

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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.

I. IDPH License ID Number: 0038604

Facility Name: BEVERLY FARM FOUNDATION

Address: 6301 HUMBERT ROAD GODFREY 62035
Number City Zip Code

County: MADISON

Telephone Number: (618) 466-0367 Fax #: (618) 466-3652

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501(c)(3)

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: CRYSTAL OFFICER Telephone Number: (618) 466-0367
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 07/01/2024 to 06/30/2025 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)

(Type or Print Name) CRYSTAL OFFICER

(Title) CEO

Paid Preparer

(Signed)

(Print Name and Title) DANIEL PHIPPS PRINCIPAL

(Firm Name & Address) SCHEFFEL BOYLE 106 W. COUNTY ROAD, JERSEYVILLE, IL 62052

(Telephone) (618) 498-6841 Fax #: (618) 498-6842

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number BEVERLY FARM FOUNDATION # 0038604 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	300	Intermediate/DD	300	109,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF	51,783							51,783	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	51,783							51,783	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 47.29%

D. How many bed reserve days during this year were paid by the Department? 577 (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 10/01/1957

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter certified beds. number of certified beds _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2025 Fiscal Year: 06/30/2025

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

Facility Name & ID Number		BEVERLY FARM FOUNDATION				#	0038604	Report Period Beginning:		07/01/2024	Ending:		Page 3	06/30/2025
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			1,478,092	1,478,092		1,478,092		1,478,092					1
2	Food Purchase		646,125		646,125		646,125		646,125					2
3	Housekeeping		45,562	136,863	182,425		182,425		182,425					3
4	Laundry			315,614	315,614		315,614		315,614					4
5	Heat and Other Utilities			523,765	523,765		523,765		523,765					5
6	Maintenance	249,928	80,650	345,241	675,819		675,819		675,819					6
7	Other (specify):* SECURITY			43,926	43,926		43,926		43,926					7
8	TOTAL General Services	249,928	772,337	2,843,501	3,865,766		3,865,766		3,865,766					8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	6,182,078	175,135	944,100	7,301,313	(217,595)	7,083,718		7,083,718					10
10a	Therapy	200,843	1,065	2,688	204,596		204,596		204,596					10a
11	Activities	46,393	4,833	2,264	53,490		53,490		53,490					11
12	Social Services	43,628			43,628		43,628		43,628					12
13	CNA Training	58,287			58,287	221,173	279,460		279,460					13
14	Program Transportation	231,866			231,866		231,866		231,866					14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	6,763,095	181,033	949,052	7,893,180	3,578	7,896,758		7,896,758					16
	C. General Administration													
17	Administrative	335,691	48,151	278,789	662,631	9,551	672,182		672,182					17
18	Directors Fees													18
19	Professional Services			666,027	666,027		666,027	(69,467)	596,560					19
20	Dues, Fees, Subscriptions & Promotions			117,655	117,655		117,655		117,655					20
21	Clerical & General Office Expenses	713,588	163,600	104,811	981,999		981,999		981,999					21
22	Employee Benefits & Payroll Taxes			2,065,042	2,065,042		2,065,042		2,065,042					22
23	Inservice Training & Education			5,114	5,114	(345)	4,769		4,769					23
24	Travel and Seminar			24,168	24,168	(19,319)	4,849		4,849					24
25	Other Admin. Staff Transportation			620	620		620		620					25
26	Insurance-Prop.Liab.Malpractice			302,461	302,461		302,461		302,461					26
27	Other (specify):* FUNDRAISING/ADV	203,745		16,339	220,084	6,535	226,619	(226,619)						27
28	TOTAL General Administration	1,253,024	211,751	3,581,026	5,045,801	(3,578)	5,042,223	(296,086)	4,746,137					28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,266,047	1,165,121	7,373,579	16,804,747		16,804,747	(296,086)	16,508,661					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 (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			1,114,538	1,114,538		1,114,538	(602,939)	511,599			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,379	129,379		129,379	(129,379)				32
33	Real Estate Taxes			267	267		267	(267)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS.			11,294	11,294		11,294		11,294			36
37	TOTAL Ownership			1,255,478	1,255,478		1,255,478	(732,585)	522,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	43,611		27,443	71,054		71,054		71,054			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			725,361	725,361		725,361		725,361			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	43,611		752,804	796,415		796,415		796,415			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	8,309,658	1,165,121	9,381,861	18,856,640		18,856,640	(1,028,671)	17,827,969			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.)

