/12	200,000	178,077	11/22	0.1409	25,446	5						
Working Capital																		
6	MB FINANCIAL			WORKING CAPITAL		11/12	3,000,000	700,000		PRIME+	52,527	6						
7												7						
8	RELATED PARTY ALLOCATION										58,170	8						
9	TOTAL Facility Related				\$83,093.00		\$ 21,071,500	\$ 16,432,473			\$ 758,680	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 21,071,500	\$ 16,432,473			\$ 758,680	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,428 Line # 36

* 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 **BRIA OF FOREST EDGE**# **0052035**

Report Period Beginning:

1/1/2019

Ending:

12/31/2019**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 2018 report.			\$	565,083	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.)			\$	587,068	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	21,985	3
4.	Real Estate Tax accrual used for 2019 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	592,939	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 \$ 76,511 For 16 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(76,511)	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	538,413	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2014	<u>476,845</u>	8	FOR BHF USE ONLY		
	2015	<u>481,021</u>	9	13	FROM R. E. TAX STATEMENT FOR 2018	13
	2016	<u>529,981</u>	10	14	PLUS APPEAL COST FROM LINE 5	14
	2017	<u>565,083</u>	11	15	LESS REFUND FROM LINE 6	15
	2018	<u>587,068</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
(
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL						
THE PAYMENT ON LINE 2 APPLIES TO THE 2018 TAX BILL.						

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.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF FOREST EDGE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0052035

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2018 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 2018.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>20-31-108-044-0000</u>	<u>NURSING HOME</u>	\$ <u>587,067.92</u>	\$ <u>587,067.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>587,067.92</u></u>	\$ <u><u>587,067.92</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

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 BRIA OF FOREST EDGE

0052035 Report Period Beginning:

1/1/2019 Ending:

12/31/2019

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,056 B. General Construction Type: Exterior BRICK Frame 7+BASEMENT Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			2005	\$ 1,500,000	1
2					2
3	TOTALS			\$ 1,500,000	3

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	328	2005	2005	\$ 17,449,000	\$ 634,509	27.5	\$ 634,509	\$	\$ 8,750,937	4
5										5
6										6
7	BRIA ALLOC			130,335	3,585		3,585			7
8										8
Improvement Type**										
9	AWNINGS		2001	10,500	382	27.5	382		6,924	9
10	FENCE		2001	2,100		15			2,100	10
11	ELEVATOR		2001	18,340	667	27.5	667		12,089	11
12	ALARM		2001	5,686	207	27.5	207		3,752	12
13	WINDOWS		2001	4,149	151	27.5	151		2,737	13
14	BOILER		2001	3,000	109	27.5	109		1,758	14
15	FURNISHING WALLPAPER & BORDERS		2001	12,953		5			12,953	15
16	KITCHEN SINK & DRAIN		2001	2,525	92	27.5	92		1,667	16
17	DOORS		2001	15,100	549	27.5	549		9,940	17
18	ELEVATOR		2002	222,811	8,102	27.5	8,102		145,836	18
19	FENCE		2002	3,100		15			3,100	19
20	DOORS & LOCKS		2002	21,741	791	27.5	791		14,139	20
21	SHOWER ROOMS		2002	4,669	170	27.5	170		2,940	21
22	ALARM AND SPRINKLER		2002	11,881	432	27.5	432		7,469	22
23	EJECTOR & SEWEGE PUMP		2002	14,604	531	27.5	531		9,182	23
24	ROOF DRAIN		2002	3,100	113	27.5	113		1,982	24
25	FURNISHING - CARPETS AND DRAPERIES		2002	91,494		5			91,494	25
26	ELEVATOR		2003	110,562	4,020	27.5	4,020		67,503	26
27	PARKING LOT		2003	64,182		15			64,182	27
28	FIRE ALARM SYSTEM		2003	25,000	909	27.5	909		15,036	28
29	ROOF		2003	26,500	964	27.5	964		15,866	29
30	EXTERIOR WALL		2003	9,796	356	27.5	356		5,830	30
31	SINKS		2003	3,146	114	27.5	114		1,886	31
32	BUILT IN WARDROBE		2003	19,398	705	27.5	705		11,486	32
33	REBUILD A/C & HEATING RETURN FAN		2004	4,700	171	27.5	171		2,715	33
34	FIRE ALARM SYSTEM		2004	13,201	480	27.5	480		7,580	34
35	BUILT IN WARDROBE		2004	21,807	793	27.5	793		12,325	35
36			2004	61,620	2,241	27.5	2,241		34,269	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 **BRIA OF FOREST EDGE**# **0052035**

Report Period Beginning:

1/1/2019

Ending:

12/31/2019**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>DOORS</u>	2004	\$ 2,995	\$ 109	27.5	\$ 109	\$	\$ 1,658	37
38	<u>BOILER REPAIR</u>	2004	5,650	206	27.5	206		3,098	38
39	<u>HOT WATER HEATER</u>	2004	5,756	209	27.5	209		3,571	39
40	<u>FLOOR TILING</u>	2004	5,326	194	27.5	194		2,918	40
41	<u>REMODEL BATHROOM</u>	2005	6,080	221	27.5	221		3,214	41
42	<u>DOORS</u>	2005	4,506	164	27.5	164		2,385	42
43	<u>FLOOR TILING</u>	2005	1,536	56	27.5	56		814	43
44	<u>2 WATER BOILERS</u>	2005	99,047	3,602	27.5	3,602		51,479	44
45	<u>CONCRETE PATIO</u>	2005	3,015	201	15	201		2,940	45
46	<u>SHOWER</u>	2006	3,040	111	27.5	111		1,503	46
47	<u>DUCT WORK</u>	2006	5,600	204	27.5	204		2,763	47
48	<u>A/C COOLING TOWER</u>	2006	13,161	479	27.5	479		6,007	48
49	<u>FIRE ALARM - BEVERLY</u>	2007	273,534	9,946	27.5	9,946		124,326	49
50	<u>COOLING TOWERS - BEVERLY</u>	2007	121,905	4,433	27.5	4,433		55,412	50
51	<u>SHOWERS - BEVERLY</u>	2007	12,160	442	27.5	442		5,525	51
52	<u>AIR CLEANERS - BEVERLY</u>	2007	10,851	395	27.5	395		4,937	52
53	<u>CONCRETE WORK - BEVERLY</u>	2007	5,100	185	27.5	185		2,405	53
54	<u>SHOWERS - BEVERLY</u>	2008	9,120	333	27.5	333		3,907	54
55	<u>DOORS - BEVERLY</u>	2008	4,520	164	27.5	164		1,961	55
56	<u>BOLIER - BEVERLY</u>	2008	5,295	193	27.5	193		2,211	56
57	<u>FLOORS - BEVERLY</u>	2008	6,260	228	27.5	228		2,575	57
58	<u>ROOFING - BEVERLY</u>	2008	3,800	138	27.5	138		1,547	58
59	<u>EXTERIOR WALL - BEVERLY</u>	2008	20,000	727	27.5	727		8,027	59
60	<u>ROOFING - BEVERLY</u>	2009	10,333	375	27.5	375		4,009	60
61	<u>CAULK JOINTS - BEVERLY</u>	2010	28,450	1,035	27.5	1,035		9,876	61
62	<u>MECHANICAL ROOM - BEVERLY</u>	2010	19,450	707	27.5	707		6,569	62
63	<u>WELDING - BEVERLY</u>	2010	3,587	130	27.5	130		1,186	63
64	<u>ROOF - BEVERLY</u>	2010	2,925	106	27.5	106		967	64
65	<u>STEEL DOOR - BEVERLY</u>	2011	1,275	46	27.5	46		404	65
66	<u>CONTROLLE R- ANNUNCIATOR - BEVERLY</u>	2011	6,649	242	27.5	242		1,886	66
67	<u>CONCRETE - SIDEWALK - BEVERLY</u>	2011	2,375	86	27.5	86		763	67
68	<u>BACKFLOW REPAIR - BEVERLY</u>	2011	4,550	165	27.5	165		1,354	68
69	<u>ELECTRICAL - BEVERLY</u>	2012	4,347	158	27.5	158		1,244	69
70	TOTAL (lines 4 thru 69)		\$ 19,099,198	\$ 687,133		\$ 687,133	\$	\$ 9,643,118	70