	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	(602,939)	30		9
10	Interest and Other Investment Income	(107,535)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(12,208)	32		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	(9,636)	32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(69,467)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(226,619)	27		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 ATTACHED	(267)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,028,671)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,028,671)		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.			\$		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

ID#0038604

Report Period Beginning:07/01/2024

Ending:06/30/2025

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	REAL ESTATE TAXES (ALLOCATED TO MC)	(267)	33	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	(267)		49

Summary A

06/30/2025

[illegible]

Summary B

Facility Name & ID Number	BEVERLY FARM FOUNDATION	#	0038604	Report Period Beginning:	07/01/2024	Ending:	06/30/2025
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06/30/2025

[illegible]

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
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			
		GROUP HOME #6	GODFREY			

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			\$			\$	\$	1
2	V								2
3	V								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			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

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

VII. RELATED PARTIES

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

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

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	BOARD OF DIRECTORS	BOD	BOD	0.00	NONE	82	0.00		\$ 0	N/A	1
2	(SEE OWNERSHIP-1)										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 BEVERLY FARM FOUNDATION # 0038604 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 GROUP HOMES #1-#6
Street Address _____
City / State / Zip Code GODFREY, IL 62035
Phone Number (618) 466-0367
Fax Number (618) 466-3652

	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	2-2	FOOD COSTS	RESIDENT COUNT	3,190	9	\$ 2,662	\$	1,733	\$ 1,446	1
2	3-2	OSHA/PANDEMIC SUPPLIES	RESIDENT COUNT	3,190	9	986		1,737	537	2
3	3-3	JANITOR SERVICE	RESIDENT COUNT	3,190	9	14,342		1,731	7,783	3
4	5-3	HEAT AND OTHER UTILITIES	RESIDENT COUNT	3,190	9	19,032		1,807	10,778	4
5	6-2	MAINTENANCE SUPPLIES	RESIDENT COUNT	3,190	9	32,526		1,817	18,527	5
6	6-3	MAINTENANCE-OTHER	RESIDENT COUNT	3,190	9	234,223		2,510	184,318	6
7	7-3	SECURITY/SAFETY	RESIDENT COUNT	3,190	9	80,942		1,731	43,926	7
8	10-2	NURSING AND MEDICAL SUPP	RESIDENT COUNT	3,190	9	52,402		2,815	46,234	8
9	10-3	CONTRACT NURSING	RESIDENT COUNT	3,190	9	848,862		2,871	763,976	9
10	11-2	ACTIVITIES SUPPLIES	RESIDENT COUNT	3,190	9	3,360		1,735	1,827	10
11	11-3	ACTIVITIES OTHER	RESIDENT COUNT	3,190	9	2,971		1,732	1,613	11
12	17-2	ADMINISTRATIVE-SUPPLIES	RESIDENT COUNT	3,190	9	62,681		1,733	34,056	12
13	17-3	ADMINISTRATIVE-OTHER	RESIDENT COUNT	3,190	9	359,738		1,782	200,995	13
14	19-3	LEGAL & ACCOUNTING	RESIDENT COUNT	3,190	9	1,227,274		1,731	666,027	14
15	20-3	DUES/SUBS/ADVERTISING	RESIDENT COUNT	3,190	9	186,408		1,963	114,737	15
16	21-2	SOFTWARE UPGRADES/SUPPI	RESIDENT COUNT	3,190	9	237,713		1,742	129,784	16
17	21-3	OUTSIDE ADMIN SERVICES	RESIDENT COUNT	3,190	9	186,012		1,769	103,167	17
18	22-3	EMPLOYEE BENEFITS	RESIDENT COUNT	3,190	9	1,240,121		2,186	849,707	18
19	23-3	MEETINGS/INSERVICE	RESIDENT COUNT	3,190	9	6,634		1,731	3,600	19
20	24-3	TRAVEL & SEMINAR	RESIDENT COUNT	3,190	9	43,153		1,741	23,551	20
21	25-3	TRANSPORTATION COSTS	RESIDENT COUNT	3,190	9	1,144		1,729	620	21
22	26-3	INSURANCE	RESIDENT COUNT	3,190	9	545,800		1,768	302,461	22
23	27-3	FUNDRAISING	RESIDENT COUNT	3,190	9	30,108		1,731	16,339	23
24	32-3	INTEREST	RESIDENT COUNT	3,190	9	213,096		1,804	120,496	24
25	TOTALS					\$ 5,632,190	\$		\$ 3,646,505	25

Facility Name & ID Number BEVERLY FARM FOUNDATION # 0038604 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 GROUP HOMES #1-#6
Street Address _____
City / State / Zip Code GODFREY, IL 62035
Phone Number (618) 466-0367
Fax Number (618) 466-3652

	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	33-3	REAL ESTATE TAXES	RESIDENT COUNT	3,190	9	\$ 492	\$	1,731	\$ 267	1
2	36-3	MORTGAGE INSURANCE	RESIDENT COUNT	3,190	9	20,811		1,731	11,294	2
3	39-3	ANCILLARY SERVICES	RESIDENT COUNT	3,190	9	30,492		2,871	27,443	3
4	6-1	MAINTENANCE SALARIES	RESIDENT COUNT	3,190	9	459,699	459,699	1,733	249,762	4
5	10-1	NURSING AND MEDICAL REC	RESIDENT COUNT	3,190	9	1,832,417	1,832,417	2,800	1,608,456	5
6	11-1	ACTIVITIES SALARIES	RESIDENT COUNT	3,190	9	85,439	85,439	1,732	46,393	6
7	13-1	CNA TRAINING SALARIES	RESIDENT COUNT	3,190	9	106,803	106,803	1,741	58,287	7
8	14-1	TRANSPORTATION SALARIES	RESIDENT COUNT	3,190	9	251,134	251,134	2,871	226,021	8
9	17-1	ADMINISTRATIVE SALARIES	RESIDENT COUNT	3,190	9	343,514	343,514	2,011	216,603	9
10	21-1	PERSONNEL-ACCOUNTING SA	RESIDENT COUNT	3,190	9	1,070,732	1,070,732	1,642	551,042	10
11	27-1	FUNDRAISING/DEVELOPMEN	RESIDENT COUNT	3,190	9	375,437	375,437	1,731	203,745	11
12	39-1	ANCILLARY SALARIES	RESIDENT COUNT	3,190	9	48,456	48,456	2,871	43,611	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					\$ 4,625,426	\$ 4,573,631		\$ 3,242,924	25

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	GERSHMAN MORTGAGE		X	REFINANCE BONDS	\$35,358.00	09/09/13	\$ 5,529,060	\$ 2,624,484	08/01/32	0.0417	\$ 104,349	1	
2	AMORTIZATION OF DEBT COST		X								3,186	2	
3												3	
4												4	
5												5	
	Working Capital												
6	WELLS FARGO		X	WORKING CAPITAL		05/13/19			N/A	VARIABLE		6	
7												7	
8												8	
9	TOTAL Facility Related				\$35,358.00		\$ 5,529,060	\$ 2,624,484			\$ 107,535	9	
	B. Non-Facility Related*												
10	FINANCE LEASES		X		\$7,100.00	7/1/22	537,244	161,649			12,208	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related				\$7,100.00		\$ 537,244	\$ 161,649			\$ 12,208	14	
15	TOTALS (line 9+line14)						\$ 6,066,304	\$ 2,786,133			\$ 119,743	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,294 Line # 36-3

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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.)				\$	2672
3. Under or (over) accrual (line 2 minus line 1).				\$	2673
4. Real Estate Tax accrual used for 2025 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.				\$	2677
Assessed Value from Real Estate Tax Bill:	2024	3,956	8		
Real Estate Tax Bill for Calendar Year:	2020	3,069	9		
	2021	3,164	10		
	2022	3,254	11		
	2023	464	12		
	2024	267	13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

FACILITY NAME	BEVERLY FARM FOUNDATION	COUNTY	MADISON
---------------	-------------------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

BRICK

Frame

WOOD & STEEL

Number of Stories

ONE

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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. 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.

K. 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	
Use		Square Feet	Year Acquired	Cost	
1	FACILITY	6,701,800	1955	\$ 60,245	1
2	GROUND IMPROV			138,971	2
3	TOTALS	6,701,800		\$ 199,216	3