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

Facility Name & ID Number **BRIA OF FOREST EDGE**# **0052035**

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,099,198	\$ 687,133		\$ 687,133	\$	\$ 9,643,118	1
2	VINYL FENCE AND GATE	2012	7,400	269	27.5	269		2,051	2
3	SOUTH ROOF FLASHING - BEVERLY	2012	4,350	158	27.5	158		1,192	3
4	KITCHEN IMPROVEMENT - BEVERLY	2012	2,640	96	27.5	96		716	4
5	SIDEWALK - BEVERLY	2012	2,150	78	27.5	78		582	5
6	NORTH ROOF FLASHING - BEVERLY	2012	1,950	71	27.5	71		530	6
7	SPRINKLER MODIFICATIONS	2012	17,530	637	27.5	637		4,592	7
8	FIRE DAMPERS, CEILING, ELECTRICAL WORK - BEVERLY	2012	49,679	1,807	27.5	1,807		13,025	8
9	COMPLETE REBUILD OF CHILLER - BEVERLY	2013	42,700	1,553	27.5	1,553		10,677	9
10	WIRING FOR SATELLITE - BEVERLY	2013	13,325	485	27.5	485		3,254	10
11	FIRE SPRINKLERS - BEVERLY	2013	16,686	607	27.5	607		4,021	11
12	BOILER REBUILD - BEVERLY	2013	8,550	311	27.5	311		2,009	12
13	INSTALL DOOR PACKAGE ON 3 ELEVATORS - BEVERLY	2013	36,000	1,309	27.5	1,309		8,127	13
14	WALK IN FREEZER NEW CONDENSING UNIT - BEVERLY	2013	7,307	266	27.5	266		1,651	14
15									15
16	COMM AWNING WITH NAME	2013	9,200	411	7	1,314	903	9,198	16
17									17
18									18
19	REPLACE ELEVATOR ENCODER & MACHINE BEARINGS	2014	18,060	657	27.5	657		3,750	19
20									20
21	1ST FLOOR DAY RM - GLASS WALLS , DOORS & GUARDS	2014	9,998	364	27.5	364		2,078	21
22	1ST FLOOR - REMOVE VCT AND INSTALL CARPET TILE	2014	20,810	757	27.5	757		4,321	22
23	LOBBY - REMOVE WALL AND INSTALL NEW GLASS								23
24	WALL , DOORS AND ACOUSTICAL CEILING	2014	87,162	3,170	27.5	3,170		18,095	24
25	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								25
26	AND CORRIDOR - PAINT ,WALL COVERING & SIGNAGE	2014	21,335	776	27.5	776		4,430	26
27	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								27
28	AND CORRIDOR - MILL WORK,ELCTRICAL	2014	10,083	367	27.5	367		2,095	28
29	ELEVATOR - WALLCOVERING AND NEW CEILING	2014	24,569	893	27.5	893		5,098	29
30	REFRESHMENT STAND	2014	2,500	91	27.5	91		519	30
31	GUEST BATHRMS & SMOKING PATIO - DOORS & FRAME	2014	8,657	315	27.5	315		1,798	31
32	2ND FLOOR - REBUILD 2 TUB ROOMS	2014	30,531	1,110	27.5	1,110		6,244	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,552,370	\$ 703,691		\$ 704,594	\$ 903	\$ 9,753,171	34

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

Facility Name & ID Number BRIA OF FOREST EDGE

0052035

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 19,552,370	\$ 703,691		\$ 704,594	\$ 903	\$ 9,753,171	1
2	SMOKING PATIO - REMOVE OLD FLR AND WALL AND								2
3	INSTALL NEW FLOOR AND WALLS	2014	5,037	183	27.5	183		1,045	3
4	NURSES STATION - NURSES STATION , ELECTRICAL ,								4
5	BUILT IN CABINETS AND COUNTER TOPS	2014	27,118	986	27.5	986		5,628	5
6	2ND FLOOR CORRIDOR & GREAT ROOM - NEW								6
7	ACOUSTICAL CEILING & LIGHTING	2014	26,708	971	27.5	971		5,543	7
8	2ND FLOOR GREAT ROOM - REMOVE OLD GLASS WALL								8
9	INSTALL NEW STUD WALL	2014	5,700	207	27.5	207		1,182	9
10	2ND FLOOR CORRIDOR & GREAT ROOM - WALL								10
11	COVERINGS	2014	25,444	925	27.5	925		5,280	11
12	2ND FLOOR - VCT AND COVE BASE REMOVAL AND								12
13	OF NEW FLOORING AND CHAIR RAILS	2014	45,077	1,639	27.5	1,639		9,356	13
14	3RD FLOOR - DEMOLISH & REBUILD THE SHOWER	2014	16,540	601	27.5	601		3,331	14
15	AREAS IN BOTH 3RD FLOOR TUB RMS.REBUILD								15
16	INCLUDES TILES, PLUMBING FIXTURES, AND TRIMS								16
17	ALL WINDOWS OF BUILDING TO BE RECAULKED	2014	30,880	1,123	27.5	1,123		5,943	17
18	FIRE SPRINKLERS - ELEVATOR AND SECOND FLOOR	2014	8,600	313	27.5	313		1,630	18
19	18 SMOKE DETECT ELEVATOR & VARIOUS LOCATION	2014	3,191	116	27.5	116		614	19
20	CONCRETE PILLARS	2014	6,800	247	27.5	247		1,286	20
21	INSTALL 2 DAMPERS ON THE MAIN AIR SUPPLY AND	2014	5,480	199	27.5	199		1,036	21
22	RETURN DUCTS								22
23	INSTALL NEW BOILER SECTIONS	2014	11,724	426	27.5	426		2,183	23
24	4 TH FLOOR TUB ROOM REMOVE OLD FLOOR AND	2014	4,430	161	27.5	161		852	24
25	DRAIN INSTALL NEW								25
26	AWNING	2014	6,520	237	27.5	237		1,294	26
27									27
28	1ST FLOOR THERAPY ROOM								28
29	REMOVAL OF EXISTING COVE BASE & VCT	2015	13,694	498	27.5	498		2,386	29
30	PREP & INSTALL OF NEW VINYL & CARPET								30
31	FLOORING & COVE BASE								31
32	FRAME NEW WALLS FOR VESTIBULE , STORAGE,	2015	10,992	400	27.5	400		1,916	32
33	AND WORK STATION, PROVIDE SEPARATE								33
34	TOTAL (lines 1 thru 33)		\$ 19,806,305	\$ 712,923		\$ 713,826	\$ 903	\$ 9,803,676	34