Facility Name & ID Number BEVERLY FARM FOUNDATION

0038604

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	129		1960	1960	\$ 340,034	\$	40	\$	\$	\$ 340,034	4
5	26		1965	1965	166,210		40			166,210	5
6	35		1969	1969	309,300		40			309,300	6
7	26		1972	1972	277,051		40			277,051	7
8	84		1979	1979	628,784		40			628,784	8
	Improvement Type**										
9	43 BEDS INCLUDED IN LINE 8 YEAR ACQUIRED 1984			1984	1,188,870	14,861	40	14,861		1,188,870	9
10	BUILDING IMPROVEMENTS			1960	85,138		40			85,138	10
11	BUILDING IMPROVEMENTS			1978	13,587		40			13,587	11
12	BUILDING IMPROVEMENTS			1979	23,978		40			23,978	12
13	BUILDING IMPROVEMENTS			1980	144,364		40			144,364	13
14	BUILDING IMPROVEMENTS			1981	449,724		40			449,724	14
15	BUILDING IMPROVEMENTS			1982	110,842		VAR			110,826	15
16	BUILDING IMPROVEMENTS			1983	175,982		VAR			175,982	16
17	BUILDING IMPROVEMENTS			1984	75,230	223	VAR	223		75,230	17
18	BUILDING IMPROVEMENTS			1985	817,404	3,726	VAR	3,726		815,541	18
19	BUILDING IMPROVEMENTS			1986	330,968	7,600	VAR	7,600		319,568	19
20	BUILDING IMPROVEMENTS			1987	123,834	2,601	VAR	2,601		117,331	20
21	BUILDING IMPROVEMENTS			1988	66,720	45	VAR	45		66,562	21
22	BUILDING IMPROVEMENTS			1990	1,053,989	24,200	VAR	24,200		909,127	22
23	BUILDING IMPROVEMENTS			1991	19,196	116	VAR	116		18,502	23
24	BUILDING IMPROVEMENTS			1992	1,483,030		VAR			1,483,030	24
25	BUILDING IMPROVEMENTS			1993	662,414		VAR			662,414	25
26	BUILDING IMPROVEMENTS			1994	159,277		VAR			159,277	26
27	BUILDING IMPROVEMENTS			1995	212,775		VAR			212,775	27
28	BUILDING IMPROVEMENTS			1996	139,129		VAR			139,129	28
29	BUILDING IMPROVEMENTS			1997	193,027		VAR			193,027	29
30	BUILDING IMPROVEMENTS			1998	160,685		VAR			160,685	30
31	BUILDING IMPROVEMENTS			1999	299,020	30	VAR	30		299,020	31
32	BUILDING IMPROVEMENTS			2000	293,611	924	VAR	924		293,149	32
33	BUILDING IMPROVEMENTS			2001	174,038	157	VAR	157		173,802	33
34	BUILDING IMPROVEMENTS			2002	88,643		VAR			88,643	34
35	BUILDING IMPROVEMENTS			2003	182,740		VAR			182,740	35
36	BUILDING IMPROVEMENTS			2004	281,459	1,227	VAR	1,227		275,939	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	BUILDING IMPROVEMENTS	2005	\$ 127,219	\$ 105	VAR	\$ 105		\$ 127,166	37
38	BUILDING IMPROVEMENTS	2006	360,423	6,539	VAR	6,539		322,218	38
39	BUILDING IMPROVEMENTS	2007	115,991	893	VAR	893		109,296	39
40	BUILDING IMPROVEMENTS	2008	79,830		VAR			79,830	40
41	BUILDING IMPROVEMENTS	2009	13,900		10			13,900	41
42	BUILDING IMPROVEMENTS	2010	109,953	353	VAR	353		108,014	42
43	BUILDING IMPROVEMENTS	2011	139,446		VAR			135,383	43
44	BUILDING IMPROVEMENTS	2012	149,474	4,850	VAR	4,850		114,252	44
45	BUILDING IMPROVEMENTS	2013	534,882	20,022	VAR	20,022		394,699	45
46	BUILDING IMPROVEMENTS	2014	339,943	2,270	VAR	2,270		339,943	46
47	BUILDING IMPROVEMENTS	2015	456,144	23,897	VAR	23,897		324,384	47
48	BUILDING IMPROVEMENTS	2016	274,864	23,268	VAR	23,268		228,376	48
49	BUILDING IMPROVEMENTS	2017	438,353	40,951	VAR	40,951		341,875	49
50	BUILDING IMPROVEMENTS	2018	577,233	50,072	VAR	50,072		417,479	50
51	BUILDING IMPROVEMENTS	2019	366,631	33,536	VAR	33,536		208,432	51
52	BUILDING IMPROVEMENTS	2020	156,528	13,000	VAR	13,000		65,566	52
53	BUILDING IMPROVEMENTS	2021	153,811	12,731	VAR	12,731		48,250	53
54	BEVERLY - HVAC ACTIVITY ROOM	2022	5,500	550	10	550		1,925	54
55	CHAPPEE - WATER HEATER	2022	6,994	700	10	700		1,748	55
56	DIETARY - 1 BOILER	2022	35,699	1,785	20	1,785		6,247	56
57	DIETARY - INSINK DISPOSER	2022	6,329	1,266	5	1,266		3,165	57
58	EVANS - ONYX SHOWER	2022	10,850	1,085	10	1,085		2,713	58
59	HERRING - 1 5 TON TRANE HVAC	2022	8,500	850	10	850		2,125	59
60	HERRING - LINEN CABINETS	2022	6,700	670	10	670		1,675	60
61	HILLIER - NEW SPRINKLER SYSTEM	2022	368,907	14,756	25	14,756		36,891	61
62	LAVENTHAL - 3 HVAC SYSTEMS	2022	16,500	1,650	10	1,650		5,775	62
63	STAHL - HVAC ACTIVITY ROOM	2022	5,500	550	10	550		1,925	63
64	STAHL DOORS 4, 5, 8 WEST ACTIVITY	2022	4,315	431	10	431		1,510	64
65	STAHL - 3 5 TON TRANE HVACS	2022	19,000	1,900	10	1,900		4,750	65
66	BEVERLY - NEW ROOF	2023	36,000	1,440	25	1,440		3,600	66
67	DONNELLEY - NEW ROOF	2023	41,125	1,645	25	1,645		4,113	67
68	DONNELLEY - 2 BOILERS	2023	95,000	4,750	20	4,750		7,125	68
69	EVANS - NEW FIRE ALARM SYSTEM	2023	9,080	908	10	908		2,270	69
70	TOTAL (lines 4 thru 69)		\$ 15,801,677	\$ 323,133		\$ 323,133	\$	\$ 14,025,959	70

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

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		\$ 15,801,677	\$ 323,133		\$ 323,133	\$	\$ 14,025,959	1
2	LOGAN -NEW CEILINGS IN BATHROOMS	2023	18,684	1,868	10	1,868		4,671	2
3	LOGAN -2 BOILERS	2023	105,000	5,250	20	5,250		7,875	3
4	MAIN CAMPUS - 7 DOORS	2023	6,565	657	10	657		1,641	4
5	STAHL - NEW ROOF	2023	40,575	1,623	25	1,623		4,057	5
6	DIETARY - INSINK DISPOSER	2024	7,515	1,503	5	1,503		2,254	6
7	DIETARY - DISHWASHER	2024	22,095	2,209	5	2,209		2,209	7
8	DONNELLEY - NEW SHOWER	2024	14,130	706	10	706		706	8
9	EVANS - EAST AND WEST HALL FIRE DOORS	2024	4,692	469	10	469		704	9
10	EVANS - NATURAL GAS WATER HEATER	2024	14,995	750	10	750		750	10
11	HILLIER - 2 HVACS WING D	2024	19,991	2,000	10	2,000		2,999	11
12	HILLIER - COMPLETE INTERIOR PAINTING	2024	34,820	3,482	5	3,482		3,482	12
13	HILLIER - 2 HVAC IN WING C	2024	19,991	1,000	10	1,000		1,000	13
14	LAVENTHAL - FIRE ALARM PANEL	2024	8,438	844	10	844		1,266	14
15	LOGAN - FIRE ALARM PANEL	2024	9,022	902	10	902		1,353	15
16	STAHL - WATER HEATER	2024	2,886	288	10	288		433	16
17	BEVERLY - DOOR	2025	3,336	167	10	167		167	17
18	DONNELLEY - REAR KITCHEN ENTRY DOOR	2025	3,286	164	10	164		164	18
19	HERRING - AIR HANDLER UNIT	2025	4,512	226	10	226		226	19
20	HERRING - FIRE ALARM CABLE	2025	17,275	345	25	345		345	20
21	HILLIER - KITCHEN WALLS/CABINETS, 4 NEW SHOWERS	2025	108,000	5,400	10	5,400		5,400	21
22	STAHL - DOOR	2025	2,585	129	10	129		129	22
23	BUILDING IMPROVEMENTS-ALLOCATED	1996	667,309	16,683	VAR	16,683		475,458	23
24	BUILDING IMPROVEMENTS-ALLOCATED	1997	10,315		VAR			10,315	24
25	BUILDING IMPROVEMENTS-ALLOCATED	1998	11,308		15			11,308	25
26	BUILDING IMPROVEMENTS-ALLOCATED	1999	618		20			618	26
27	BUILDING IMPROVEMENTS-ALLOCATED	2000	329		20			329	27
28	BUILDING IMPROVEMENTS-ALLOCATED	2004	752		10			752	28
29	BUILDING IMPROVEMENTS-ALLOCATED	2012	2,870		VAR			2,840	29
30	BUILDING IMPROVEMENTS-ALLOCATED	2013	33,415		VAR			33,415	30
31	BUILDING IMPROVEMENTS-ALLOCATED	2014	10,619		10			10,619	31
32	BUILDING IMPROVEMENTS-ALLOCATED	2015	16,934	926	VAR	926		16,934	32
33	BUILDING IMPROVEMENTS-ALLOCATED	2016	78,163	5,264	20	5,264		59,227	33
34	TOTAL (lines 1 thru 33)		\$ 17,102,702	\$ 375,988		\$ 375,988	\$	\$ 14,689,605	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 17,102,702	\$ 375,988		\$ 375,988	\$	\$ 14,689,605	1
2	BUILDING IMPROVEMENTS-ALLOCATED	2017	336,136	14,274	VAR	14,274		111,781	2
3	BUILDING IMPROVEMENTS-ALLOCATED	2018	35,000	2,987	VAR	2,987		25,015	3
4	BUILDING IMPROVEMENTS-ALLOCATED	2019	23,431	2,317	10	2,317		14,732	4
5	BUILDING IMPROVEMENTS-ALLOCATED	2020	2,123	212	10	212		1,044	5
6	BUILDING IMPROVEMENTS-ALLOCATED	2021	7,860	786	10	786		2,751	6
7	ADMIN - NEW HVAC - ALLOCATED	2022	4,200	420	10	420		1,470	7
8	ADMIN - DOORS - ALLOCATED	2023	3,913	391	10	391		587	8
9	OUTSIDE LIGHT FIXTURES - ALLOCATED	2024	2,183	218	10	218		328	9
10	ADMIN - CONCRETE PAD - ALLOCATED	2025	6,528	218	10	218		218	10
11	TRANSPORTATION - FIRE PANEL - ALLOCATED	2025	6,050	302	10	302		302	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	TOTAL (lines 1 thru 33)		\$ 17,530,126	\$ 398,113		\$ 398,113	\$	\$ 14,847,833	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	\$ 1,400,327	\$ 85,381	\$ 85,381	\$	5-10	\$ 1,141,323	71
72	Current Year Purchases	36,765	3,677	3,677		5-10	3,677	72
73	Fully Depreciated Assets	3,816,201	6,337	6,337		5-10	3,816,201	73
74								74
75	TOTALS	\$ 5,253,293	\$ 95,395	\$ 95,395	\$		\$ 4,961,201	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	SEE ATTACHED SCHEDULE			\$ 519,094	\$ 902	\$ 902	\$	5-10	\$ 515,935	76
77	TRANSPORTATION	2016 SAVANNA 2500 VAN	2015	30,464	3,046	3,046		10	29,195	77
78	TRANSPORTATION	2020 CHEVY 2500 TURTLE TO	2020	70,715	14,143	14,143		5	69,536	78
79										79
80	TOTALS			\$ 620,273	\$ 18,091	\$ 18,091	\$		\$ 614,666	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)	\$ 23,602,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 511,599	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 511,599	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)	\$ 20,423,700	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	SEE ATTACHED SCHEDULE	\$ 15,189,800	\$ 602,939	\$ 11,148,379	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 15,189,800	\$ 602,939	\$ 11,148,379	91

G. Construction-in-Progress

	Description	Cost	
92	ASPHALT - ALLOCATED	\$ 24,660	92
93	LOGAN - 4 NEW SHOWERS	18,000	93
94			94
95		\$ 42,660	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: _____*

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

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ 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

☒

☐

☐

80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

85

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		3,412		3,412
3	Classroom Wages (a)	6,528	87,296		93,824
4	Clinical Wages (b)		115,600		115,600
5	In-House Trainer Wages (c)	3,419	59,989		63,408
6	Transportation				
7	Contractual Payments	126	3,090		3,216
8	CNA Competency Tests				
9	TOTALS	\$ 10,073	\$ 269,387	\$	\$ 279,460
10	SUM OF line 9, col. 1 and 2 (e)	\$ 279,460			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	85
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	93

- (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	10a-1/10a-2	hrs	200,843			1,065		201,908	4
5	Physician Care	39-1/39-3	visits		174	13,906		174	13,906	5
6	Dental Care	39-1/39-3	visits	43,611	135	13,537		135	57,148	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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 244,454	309	\$ 27,443	\$ 1,065	309	\$ 272,962	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$2,571,462	\$	1
2	Cash-Patient Deposits	368,514		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance905,844)	5,983,836		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	23,729,598		5
6	Prepaid Insurance	84,248		6
7	Other Prepaid Expenses	287,458		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$33,025,116	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,997,429		12
13	Land	311,612		13
14	Buildings, at Historical Cost	29,716,247		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,807,509		16
17	Accumulated Depreciation (book methods)	(31,572,079)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$28,260,718	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$61,285,834	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$658,291	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	368,514		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,199,255		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	24,611		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER ACCRUED EXPENSES	202,225		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$2,452,896	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,332,529		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	FINANCE LEASES	269,416		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$4,601,945	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$7,054,841	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$54,230,993	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$61,285,834	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 51,830,121	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 51,830,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,514,044)	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) SEE ATTACHED	3,914,916	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,400,872	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)	\$ 54,230,993	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BEVERLY FARM FOUNDATION

0038604

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 11,771,276	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,771,276	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	2,211,104	24
25	Interest and Other Investment Income***	3,239,193	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,450,297	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	6,149	28
28a	GOVERNMENT GRANTS	114,874	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,023	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,342,596	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,865,766	31
32	Health Care	7,896,758	32
33	General Administration	5,042,223	33
	B. Capital Expense		
34	Ownership	1,255,478	34
	C. Ancillary Expense		
35	Special Cost Centers	71,054	35
36	Provider Participation Fee	725,361	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,856,640	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,514,044)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,514,044)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	56

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	1,603	1,914	\$ 88,375	\$ 46.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,205	11,861	515,821	43.49	3
4	Licensed Practical Nurses	15,870	18,572	753,537	40.57	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	5,443	6,243	200,843	32.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,064	1,159	21,272	18.35	9
10	Activity Assistants	976	1,149	25,121	21.86	10
11	Social Service Workers	1,466	1,715	43,628	25.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	11,044	12,143	249,928	20.58	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,925	2,182	119,088	54.58	20
21	Assistant Administrator	2,221	2,536	91,027	35.89	21
22	Other Administrative	5,486	6,033	364,099	60.35	22
23	Office Manager					23
24	Clerical	19,991	22,795	508,463	22.31	24
25	Vocational Instruction					25
26	Academic Instruction	1,690	1,895	58,287	30.76	26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	10,322	11,656	326,232	27.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	190,152	202,293	4,310,113	21.31	30
31	Medical Records	6,672	7,596	188,000	24.75	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	15,241	17,104	445,824	26.07	33
34	TOTAL (lines 1 - 33)	301,371	328,846	\$ 8,309,658 *	\$ 25.27	34

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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11 MONTHS	5,737	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) PSYCHOLOGIST	22	2,688	10a-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	22	\$ 8,425		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	688	\$ 67,313	10-3	50
51	Licensed Practical Nurses	3,320	280,028	10-3	51
52	Certified Nurse Assistants/Aides	15,423	591,022	10-3	52
53	TOTAL (lines 50 - 52)	19,431	\$ 938,363		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
CRYSTAL OFFICER	CHIEF EXEC. OFFICER	0	\$ 156,674
JARROD ECKARD	CONTROLLER	0	59,929
LORI RODGERS	CLINICAL DIRECTOR	0	119,088
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 335,691
B. Administrative - Other			
Description			Amount
OUTSOURCING-PAYROLL/IT/FINANCE		\$	271,823
MISCELLANEOUS			6,966
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 278,789
C. Professional Services			
Vendor/Payee	Type		Amount
SEE ENCLOSED WORKSHEET	LEGAL FEES	\$	213,229
SCHEFFEL BOYLE	ACCOUNTING & AUDITING		85,813
CHB ADVISORS	OUTSOURCED FINANCE		363,973
ALERUS FINANCIAL	401K INVESTMENT		108
ARCO CONSULTING SERVICES	CONSULTING SERVICES		2,713
ARMANINO ADVISORY LLC	TECHNOLOGY SERVICES		83
TAXBANDITS	1099 FILING		108
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 666,027
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	262,154
Unemployment Compensation Insurance			70,590
FICA Taxes			614,699
Employee Health Insurance			959,350
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
MISC EMPLOYEE BENEFITS			100,523
RETIREMENT			57,726
TOTAL (agree to Schedule V, line 22, col.8)			\$ 2,065,042
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			27,862
Health Care Worker Background Check (Indicate # of checks performed _____)			2,565
Patient Background Checks _____			20
Association Dues (total from pg 22, #4)			22,500
DUES/SUBS/LICENSE FEES			42,113
PROMOTIONS			22,595
Less: Public Relations Expense (_____)			
PAC and Lobbying payments (_____)			
All non-allowable advertising (_____)			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 117,655
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
MEETINGS/SEMINARS/TRAVEL			4,849
Entertainment Expense (_____)			
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	4,849

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|---------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>1,525</u> |
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>20,975</u> |
| | |
| | <u>22,500</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|-------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | |
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | |
| | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>1,525</u> |
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>20,975</u> |
| | |
| | |
| | <u>22,500</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 105,000 Line 10-2
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 725,361
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 0
- (12) 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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 92%
- 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?
- g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (13) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SCHEFFEL BOYLE
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (15) 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.

BEVERLY FARM FOUNDATION #0038604
PAGES 3 & 4, SCHEDULE V RECLASSIFICATIONS
JUNE 30, 2025

CNA TRAINING INCLUDED AS NURSING	\$ 217,595	13
	(217,595)	10
FUNDRAISING INCLUDED AS MEETINGS/INSERVICE	\$ 562	27
	(562)	23
FUNDRAISING INCLUDED AS TRAVEL/SEMINAR	\$ 5,973	27
CNA TRAINING INCLUDED AS TRAVEL/SEMINAR	3,578	13
TUITION REIMBURSEMENT INCLUDED AS TRAVEL/ SEM	9,551	17
MEETINGS/INSERVICE INCLUDED AS TRAVEL/SEMINAR	217	23
	(19,319)	24

BEVERLY FARM FOUNDATION #0038604
PAGE 10, SCHEDULE IX - REAL ESTATE TAXES
JUNE 30, 2025

REAL ESTATE TAXES ON PAGE 10 OF THE COST REPORT ARE ON LAND HELD
FOR NON-CARE RELATED PURPOSES.

BEVERLY FARM FOUNDATION #0038604
VEHICLE DEPRECIATION-SCHEDULE XI., SECTION D.
JUNE 30, 2025

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
IDOT VAN #15	\$ 26,612	\$ -	\$ -	\$ 26,612
IDOT VAN #16	26,612	-	-	26,612
MAINT. #8 F350 TRUCK	15,944	-	-	15,944
TRUCK FOR MAINTENANCE	3,081	-	-	3,081
2006 CHRYSLER VAN #10	10,407	-	-	10,407
VANS-WHEELCHAIR STRAP	1,454	-	-	1,454
TRANSPORTATION VAN	21,651	-	-	21,651
TRANSPORTATION VAN	17,190	-	-	17,190
IDOT VAN	19,538	-	-	19,538
MAINTENANCE - TRUCK	20,434	-	-	20,434
SHOULDER HARNESES	1,036	-	-	1,036
IDOT VAN	34,646	-	-	34,646
2010 CHRYSLER	18,885	-	-	18,885
MAINTENANCE TRUCK	3,315	-	-	3,315
4X4 CHEVY TRUCK	10,482	-	-	10,482
CHEVY C1500 SILVERADO	13,439	-	-	13,439
2008 MERCURY MARINER	10,336	-	-	10,336
FORD E250	24,539	-	-	24,539
FLEET REPAIRS	4,055	-	-	4,055
DUMP TRUCK REPAIRS	420	-	-	420
VAN SEAT REPAIR	2,631	-	-	2,631
VAN	34,122	-	-	34,122
1997 FORD PICKUP	3,530	-	-	3,530
MAINT-2010 F150 4X2	9,063	-	-	9,063
MAINT-2012 4X4 F-150	9,063	-	-	9,063
TRANSPORTATION-VAN #14 LIFT	3,458	-	-	3,458
TRANSPORTATION-VAN #6 LIFT	776	-	-	776
TRANSPORTATION-TURTLE TOP BUS	39,863	-	-	39,863
TRANSPORTATION-NEW VAN	15,216	-	-	15,216
TRANSPORTATION-NEW VAN	29,521	-	-	29,521
SECURITY VEHICLE 2018 FORD FUSION	13,784	-	-	13,784
2019 GRAND CARAVAN	14,024	-	-	14,024
2017 FORD TRANSIT VAN TRANSIT-350	20,100	-	-	20,100
2018 FORD E-350 WHEELCHAIR BUS	35,354	-	-	35,354
TRANSMISSION VAN 37	4,513	902	902	1,354
	<u>\$ 519,094</u>	<u>\$ 902</u>	<u>\$ 902</u>	<u>\$ 515,935</u>

BEVERLY FARM FOUNDATION #0038604
DEPRECIABLE NON-CARE ASSETS-SCHEDULE XI., SECTION F.
JUNE 30, 2025

DESCRIPTION	Cost	Current Book Depreciation	Accumulated Depreciation
COMMUNITY DAY SERVICES BUILDING	\$ 2,307,995	\$ 80,193	\$ 1,898,185
COMMUNITY DAY SERVICES ALLOCATED ADMIN BLDG	210,010	7,502	130,008
COMMUNITY DAY SERVICES EQUIPMENT	332,265	2,981	328,149
COMMUNITY DAY SERVICES ALLOCATED ADMIN EQUIP	145,426	4,208	133,026
COMMUNITY DAY SERVICES VEHICLES	15,187		15,187
COMMUNITY DAY SERVICES ALLOCATED VEHICLES	86,512	151	85,985
GROUP HOMES BUILDINGS	2,888,293	103,774	2,212,602
GROUP HOMES WORK IN PROCESS	37,315	-	-
GROUP HOMES ALLOCATED ADMIN BLDG	630,030	22,500	390,024
GROUP HOMES EQUIPMENT	436,199	4,545	418,981
GROUP HOMES ALLOCATED ADMIN EQUIP	436,272	12,630	399,078
GROUP HOME VEHICLES	259,554	450	257,976
GROUP HOMES LAND	30,000	-	-
MAINT WORK IN PROCESS	4,110		
ACTIVITIES BUILDING	11,280	596	11,066
ARENA BUILDING	445,175	17,382	281,411
GROVES B. SMITH BUILDING	1,204,751	33,826	922,295
GREENHOUSE BUILDING	145,295	3,029	131,932
GREENHOUSE EQUIPMENT	10,125	405	608
HARDIN APARTMENTS BUILDING	1,636,870	54,758	1,174,003
HORTICULTURE BUILDING	115,669	2,650	103,733
JUDAH SENIORS BUILDING	479,369	12,491	288,540
JUDAH WORK IN PROCESS	3,500	-	-
TOMBSTONES	3,186	-	3,186
TREIN VOCATIONAL BUILDING	755,990	16,694	513,924
GIFT SHOP BUILDING	340,001	13,920	248,118
ARENA EQUIPMENT	74,564	936	73,194
GIFT SHOP EQUIPMENT	19,961	205	19,961
GROVES B. SMITH EQUIPMENT	54,347	269	51,924
HARDIN APARTMENTS EQUIPMENT	292,201	1,721	282,102
JUDAH EQUIPMENT	16,306	-	16,306
TREIN EQUIPMENT	3,764	-	3,764
ACTIVITIES EQUIPMENT	18,055	100	18,055
OTHER LAND	57,643	-	-
HARDIN APARTMENTS VEHICLES	132,190	19,090	74,657
CILA VEHICLES	18,195	1,820	16,982
CILA EQUIPMENT	45,576	1,418	44,930
CILA LAND	24,753	-	-
CILA BUILDING	924,622	42,267	331,314
ROU VEHICLES	537,244	140,428	267,173
	<u>\$ 15,189,800</u>	<u>\$ 602,939</u>	<u>\$ 11,148,379</u>

BEVERLY FARM FOUNDATION #0038604
INCOME RECEIVED BY BROAD CATEGORY NOT LISTED ON P. 19
JUNE 30, 2025

CDS/DAY TRAINING	\$ 5,737,491
APARTMENTS	990,003
GROUP HOMES	8,114,529
OTHER - ARENA, COFFEE/GIFT SHOP, AND TACK SHOP	398,256
CILA	1,909,302
	<u>\$ 17,149,581</u>

EXPENSES INCURRED BY BROAD CATEGORY
NOT LISTED IN THIS COST REPORT

CDS/DAY TRAINING (DIRECT) EXPENSES AND PAYROLL	\$ 2,521,898
APARTMENTS (DIRECT) EXPENSES AND PAYROLL	783,141
APARTMENTS (ALLOCATED) EXPENSES AND PAYROLL	592,964
CREDIT LOSS EXPENSE	537,585
TACK SHOP (DIRECT) EXPENSES	77,163
ARENA (DIRECT) EXPENSE AND PAYROLL	363,531
COFFEE/GIFT SHOP (DIRECT) EXPENSES AND PAYROLL	191,998
CILA (DIRECT) EXPENSES AND PAYROLL	1,047,019
CILA (ALLOCATED) EXPENSES AND PAYROLL	377,977
JUDAH (DIRECT) EXPENSES	9,509
RESIDENT (DIRECT) PAYROLL	74,463
GROUP HOMES (DIRECT) EXPENSES AND PAYROLL	4,260,172
GROUP HOMES (ALLOCATED) EXPENSES AND PAYROLL	2,397,245
	<u>\$ 13,234,665</u>
NET INCOME (Page 18, Schedule XVI, Line 15)	<u>\$ 3,914,916</u>

BEVERLY FARM FOUNDATION
OTHER REVENUE, PAGE 19, LINES 28 & LINE 29
JUNE 30, 2025

MISCELLANEOUS INCOME

REFUNDS, REIMBURSEMENTS, AND INSURANCE CLAIMS	<u>\$ 6,149</u>
	<u><u>\$ 6,149</u></u>

GOVERNMENT GRANTS

RECRUITMENT AND RETENTION PROGRAM - CDS	<u>\$ 114,874</u>
	<u><u>\$ 114,874</u></u>

BEVERLY FARM FOUNDATION #0038604
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2025

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
DENTAL ASSISTANT	976	1,161	43,611	37.56
TRANSPORTATION	11,336	12,638	231,866	18.35
DEVELOPMENT DIRECTOR	1,916	2,195	138,674	63.18
MARKETING MANAGER	1,013	1,110	31,673	28.53
	15,241	17,104	\$ 445,824	