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

Facility Name & ID Number BRIA OF FOREST EDGE

0052035

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 19,806,305	\$ 712,923		\$ 713,826	\$ 903	\$ 9,803,676	1
2	SWITCHING FOR VESTIBULE LIGHTING AND								2
3	6 NEW OUTLETS AND INSTALL DRYWALL ,								3
4	TAPE JOINTS, SMOOTH AND PRIME READY FOR								4
5	FINISHES								5
6	FURNISH & INSTALL NEW CEILING & LIGHTING	2015	15,140	551	27.5	551		2,640	6
7	CEILING TO BE 2X2 FIRE RATED LIGHTING TO BE								7
8	DIRECT INDIRECT RECESSED LIGHTING								8
9	PREP WALLS , INSTALL WALLCOVERING & PAINT	2015	4,569	202	7	202		2,487	9
10	MIRROR WALL 16'11"W X 8'H WITH	2015	2,640	96	27.5	96		460	10
11	CRACK ISOLATION MEMBRANE								11
12	CUSTOM CHARTING STATION WITH 4 LOCKING	2015	9,780	355	27.5	355		1,702	12
13	UPPER CABINETS , 3 PEDESTALS 2 LATERAL FILES								13
14	LAMINATED TOP WITH GRANITE TRANS TOP								14
15	FREIGHT & TAX FOR THERAPY ROOM PROJECT	2015	5,330	194	27.5	194		929	15
16	BUILD WALL WITH DOOR OPENING FOR NEW	2015	4,270	155	27.5	155		743	16
17	THERAPY RM , INSTALL NEW DRY WALL, TAPE								17
18	JOINTS , SAND SMOOTH & PRIME, INSTALL PAIR								18
19	OF DOUBLE DOORS								19
20	WINDOW TREATMENTS -CORNICE ROLLER SHADE	2015	6,354	280	7	280		3,458	20
21	CUBICLE CURTAINS WITH SUSPENDED TRACK	2015	1,920	88	7	88		1,047	21
22	SIGNAGE ON ENTRY & THERAPY RECEPTION AREA	2015	6,796	307	7	307		3,705	22
23	SECURITY SYSTEM IN 2ND FLOOR TO 7TH FLOOR								23
24	STAIR WELL DOORS	2015	24,564	893	27.5	893		3,832	24
25	INSTALLED AS PER CODE ONE ROPE GRIPPER.	2016	36,711	1,335	27.5	1,335		5,062	25
26	SERVICE ELEVATOR- FURNISHED AND INSTALLED NEW ALUMINUM DIAMOND PLATE; REPAIRED PLYWOOD FLOORING IF NECESSAR								26
27	ADJUST AND RETURN CAR TO SERVICE	2016	5,300	193	27.5	193		732	27
28	ROOM 212 AND ROOM 214- REMOVE PLUMBING FIXTURES AND HARDWARE FROM BATHROOMS IN BOTH ROOMS. CAP OFF PLUMBING								28
29	INSIDE WALLS AND PLUG TOILET DRAINS. REMOVE OVERBED LIGHTS, CUBICLE TRACKS, WALL BETWEEN BATHROOMS, CLOSETS								29
30	AND WALL BETWEEN TWO ROOMS. REMOVE AND REROUTE EXISTING ELECTRIC AFTER WALL REMOVAL. PATCH & SAND WALLS AI								30
31	AWININGS								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,929,679	\$ 717,572		\$ 718,475	\$ 903	\$ 9,830,473	34

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

Facility Name & ID Number **BRIA OF FOREST EDGE**# **0052035**

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 19,929,679	\$ 717,572		\$ 718,475	\$ 903	\$ 9,830,473	1
2	WALLS REMOVAL. PREP FOR NEW FINISHES. NURSE CALLS BY OTHERS. FURNISH & INSTALL NEW DOOR & FRAME FOR NEW STORAC								2
3	CLOSET.	2016	14,987	545	27.5	545		1,976	3
4	MODIFY FIRE SPRINKLERS, REMOVE EXISTING LINES FOR DEMO OF THE WALL BETWEEN ROOM 212 & ROOM 214. INSTALL 6 NEW								4
5	HEADS IN THE MIDDLE OF THE ROOM. REMOVE EXISTING LINES FOR DEMO OF THE BATHROOM AND WARDROBE CLOSETS. ADD 2 N								5
6	HEADS UNDER THE SOFFIT	2016	10,332	376	27.5	376		1,363	6
7	ROOMS 212 AND 214- EXISTING COVE BASE AND VCT REMOVAL, PREP FLOOR AND VCT1 AND VCT2 INSTALLATION, CUSTOM PVT								7
8	INSTALLATION, MILLWORK BASE INSTALLATION	2016	3,467	126	27.5	126		457	8
9	ROOM 212 AND 214- WINDOW TREATMENTS INCLUDING 2 CORNICES & 4 ROLLER SHADES &								9
10	INSTALLATION	2016	3,094	112	27.5	112		406	10
11									11
12	AWININGS	2016	5,950	397	15	397		1,390	12
13	INSTALLED NEW CEILING TILE AND LIGHTS; REMOVE A	2016	4,677	170	27.5	170		616	13
14	REPLACE EXISTING DOOR								14
15	EXTEND WALL IN PHYSICAL THERAPY ROOM TO MEET	2016	2,540	92	27.5	92		280	15
16	THE EXTERIOR GLASS WALL.								16
17	REPLACEMENT OF SIDEWALK IN REAR PARK OF THE BU	2017	4,800	320	15	320		800	17
18	SIDEWALK REMOVAL AND REPAIR AT THE REAR OF THI	2017	5,600	373	15	373		933	18
19	REMOVE AND REPLACE REAE CONCRETE STAIRS	2017	7,950	530	15	530		1,325	19
20	EJECTOR PUMP REPLACEMENT; EXISTING PUMP HAS A	2017	8,900	324	27.5	324		824	20
21	BAD PUMP MOTOR AND PUMPHOUSING BOLTING IS								21
22	STRIPPED PREVENTING PUMP FROM PRIMING. ALSO								22
23	FLOAT SYSTEM USED FOR BOTH PUMPS HAS FAILED AND								23
24	REQUIRED REPLACEMENT TO PROVIDE AND REPLACE THE								24
25	LEFT PUMP WITH A NEW OF EQUAL SIZE AND APPLICATION.								25
26	ALSO REPLACE THE PIPING CIRCUIT, THE GATE VALVE,								26
27	CHECK VALVE AND FLOAT BALL W/ROD								27
28	8 FEET TALL CEDAR FENCE	2018	13,500	900	15	900		1,350	28
29	INSTALL ELEVATOR DOOR EQUIPMENT	2019	26,711	607	27.5	607		607	29
30	PARKIN LOT-REPLACE CONCRETE/ASPHALT, SEAL COAT	2019	11,074	369	15	369		369	30
31	PAINTING COMMON AREA/BATHROOMS, HANDRAILS	2019	20,825	2,083	5	2,083		2,083	31
32	NORTH WING ROOF-APPLIED AN ELASTOMERIC COATIN	2019	22,950	383	27.5	383		383	32
33	2ND,3RD,4TH,5TH,6TH,7TH FLOOR-WINDOW TREATMENT	2019	88,159	8,816	5	8,816		8,816	33
34	TOTAL (lines 1 thru 33)		\$ 20,185,195	\$ 734,095		\$ 734,998	\$ 903	\$ 9,854,451	34

**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	\$ 436,477	\$ 16,538	\$ 43,648	\$ 27,110	10 YRS	\$ 165,968	71
72	Current Year Purchases	8,950	8,950	448	(8,502)	10 YRS	448	72
73	Fully Depreciated Assets	775,564					775,564	73
74	RELATED PARTY		129,243	129,243				74
75	TOTALS	\$ 1,220,991	\$ 154,731	\$ 173,339	\$ 18,608		\$ 941,980	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 22,906,186	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 888,826	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 908,337	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,511	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,796,431	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number **BRIA OF FOREST EDGE**

0052035

Report Period Beginning: **1/1/2019**

Ending: **12/31/2019**

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A - RELATED PARTY**

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

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.	_____	\$ _____
13.	_____	\$ _____
14.	_____	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **11,961** Description: **SEE ATTACHED SCHEDULE**

(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	FACILITY VAN	2019 FORD E350	\$ 847.77	\$ 11,573	17
18					18
19					19
20					20
21	TOTAL		\$ 847.77	\$ 11,573	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 353,817	\$		\$ 353,817	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			102,737			102,737	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			311,496			311,496	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 prescrpts				56,240		56,240	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): IV THERAPY						18,322 8,925		18,322 8,925	13
14	TOTAL			\$		\$ 768,050	\$ 83,487		\$ 851,537	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.

Facility Name & ID Number **BRIA OF FOREST EDGE**# **0052035**Report Period Beginning: **1/1/2019**

Ending:

12/31/2019**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2019**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,548	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>787,000</u>)	5,182,608		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	277,850		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	291,485		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,771,491	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	474,266		16
17	Accumulated Depreciation (book methods)	(447,609)		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): <u>Due From Presidential Pavilion</u>	896,470		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 923,127	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,694,618	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,623,548	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	700,000		29
30	Accrued Salaries Payable	200,281		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,751		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
	Other Current Liabilities(specify):			
36	<u>PA LOAN</u>	1,549,200		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,097,780	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	229,893		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)	\$ 229,893	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,327,673	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,366,945	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,694,618	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,663,878	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,663,878	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,228,067	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	(525,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 703,067	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,366,945	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 19,190,622	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,190,622	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,450	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,450	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,203,072	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,774,192	31
32	Health Care	6,112,647	32
33	General Administration	4,051,398	33
B. Capital Expense			
34	Ownership	2,457,112	34
C. Ancillary Expense			
35	Special Cost Centers	851,537	35
36	Provider Participation Fee	728,119	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,975,005	40
41	Income before Income Taxes (line 30 minus line 40)**	1,228,067	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,228,067	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 16,446,119	44
45	Private Pay - Net Inpatient Revenue	2,340	45
46	Medicare - Net Inpatient Revenue	2,312,232	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	102,354	47
48	Other-(specify) <u>MANAGED CARE</u>	327,577	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,190,622	49

* This must agree with page 4, line 45, column 4.
 ** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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.

**TAX RETURN
 PREPARED ON
 CASH BASIS

Facility Name & ID Number **BRIA OF FOREST EDGE**

0052035

Report Period Beginning: **1/1/2019**

Ending:

12/31/2019

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	1,828	2,020	\$ 134,990	\$ 66.83	1
2	Assistant Director of Nursing	1,961	2,089	79,558	38.08	2
3	Registered Nurses	22,537	23,446	797,594	34.02	3
4	Licensed Practical Nurses	48,357	50,701	1,415,451	27.92	4
5	CNAs & Orderlies	138,881	148,944	2,110,659	14.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,427	17,806	241,449	13.56	10
11	Social Service Workers	21,726	23,030	409,965	17.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,610	7,408	143,181	19.33	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	3,896	4,160	194,612	46.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,882	20,089	402,964	20.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,535	5,933	95,769	16.14	31
32	Other Health C: Care Plan Coord	11,667	12,619	488,855	38.74	32
33	Other(specify) <u>Security</u>	26,338	28,484	385,576	13.54	33
34	TOTAL (lines 1 - 33)	324,645	346,729	\$ 6,900,623 *	\$ 19.90	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	M	\$ 0	1-3	35
36	Medical Director	O	30,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	6,000	10-3	38
39	Pharmacist Consultant	H	20,033	10-3	39
40	Physical Therapy Consultant	L	29,240	10a-3	40
41	Occupational Therapy Consultant	Y	33,823	10a-3	41
42	Respiratory Therapy Consultant		6,054	10a-3	42
43	Speech Therapy Consultant	F	7,372	10a-3	43
44	Activity Consultant	E	352	11-3	44
45	Social Service Consultant	E	512	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 133,386		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JANET OLADELE	ADMINISTRATOR	0	\$ 121,245	Workers' Compensation Insurance	\$ 135,132	IDPH License Fee	\$ 1,990	
JULIE KOSMAN	ADMINISTRATOR	0	73,367	Unemployment Compensation Insurance	55,250	Advertising: Employee Recruitment	21,216	
				FICA Taxes	523,658	Health Care Worker Background Check	1,920	
				Employee Health Insurance	272,994	(Indicate # of checks performed 19)		
				Employee Meals	0	Patient Background Checks	32 4,495	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	24,420	
				EMPLOYEE BENEFITS - OTHER	17,032	MARKETING/ADV/PROMO	7,959	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	23,748	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	923	
				INSURANCE - EXECUTIVE LIFE	0	TRUST/FRANCHISE/CONTRIB/ETC	(24,420)	
						Less: Public Relations Expense	(0)	
						Non-allowable advertising	(7,959)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 194,612	INSURANCE - EXECUTIVE LIFE VI 21	0			
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,004,066	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 54,292	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
BRIA HEALTH CARE SERVICE MANAGEMENT FEES			\$ 860,500				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 860,500					11,236
							MGMT ALLOC	9,573
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount					0
ALPHA DATA	DATA PROCESSING		\$ 1,823				Entertainment Expense	()
NATIONAL DATACARE CORP	DATA PROCESSING		6,329				(agree to Sch. V, line 24, col. 8)	
PARAGON	DATA PROCESSING		11,399				TOTAL	\$ 20,809
KBKB LTD	ACCOUNTING		18,000					
RICARD PEELO & ASSOCIATES	MEDICARE CONSULTANT		4,500					
PERSONNEL PLANNERS	UC CONSULTANT		12,200					
RESOLUTE HEALTHCARE SOL	LTC MEDICAID PROCESS		300					
FODOR ENGINEERING & DESIGN	STRUCTURAL ENGINEER SE		3,300					
US HOUSING CONSULTANTS	PRE - REAC INSPECTION		8,888					
ELEVATE ENERGY	BENCHMARK REPORTING		650					
SEE LEGAL SCHEDULE ATTACHED			466,929					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 534,318	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

BUA OF FOREST EDGE
SCHOOL LOCAL

01/01/19
1/31/19

INVOICE DATE FIRM NAME

DESCRIPTION AMOUNT

1120219 ADR SYSTEMS MEDATION 1,880.00

1102219 ADR SYSTEMS MEDATION 4,880.00

1020219 ALLEGRO RECORD SOLUTIONS MEDICAL RECORD PROCESSING FEE 71.50

1420219 ALLEGRO RECORD SOLUTIONS MEDICAL RECORD PROCESSING FEE 71.50

2440219 ALLEGRO RECORD SOLUTIONS MEDICAL RECORD PROCESSING FEE 71.50

440219 ALLEGRO RECORD SOLUTIONS MEDICAL RECORD PROCESSING FEE 71.50

1020219 ALLEGRO RECORD SOLUTIONS MEDICAL RECORD PROCESSING FEE 71.50

1020219 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 2,650.00

1020219 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 980.00

240219 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 1,450.00

1020219 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 350.00

6012019 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 268.00

7162019 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 98.50

1020219 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 350.00

1020219 ANDERSON RASOR & PARTNERS LLP DEFENSE OF LIABILITY SUIT 67.50

830219 CARDEN & SAA DEFENSE OF LIABILITY SUIT 4,508.01

8412019 CARDEN & SAA DEFENSE OF LIABILITY SUIT 688.00

9412019 CARDEN & SAA DEFENSE OF LIABILITY SUIT 3,280.00

6202019 CARDEN & SAA DEFENSE OF LIABILITY SUIT 4,187.00

11060219 CARDEN & SAA DEFENSE OF LIABILITY SUIT 1,166.00

1012019 CARDEN & SAA DEFENSE OF LIABILITY SUIT 4,274.00

280219 CARDEN & SAA DEFENSE OF LIABILITY SUIT 1,150.00

10180219 CHUBB GROUP OF INSURANCE CO LEGAL SERVICES 168.00

9272019 CUNNINGHAM MEYER & WEDRNE P.C. LEGAL SETTLEMENT 4,642.00

6020219 CUNNINGHAM MEYER & WEDRNE P.C. FILING FEE 467.00

10102019 CUNNINGHAM MEYER & WEDRNE P.C. LEGAL SETTLEMENT 3,610.00

10302019 CUNNINGHAM MEYER & WEDRNE P.C. FILING FEE 465.00

10302019 CUNNINGHAM MEYER & WEDRNE P.C. LEGAL SERVICES 8,000.00

11102019 CUNNINGHAM MEYER & WEDRNE P.C. FILING FEE 3,811.00

12102019 CUNNINGHAM MEYER & WEDRNE P.C. LEGAL SERVICES 3,817.00

8002019 FEDERAL INSURANCE COMPANY LEGAL SETTLEMENT 805.50

8620219 HEPLER BROOK LLC LEGAL SETTLEMENT 1,174.00

12102019 HEPLER BROOK LLC LEGAL SETTLEMENT 2,259.00

10202019 HEPLER BROOK LLC LEGAL SETTLEMENT 2,340.00

11102019 HEPLER BROOK LLC LEGAL SETTLEMENT 1,539.00

1102019 HEPLER BROOK LLC LEGAL SETTLEMENT 1,838.84

8180219 JACKSON LEWIS P.C. CONSULTATIONS 331.00

8202019 KYRA S G. PAYNE P.C. GUARDIANSHIP 11,600.00

12130219 LAY BULLETIN PUBLISHING CO FACT SEARCH 25.00

8412019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 71.50

9302019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 10,380.00

10312019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 5,300.00

1102019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,380.00

113002019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

1102019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

1102019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,800.00

12012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

12012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

10202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 482.50

10202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,650.00

10202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 3,630.00

1012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

1012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

1012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

10202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

20202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

20202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

20202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

20202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

3012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

3012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

40202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

40202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

40202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

5012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

6002019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

6002019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

7112019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 791.00

7012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

7012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

7012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

7012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

80202019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

8012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

8012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

8012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 1,500.00

8012019 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,300.00

870219 MCCABE KRISNER DEFENSE OF LIABILITY SUIT 2,600.00

9012019 MCCABE KRISNER P.L.L.C. LITIGATION 1,500.00

9012019 MCCABE KRISNER P.L.L.C. LITIGATION 1,500.00

103002019 MCCABE KRISNER P.L.L.C. LITIGATION 1,500.00

103002019 MCCABE KRISNER P.L.L.C. LITIGATION 1,500.00

3410219 MICHAEL HUBBARD GUARDIANSHIP 1,182.50

7302019 MICHAEL LIPCHICK HLABARD RELATIONS CONSULTANT 4,620.00

10020219 MORRIS MANNING & MATRIN LLP RE HABERFEL LEGAL CONSULTING 20,000.00

10120219 MORRIS MANNING & MATRIN LLP LEGAL REGARDING RFD 22,832.25

10202019 SKOPEL SKY & ASSOCIATES REAL ESTATE TAX REDUCTION 65,344.60

12302019 PPRETZEL STOFFER REFUND OF OVERPAYMENT (5,912.81)

1102019 HENS RAGDS LEGAL FEES 2,867.50

73012019 SATWANT KINGRA, MD LETTERS OF OFFICE FEE 2,160.00

11012019 SAKLAW COURT CASE 6,417.41

11012019 SAKLAW COURT CASE 490.00

11012019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

1202019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 900.00

2102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

2102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

312019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

312019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

412019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

412019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

512019 SBC INC CLASS ACTION FOR PAYMENT OF ME 900.00

602019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

602019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

602019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

7102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 900.00

7102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

8102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

802019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

802019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

1012019 SBC INC CLASS ACTION FOR PAYMENT OF ME 900.00

1102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 900.00

102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

102019 SBC INC CLASS ACTION FOR PAYMENT OF ME 188.67

120219 SBC INC CLASS ACTION FOR PAYMENT OF ME 900.00

780219 SORHAN ZEFFREN LEGAL FEES 650.00

1012019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

2082019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

402019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

402019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

602019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

602019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

8102019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

802019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

802019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

11020219 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

1202019 STONE MCGUIRE & SECIGL COMPLIANCE MEETINGS & EDUCATE 700.00

3410219 THOMPSON COBURN LLP REVOLVING LINE LOAN 846.00

1042019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

10202019 U.S. LEGAL SUPPORT COURT REPORTING FEES 29.00

1062019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

10202019 U.S. LEGAL SUPPORT COURT REPORTING FEES 29.00

8012019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

8102019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

8102019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

8102019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

8102019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

8102019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

8102019 U.S. LEGAL SUPPORT COURT REPORTING FEES 190.00

10202019 VANEK LARSON & KOLE LLC GUARDIANSHIP 730.00

8102019 VANEK LARSON & KOLE LLC GUARDIANSHIP 730.00

5012019 CHUBB GROUP OF INSURANCE CO LEGAL SETTLEMENT (32,500.00)

80202019 DELAINE WILLIAMS LEGAL SETTLEMENT 12,790.00

80202019 HEPLER BROOK LLC LEGAL SETTLEMENT 6,819.76

1802019 HEPLER BROOK LLC LEGAL SETTLEMENT 3,185.00

2102019 HEPLER BROOK LLC LEGAL SETTLEMENT 8,840.00

3402019 HEPLER BROOK LLC LEGAL SETTLEMENT 4,854.85

4102019 HEPLER BROOK LLC LEGAL SETTLEMENT 866.88

5102019 HEPLER BROOK LLC LEGAL SETTLEMENT 361.00

7102019 HEPLER BROOK LLC LEGAL SETTLEMENT 1,207.00

9102019 HEPLER BROOK LLC LEGAL SETTLEMENT 862.00

80202019 KATHRYN BURRIDGE LEGAL SETTLEMENT 18,500.00

2082019 LAW OFFICES OF STEVEN J. HALAMAN LEGAL SETTLEMENT 30,000.00

30702019 LAW OFFICES OF STEVEN J. HALAMAN LEGAL SETTLEMENT 31,250.00

3102019 PEARLINE HOLY & ATTY MARION GRAY LEGAL SETTLEMENT 25,000.00

5012019 SPREIBERGER LAW GROUP LEGAL SETTLEMENT 17,000.00

10102019 TAMMY VISVADOS ALLEN N. SCHWARTZ LEGAL SETTLEMENT 7,607.37

12102019 HELLGABEL VERLY VEALS LEGAL SETTLEMENT - GUARDIANSHIP 16,895.60

TOTAL 16,895.60

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. HEALTH CARE COUNCIL OF ILL \$22,416
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,231 Line 10-2
- (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 _____ 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. \$ 728,119
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees