

		FOR BHF USE					

LL1

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: 0052035

Facility Name: BRIA OF FOREST EDGE

Address: 8001 S WESTERN AVE CHICAGO 60620

County: COOK

Telephone Number: (773) 436-6600 Fax #: (773) 471-1661

HFS ID Number:

Date of Initial License for Current Owners: 11/1/12

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: MITCH KOHANANOO Telephone Number: (847) 675-3585

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 01/01/2025 to 12/31/2025 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) AVRUM WEINFELD

(Title) CEO

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)

(Date)

Paid Preparer

(Print Name and Title) MITCH KOHANANOO PARTNER

(Firm Name & Address) ACCOUNTING ASSOCIATES, LLC 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714

(Telephone) (847) 675-3585 Fax #: (847) 675-5777

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 BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	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	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				78		1,576	53	1,707	8
9	SNF/PED									9
10	ICF	5,248	61,299	2,919		411		692	70,569	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,248	61,299	2,919	78	411	1,576	745	72,276	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 60.37%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 11/01/12

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/01/12 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 112

Medicare Intermediary WPS WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BRIA OF FOREST EDGE** # **0052035** Report Period Beginning: **01/01/2025** Ending: **12/31/2025**

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		34,994	1,337,964	1,372,958		1,372,958		1,372,958			1
2	Food Purchase		473,301		473,301		473,301		473,301			2
3	Housekeeping		2,724	661,263	663,987		663,987		663,987			3
4	Laundry		50	652,696	652,746		652,746		652,746			4
5	Heat and Other Utilities			355,640	355,640		355,640	2,002	357,642			5
6	Maintenance	223,449	34,234	152,530	410,213		410,213	21,920	432,133			6
7	Other (specify):* Security, Scavenger	486,975		54,042	541,017		541,017	384	541,401			7
8	TOTAL General Services	710,424	545,303	3,214,135	4,469,862		4,469,862	24,306	4,494,168			8
	B. Health Care and Programs											
9	Medical Director			31,334	31,334		31,334		31,334			9
10	Nursing and Medical Records	7,239,238	191,315	38,783	7,469,336		7,469,336	127,174	7,596,510			10
10a	Therapy	291,602		20,291	311,893		311,893		311,893			10a
11	Activities	146,154	4,188	1,945	152,287		152,287		152,287			11
12	Social Services	433,525	1,539	2,025	437,089		437,089		437,089			12
13	CNA Training											13
14	Program Transportation			941	941		941		941			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,110,519	197,042	95,319	8,402,880		8,402,880	127,174	8,530,054			16
	C. General Administration											
17	Administrative	374,202		996,436	1,370,638		1,370,638	(950,976)	419,662			17
18	Directors Fees											18
19	Professional Services			877,948	877,948		877,948	(448,551)	429,397			19
20	Dues, Fees, Subscriptions & Promotions			53,843	53,843		53,843	(16,149)	37,694			20
21	Clerical & General Office Expenses	632,983	15,403	257,530	905,916		905,916	(58,622)	847,294			21
22	Employee Benefits & Payroll Taxes			1,479,168	1,479,168		1,479,168		1,479,168			22
23	Inservice Training & Education			32,960	32,960		32,960	175	33,135			23
24	Travel and Seminar							5,580	5,580			24
25	Other Admin. Staff Transportation			14,185	14,185		14,185	(4,987)	9,198			25
26	Insurance-Prop.Liab.Malpractice			809,452	809,452		809,452	165,096	974,548			26
27	Other (specify):*			230,165	230,165		230,165	(173,340)	56,825			27
28	TOTAL General Administration	1,007,185	15,403	4,751,687	5,774,275		5,774,275	(1,481,774)	4,292,501			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,828,128	757,748	8,061,141	18,647,017		18,647,017	(1,330,294)	17,316,723			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	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	57,233		CONTRACT NURSING	XVIII C 53-2	
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		2,742
	CONTRACTED DIETARY SERVICES		1,280,731		PURCHASED SERVICES		
			1,337,964		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		661,263		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			661,263		PHARMACY CONSULTANT	XVIII B 39-2	12,032
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		652,696		PSYCHIATRIC	XVIII B __-2	
			652,696		RN CONSULTANT	XVIII B 38-2	24,009
5	HEAT & OTHER UTILITIES						
	GAS HEAT		97,185				
	ELECTRICITY		167,238				
	WATER		88,575				38,783
	CABLE TV - LOBBY		2,642		THERAPY		
6			355,640	11	PHYSICAL THERAPY SERVICES		
	MAINTENANCE				SPEECH THERAPY SERVICES		
	GROUND MAINTENANCE		17,889		OCCUPATIONAL THERAPY SERVICES		
	PAINTING & DECORATING				REHABILITATION CONSULTANT	XVIII B __-2	
	BUILDING REPAIRS				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	8,835
	MAINTENANCE TRAVEL				OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	11,240
	EQUIPMENT MAINTENANCE & REPAIR		1,557		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	
	ELEVATOR MAINTENANCE & REPAIR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	216
	OUTSIDE LABOR						
	EXTERMINATING SERVICE						
	FIRE SERVICE		28,625				20,291
	CONTRACTED BUILDING MAINTENANCE		104,459	12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,945
7			152,530	13			1,945
	OTHER				SOCIAL SERVICES		
	SCAVENGER		54,042		SOCIAL REHABILITATION SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	2,025
					SOCIAL WORKER	XVIII B 45-2	
9			54,042				2,025
	MEDICAL DIRECTOR				NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		31,334		NURSE AIDE TRAINING COSTS	XIII	0

8,061,141

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			41,587	41,587		41,587	507,805	549,392			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,524	11,524		11,524	593,532	605,056			32
33	Real Estate Taxes							1,032,031	1,032,031			33
34	Rent-Facility & Grounds			3,209,359	3,209,359		3,209,359	(3,209,359)				34
35	Rent-Equipment & Vehicles			72,630	72,630		72,630	1,454	74,084			35
36	Other (specify):* RENT OFFICE			15,400	15,400		15,400	51,907	67,307			36
37	TOTAL Ownership			3,350,500	3,350,500		3,350,500	(1,022,630)	2,327,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,340	56,531	79,871		79,871		79,871			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			724,558	724,558		724,558		724,558			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		23,340	781,089	804,429		804,429		804,429			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	9,828,128	781,088	12,192,730	22,801,946		22,801,946	(2,352,924)	20,449,022			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	(249,708)	30		9
10	Interest and Other Investment Income	(17,998)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(15,375)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(230,165)	27		24
25	Fund Raising, Advertising and Promotional	(10,065)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(254,766)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (778,077)		\$	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)	(1,574,847)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,574,847)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,352,924)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (16,737)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING SALARIES	(233,042)	21	3
4	MARKETING TRAVEL	(4,987)	25	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	(254,766)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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

[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
SEE PG OWNERSHIP-1						

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 3,209,359	FOREST EDGE HEALTHCARE REALTY LLC		\$	\$ (3,209,359)	1
2	V								2
3	V	19	PROFESSIONAL FEES				11,565	11,565	3
4	V	26	INSURANCE - PROPERTY				162,648	162,648	4
5	V	30	DEPRECIATION-SL				748,964	748,964	5
6	V	32	INTERST				531,806	531,806	6
7	V	33	REAL ESTATE TAXES				1,024,145	1,024,145	7
8	V	36	M.I.P. INSURANCE				67,307	67,307	8
9	V	32	AMORT LOAN COST				5,703	5,703	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,209,359			\$ 2,552,138	\$ * (657,221)	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	19	BOOKKEEPING/ADM SERVICES	\$ 517,440	BRIA HEALTH SERVICES, LLC		\$	\$ (517,440)	15
16	V	17	MANAGEMENT FEES	996,436				(996,436)	16
17	V								17
18	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	18
19	V	17	SALARIES-CFO				36,472	36,472	19
20	V	6	SALARIES-MAINTENANCE				16,838	16,838	20
21	V	10	SALARIES-A/R				127,174	127,174	21
22	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	22
23	V	21	SALARIES-CLERICAL				166,665	166,665	23
24	V	6	MAINTENANCE				4,111	4,111	24
25	V	7	SCAVENGER				384	384	25
26	V	19	PROFESSIONAL FEES				57,238	57,238	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				10,653	10,653	27
28	V	21	OFFICE EXPENSE				20,531	20,531	28
29	V	23	SEMINARS				175	175	29
30	V	24	TRAVEL				5,580	5,580	30
31	V	26	INSURANCE				2,054	2,054	31
32	V	27	EMPLOYEE BENEFITS				56,825	56,825	32
33	V	30	DEPRECIATION				5,372	5,372	33
34	V	32	INTEREST				70,453	70,453	34
35	V	35	AUTO LEASE				693	693	35
36	V	35	EQUIPMENT RENTAL				761	761	36
37	V								37
38	V								38
39	Total			\$ 1,513,876			\$ 593,079	\$ * (920,797)	39

* 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	36	OFFICE RENT	\$ 15,400	IME REALTY CORPORATION		\$	\$ (15,400)	15
16	V								16
17	V	5	UTILITIES				2,002	2,002	17
18	V	6	MAINTENANCE				971	971	18
19	V	19	PROFESSIONAL FEES				86	86	19
20	V	26	INSURANCE				394	394	20
21	V	30	DEPRECIATION				3,177	3,177	21
22	V	32	INTEREST				3,568	3,568	22
23	V	33	RE TAX				7,886	7,886	23
24	V	21	OFFICE EXPENSE				487	487	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			\$ 15,400			\$ 18,571	\$ * 3,171	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:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	BRIA OF CAHOKIA	CAHOKIA	LYDIA CARE CENTER	ROBBINS	BRIA HEALTH	SKOKIE	MANAGEMENT	1
2					SERVICES, LLC		SERVICES	2
3	BRIA OF BELLEVILLE	BELLEVILLE	BRIA OF ELMWOOD PARK	ELMWOOD PARK				3
4					FOREST EDGE HC			4
5	BRIA OF GENEVA	GENEVA			REALTY	SKOKIE	REAL ESTATE	5
6								6
7	LAKE PARK CENTER	WAUKEGAN			IME REALTY	SKOKIE	CORPORATE	7
8							OFFICE	8
9	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO						9
10		HEIGHTS			DA WESTMONT	SKOKIE	MGMT CONSULT	10
11								11
12	BRIA OF WESTMONT	WESTMONT			WEISS MGMT		MANAGEMENT/	12
13					GROUP, INC	SKOKIE	CLERICAL	13
14	BRIA OF PALOS HILLS	PALOS HILLS						14
15								15
16	BRIA OF RIVER OAKS	BURNHAM						16
17								17
18	BRIA OF ALTON	ALTON						18
19								19
20	BELLEVILLE HEALTHCARE CENTER	BELLEVILLE						20
21								21
22	BRIA OF COLUMBIA	COLUMBIA						22
23								23
24	BRIA OF GODFREY	GODFREY						24
25								25
26	BRIA OF WOODRIVER	WOODRIVER						26
27								27
28	BRIA OF MASCOUTAH	MASCOUTAH						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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:								\$		1
2	ARIELLA WEIL	RELATIVE	ACCOUNTS PAYABLE					SALARY		21-7	2
3	FRED BERKOVITS	MEMBER	REGIONAL DIR	23.75	SEE			MGMT FEES	8,988	17-7	3
4	MIRYAM CLEVS	RELATIVE	OFFICE CLERK		ATTACHED			SALARY	2,112	21-7	4
5					SCHEDULE						5
6	ALLOCATION FROM DA WESTMONT:										6
7	AVRUM WEINFELD	MEMBER	CFO	23.75				SALARY	9,000	17-7	7
8	DANIEL WEISS	MEMBER	ADMINISTRATIV	23.75				SALARY	6,000	17-7	8
9	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										9
10	NATAN WEISS	MEMBER	FINANCE/MGMT	11.88				MGMT FEES	20,250	17-7	10
11	DANIEL WEISS	MEMBER	ADMINISTRATIV	23.75				SALARY	11,902	17-7	11
12											12
13								TOTAL	\$ 58,252		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: 01/01/2025 Ending: 2/31/2025

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 IME REALTY CORPORATION
Street Address 5151 CHURCH STREET
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 933-9200
Fax Number (847) 674-5794

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	CENSUS DAYS	821,683	19	\$ 22,755	\$	72,275	\$ 2,002	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		72,275	971	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		72,275	86	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		72,275	394	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		72,275	3,177	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		72,275	3,568	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		72,275	7,886	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		72,275	487	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 211,108	\$		\$ 18,571	25

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 BRIA HEALTH SERVICES, LLC
Street Address 5151 CHURCH STREET
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 933-9200
Fax Number (847) 674-5794

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	MANAGEMENT FEES-RELATED	wghtd avr hours	40	19	\$ 179,753	\$	2	\$ 8,988	1
2	17	SALARIES-CFO	CENSUS DAYS	821,683	19	414,635	414,635	72,276	36,472	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	72,276	16,838	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	72,276	127,174	4
5	21	SALARIES-CLERICAL RELATED	wghtd avr hours	38	19	83,882	83,882	2	2,112	5
6	21	SALARIES-CLERICAL	CENSUS DAYS	821,683	19	1,894,762	1,894,762	72,276	166,665	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		72,276	4,111	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		72,276	384	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		72,276	57,238	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		72,276	10,653	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		72,276	20,531	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		72,276	175	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		72,276	5,580	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		72,276	2,054	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		72,276	56,825	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		72,276	5,372	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		72,276	70,453	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		72,276	693	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		72,276	761	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,996	\$ 4,030,510		\$ 593,079	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	HUD - CAMBRIDGE		X	MORTGAGE	\$193,613.59	6/01/12	\$ 17,721,500	\$ 13,271,930	05/01/43	0.0395	\$ 531,806	1							
2												2							
3	LOAN COST		X	AMORTIZE OVER LIFE OF LOAN			131,176	117,869			5,703	3							
4												4							
5												5							
	Working Capital																		
6	BENNLE WEINFELD	X		WORKING CAPITAL								6							
7												7							
8	RELATED PARTY ALLOCATION										74,021	8							
9	TOTAL Facility Related				\$193,613.59		\$ 17,852,676	\$ 13,389,799			\$ 611,530	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 17,852,676	\$ 13,389,799			\$ 611,530	15							

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

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.				\$	1,347,310	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.)				\$	1,179,831	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(167,479)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	1,191,624	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.				\$	1,024,145	7
Assessed Value from Real Estate Tax Bill:	2024	5,872,500	8			
Real Estate Tax Bill for Calendar Year:	2020	823,135	9			
	2021	738,802	10			
	2022	1,300,412	11			
	2023	1,333,970	12			
	2024	1,179,831	13			
				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	<u>BRIA OF FOREST EDGE</u>	COUNTY	<u>COOK</u>
---------------	----------------------------	--------	-------------

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: 92,056 B. General Construction Type: Exterior BRICK Frame 7+BASEMENT Number of Stories 4

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

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (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? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

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	\$ 748,964	27.5	\$ 370,130	\$ (378,834)	\$ 12,293,612	4
5											5
6											6
7	IME-BLDG				123,845	3,175		3,175			7
8	RELATED PARTY -IMPR				83,676	2,124		2,124			8
	Improvement Type**										
9	AWNINGS			2001	10,500		27.5	223	223	9,057	9
10	FENCE			2001	2,100		15			2,100	10
11	ELEVATOR			2001	18,340		27.5	389	389	15,813	11
12	ALARM			2001	5,686		27.5	121	121	4,908	12
13	WINDOWS			2001	4,149		27.5	88	88	3,580	13
14	BOILER			2001	3,000		27.5	64	64	2,367	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953		5			12,953	15
16	KITCHEN SINK & DRAIN			2001	2,525		27.5	54	54	2,181	16
17	DOORS			2001	15,100		27.5	320	320	13,005	17
18	ELEVATOR			2002	222,811		27.5	4,726	4,726	191,072	18
19	FENCE			2002	3,100		15			3,100	19
20	DOORS & LOCKS			2002	21,741		27.5	461	461	18,555	20
21	SHOWER ROOMS			2002	4,669		27.5	99	99	3,889	21
22	ALARM AND SPRINKLER			2002	11,881		27.5	252	252	9,881	22
23	EJECTOR & SEWEGE PUMP			2002	14,604		27.5	310	310	12,147	23
24	ROOF DRAIN			2002	3,100		27.5	66	66	2,613	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494		5			91,494	25
26	ELEVATIR			2003	110,562		27.5	2,345	2,345	89,948	26
27	PARKING LOT			2003	64,182		15			64,182	27
28	FIRE ALARM SYSTEM			2003	25,000		27.5	530	530	20,111	28
29	ROOF			2003	26,500		27.5	562	562	21,248	29
30	EXTERIOR WALL			2003	9,796		27.5	208	208	7,818	30
31	SINKS			2003	3,146		27.5	67	67	2,523	31
32	BUILT IN WARDROBE			2003	19,398		27.5	411	411	15,422	32
33	REBUILD A/C & HEATING RETURN FAN			2004	4,700		27.5	100	100	3,670	33
34	FIRE ALARM SYSTEM			2004	13,201		27.5	280	280	10,260	34
35	BUILT IN WARDROBE			2004	21,807		27.5	463	463	16,753	35
36				2004	61,620		27.5	1,307	1,307	46,781	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:

01/01/2025 Ending: 12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2004	\$ 2,995	\$	27.5	\$ 64	\$ 64	\$ 2,267	37
38	BOILER REPAIR	2004	5,650		27.5	120	120	4,248	38
39	HOT WATER HEATER	2004	5,756		27.5	122	122	4,738	39
40	FLOOR TILING	2004	5,326		27.5	113	113	4,001	40
41	REMODEL BATHROOM	2005	6,080		27.5	129	129	4,448	41
42	DOORS	2005	4,506		27.5	96	96	3,301	42
43	FLOOR TILING	2005	1,536		27.5	33	33	1,127	43
44	2 WATER BOILERS	2005	99,047		27.5	2,101	2,101	71,590	44
45	CONCRETE PATIO	2005	3,015		15			3,015	45
46	SHOWER	2006	3,040		27.5	65	65	2,123	46
47	DUCT WORK	2006	5,600		27.5	119	119	3,902	47
48	A/C COOLING TOWER	2006	13,161		27.5	279	279	8,681	48
49	FIRE ALARM - BEVERLY	2007	273,534		27.5	5,802	5,802	179,858	49
50	COOLING TOWERS - BEVERLY	2007	121,905		27.5	2,586	2,586	80,163	50
51	SHOWERS - BEVERLY	2007	12,160		27.5	258	258	7,993	51
52	AIR CLEANERS - BEVERLY	2007	10,851		27.5	230	230	7,142	52
53	CONCRETE WORK - BEVERLY	2007	5,100		27.5	108	108	3,438	53
54	SHOWERS - BEVERLY	2008	9,120		27.5	194	194	5,766	54
55	DOORS - BEVERLY	2008	4,520		27.5	96	96	2,877	55
56	BOLIER - BEVERLY	2008	5,295		27.5	113	113	3,289	56
57	FLOORS - BEVERLY	2008	6,260		27.5	133	133	3,848	57
58	ROOFING - BEVERLY	2008	3,800		27.5	81	81	2,318	58
59	EXTERIOR WALL - BEVERLY	2008	20,000		27.5	424	424	12,086	59
60	ROOFING - BEVERLY	2009	10,333		27.5	219	219	6,103	60
61	CAULK JOINTS - BEVERLY	2010	28,450		27.5	604	604	15,655	61
62	MECHANICAL ROOM - BEVERLY	2010	19,450		27.5	412	412	10,516	62
63	WELDING - BEVERLY	2010	3,587		27.5	76	76	1,912	63
64	ROOF - BEVERLY	2010	2,925		27.5	62	62	1,559	64
65	STEEL DOOR - BEVERLY	2011	1,275		27.5	27	27	661	65
66	CONTROLLE R- ANNUNCIATOR - BEVERLY	2011	6,649		27.5	141	141	3,237	66
67	CONCRETE - SIDEWALK - BEVERLY	2011	2,375		27.5	50	50	1,243	67
68	BACKFLOW REPAIR - BEVERLY	2011	4,550		27.5	96	96	2,275	68
69	ELECTRICAL - BEVERLY	2012	4,347		27.5	92	92	2,126	69
70	TOTAL (lines 4 thru 69)		\$ 19,176,384	\$ 754,263		\$ 403,918	\$ (350,345)	\$ 13,458,547	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:

01/01/2025 Ending: 12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,176,384	\$ 754,263		\$ 403,918	\$ (350,345)	\$ 13,458,547	1
2	VINYL FENCE AND GATE	2012	7,400		27.5	157	157	3,553	2
3	SOUTH ROOF FLASHING - BEVERLY	2012	4,350		27.5	92	92	2,074	3
4	KITCHEN IMPROVEMENT - BEVERLY	2012	2,640		27.5	56	56	1,252	4
5	SIDEWALK - BEVERLY	2012	2,150		27.5	46	46	1,018	5
6	NORTH ROOF FLASHING - BEVERLY	2012	1,950		27.5	41	41	926	6
7	SPRINKLER MODIFICATIONS	2012	17,530		27.5	372	372	8,149	7
8	FIRE DAMPERS, CEILING, ELECTRICAL WORK - BEVERLY	2012	49,679		27.5	1,054	1,054	23,114	8
9	COMPLETE REBUILD OF CHILLER - BEVERLY	2013	42,700		27.5	906	906	19,348	9
10	WIRING FOR SATELLITE - BEVERLY	2013	13,325		27.5	283	283	5,962	10
11	FIRE SPRINKLERS - BEVERLY	2013	16,686		27.5	354	354	7,410	11
12	BOILER REBUILD - BEVERLY	2013	8,550		27.5	181	181	3,745	12
13	INSTALL DOOR PACKAGE ON 3 ELEVATORS - BEVERLY	2013	36,000		27.5	764	764	15,436	13
14	WALK IN FREEZER NEW CONDENSING UNIT - BEVERLY	2013	7,307		27.5	155	155	3,136	14
15									15
16	COMM AWNING WITH NAME	2013	9,200		7			9,200	16
17									17
18									18
19	REPLACE ELEVATOR ENCODER & MACHINE BEARINGS	2014	18,060		27.5	383	383	7,418	19
20									20
21	1ST FLOOR DAY RM - GLASS WALLS , DOORS & GUARDS	2014	9,998		27.5	212	212	4,110	21
22	1ST FLOOR - REMOVE VCT AND INSTALL CARPET TILE	2014	20,810		27.5	442	442	8,548	22
23	LOBBY - REMOVE WALL AND INSTALL NEW GLASS								23
24	WALL , DOORS AND ACOUSTICAL CEILING	2014	87,162		27.5	1,849	1,849	35,794	24
25	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								25
26	AND CORRIDOR - PAINT ,WALL COVERING & SIGNAGE	2014	21,335		27.5	453	453	8,763	26
27	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								27
28	AND CORRIDOR - MILL WORK,ELCTRICAL	2014	10,083		27.5	214	214	4,144	28
29	ELEVATOR - WALLCOVERING AND NEW CEILING	2014	24,569		27.5	521	521	10,084	29
30	REFRESHMENT STAND	2014	2,500		27.5	53	53	1,027	30
31	GUEST BATHRMS & SMOKING PATIO - DOORS & FRAME	2014	8,657		27.5	184	184	3,557	31
32	2ND FLOOR - REBUILD 2 TUB ROOMS	2014	30,531		27.5	648	648	12,442	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,629,556	\$ 754,263		\$ 413,337	\$ (340,926)	\$ 13,658,756	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	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		\$ 19,629,556	\$ 754,263		\$ 413,337	\$ (340,926)	\$ 13,658,756	1
2	SMOKING PATIO - REMOVE OLD FLR AND WALL AND								2
3	INSTALL NEW FLOOR AND WALLS	2014	5,037		27.5	107	107	2,067	3
4	NURSES STATION - NURSES STATION , ELECTRICAL ,								4
5	BUILT IN CABINETS AND COUNTER TOPS	2014	27,118		27.5	575	575	11,133	5
6	2ND FLOOR CORRIDOR & GREAT ROOM - NEW								6
7	ACOUSTICAL CEILING & LIGHTING	2014	26,708		27.5	566	566	10,964	7
8	2ND FLOOR GREAT ROOM - REMOVE OLD GLASS WALL								8
9	INSTALL NEW STUD WALL	2014	5,700		27.5	121	121	2,338	9
10	2ND FLOOR CORRIDOR & GREAT ROOM - WALL								10
11	COVERINGS	2014	25,444		27.5	540	540	10,445	11
12	2ND FLOOR - VCT AND COVE BASE REMOVAL AND								12
13	OF NEW FLOORING AND CHAIR RAILS	2014	45,077		27.5	956	956	18,507	13
14	3RD FLOOR - DEMOLISH & REBUILD THE SHOWER	2014	16,540		27.5	351	351	6,687	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		27.5	655	655	12,213	17
18	FIRE SPRINKLERS - ELEVATOR AND SECOND FLOOR	2014	8,600		27.5	183	183	3,378	18
19	18 SMOKE DETECT ELEVATOR & VARIOUS LOCATION	2014	3,191		27.5	68	68	1,262	19
20	CONCRETE PILLARS	2014	6,800		27.5	144	144	2,665	20
21	INSTALL 2 DAMPERS ON THE MAIN AIR SUPPLY AND	2014	5,480		27.5	116	116	2,147	21
22	RETURN DUCTS								22
23	INSTALL NEW BOILER SECTIONS	2014	11,724		27.5	249	249	4,562	23
24	4 TH FLOOR TUB ROOM REMOVE OLD FLOOR AND	2014	4,430		27.5	94	94	1,751	24
25	DRAIN INSTALL NEW								25
26	AWNING	2014	6,520		27.5	138	138	2,617	26
27									27
28	1ST FLOOR THERAPY ROOM								28
29	REMOVAL OF EXISTING COVE BASE & VCT	2015	13,694		27.5	291	291	5,167	29
30	PREP & INSTALL OF NEW VINYL & CARPET								30
31	FLOORING & COVE BASE								31
32	FRAME NEW WALLS FOR VESTIBULE , STORAGE,	2015	10,992		27.5	233	233	4,149	32
33	AND WORK STATION, PROVIDE SEPARATE								33
34	TOTAL (lines 1 thru 33)		\$ 19,883,491	\$ 754,263		\$ 418,723	\$ (335,541)	\$ 13,760,806	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	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		\$ 19,883,491	\$ 754,263		\$ 418,723	\$ (335,541)	\$ 13,760,806	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		27.5	321	321	5,716	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		7			4,569	9
10	MIRROR WALL 16'11"W X 8'H WITH	2015	2,640		27.5	56	56	996	10
11	CRACK ISOLATION MEMBRANE								11
12	CUSTOM CHARTING STATION WITH 4 LOCKING	2015	9,780		27.5	207	207	3,684	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		27.5	113	113	2,012	15
16	BUILD WALL WITH DOOR OPENING FOR NEW	2015	4,270		27.5	90	90	1,608	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		7			6,354	20
21	CUBICLE CURTAINS WITH SUSPENDED TRACK	2015	1,920		7			1,920	21
22	SIGNAGE ON ENTRY & THERAPY RECEPTION AREA	2015	6,796		7			6,796	22
23	SECURITY SYSTEM IN 2ND FLOOR TO 7TH FLOOR								23
24	STAIR WELL DOORS	2015	24,564		27.5	521	521	8,818	24
25	INSTALLED AS PER CODE ONE ROPE GRIPPER.	2016	36,711		27.5	779	779	12,516	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		27.5	113	113	1,810	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, CUBCLICE TRACKS, WALL BETWEEN BATHROOMS, CLOSETS								29
30	AND WALL BETWEEN TWO ROOMS. REMOVE AND REROUTE EXISTING ELECTRIC AFTER WALL REMOVAL. PATCH & SAND WALLS A								30
31	AWININGS								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,006,865	\$ 754,263		\$ 420,923	\$ (333,340)	\$ 13,817,606	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:

01/01/2025

Ending:

12/31/2025

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		\$ 20,006,865	\$ 754,263		\$ 420,923	\$ (333,340)	\$ 13,817,606	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		27.5	318	318	5,019	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		27.5	219	219	3,462	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		27.5	74	74	1,161	8
9	ROOM 212 AND 214- WINDOW TREATMENTS INCLUDING 2 CORNICES & 4 ROLLER SHADES &								9
10	INSTALLATION	2016	3,094		27.5	65	65	1,031	10
11									11
12	AWININGS	2016	5,950		27.5	232	232	3,607	12
13	INSTALLED NEW CEILING TILE AND LIGHTS; REMOVE A	2016	4,677		27.5	99	99	1,565	13
14	REPLACE EXISTING DOOR								14
15	EXTEND WALL IN PHYSICAL THERAPY ROOM TO MEET	2016	2,540		27.5	54	54	794	15
16	THE EXTERIOR GLASS WALL.								16
17	REPLACEMENT OF SIDEWALK IN REAR PARK OF THE BU	2017	4,800		27.5	187	187	2,587	17
18	SIDEWALK REMOVAL AND REPAIR AT THE REAR OF THI	2017	5,600		27.5	218	218	3,016	18
19	REMOVE AND REPLACE REAE CONCRETE STAIRS	2017	7,950		27.5	309	309	4,284	19
20	EJECTOR PUMP REPLACEMENT; EXISTING PUMP HAS A	2017	8,900		27.5	189	189	2,633	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		15	525	525	6,375	28
29	INSTALL ELEVATOR DOOR EQUIPMENT	2019	26,711		27.5	566	566	6,028	29
30	PARKIN LOT-REPLACE CONCRETE/ASPHALT, SEAL COAT	2019	11,074		15	431	431	4,490	30
31	PAINTING COMMON AREA/BATHROOMS, HANDRAILS	2019	20,825		5	(2,083)	(2,083)	20,825	31
32	NORTH WING ROOF-APPLIED AN ELASTOMERIC COATIN	2019	22,950		27.5	487	487	5,045	32
33	2ND,3RD,4TH,5TH,6TH,7TH FLOOR-WINDOW TREATMENT	2019	88,159		5			88,159	33
34	TOTAL (lines 1 thru 33)		\$ 20,262,381	\$ 754,263		\$ 422,812	\$ (331,451)	\$ 13,977,686	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:

01/01/2025 Ending: 12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 20,262,381	\$ 754,263		\$ 422,812	\$ (331,451)	\$ 13,977,686	1
2	INSTALL NEW HOIST ROPES ON PASSENGER CARS	2020	34,117		27.5	724	724	6,360	2
3	REPLACED SPRINKLER HEADS FOR ENTIRE BUILDING	2021	63,541		27.5	1,348	1,348	10,206	3
4	TUCKPOINTED EAST FACING BRICK WALL	2021	42,500		15	1,653	1,653	12,277	4
5	REPLACE SIDE WALK CONCRETE	2021	18,120		15	705	705	4,732	5
6	1ST,2ND,3RD,4TH FLOOR, LOBBY-FLOORING	2021	41,623		27.5	883	883	5,425	6
7									7
8									8
9	REPAIR LEAK IN CAST IRON SEWER PIPE, JET LINES FOR								9
10	PROPER WATER FLOW	2022	6,000		27.5	90	90	552	10
11	REPLACE EXISTING EXHAUST FAN WITH NEW EXHAUST								11
12	HOOD	2022	9,150		27.5	186	186	1,143	12
13	BOOSTER WATER PUMP:ISTALLED 2 NEW ISOLATION VALVES,								13
14	NEW MECHANICAL SEAL KIT, REBUILT & ASSEMBLED PUMP								14
15	WITH EXISTING COMPONENTS.	2022	19,876		27.5	334	334	2,050	15
16	REPAIR RADIATOR: SET UP ENGINE EQUIPMENT, REMOVE								16
17	RADIATOR,DISCONNECT GENERATOR END, PULL OUT								17
18	ENGINE, DRAIN OIL, INSTALL PARTS & TEST THE SYSTEM	2022	17,658		27.5	203	203	1,247	18
19	SUBURBAN ELEVATOR: FURNISH & INSTALL 3 CODE COMPLIANT								19
20	PIT LADDERS, REPLACE 2 GOVERNOR ROPES & TAIL SHEAVES, NEW								20
21	PIT SWITCHES ON ALL CARS, ELECTRICAL UPGRADES	2022	50,799		27.5	494	494	3,035	21
22	1ST, 2ND & 3RD FLOOR:RAN ELECTRICAL LINES TO NORTH								22
23	CORRIDOR; INSTALLED WALL MOUNT DUPLEX RECEPTACLE								23
24	OUTLETS, LOCKED PAD	2022	5,627		27.5	45	45	276	24
25	PENTHOUSE A/C: REPLACED BEARING ON AHU	2022	7,782		27.5	48	48	297	25
26	INSTALL NEW 4.4 M BOILER	2022	93,495		27.5	413	413	2,537	26
27	INSTALL OF THE WINDOW SECURE GLASS, SCAFFORD								27
28	METAL DIVISION BAR, SILICONE WINDOWS	2022	19,000		27.5	50	50	308	28
29	INSTALL SILICONE ROOF COATING , SEAL AROUND								29
30	ROOF PENETRATIONS	2023	30,000		27.5	636	636	2,818	30
31	REPLACE 3 PHASE AUTOMATIC TRANSFER SWITCHES								31
32	IN LOWER LEVEL ELECTRICAL ROOM	2023	7,750		27.5	165	165	729	32
33	INSTALL 2 ELECTRIC-PNEUMATIC RELAYS	2023	3,030		27.5	64	64	284	33
34	TOTAL (lines 1 thru 33)		\$ 20,732,449	\$ 754,263		\$ 430,852	\$ (323,411)	\$ 14,031,961	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:

01/01/2025 Ending: 12/31/2025

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 12F, Carried Forward		\$ 20,732,449	\$ 754,263		\$ 430,852	\$ (323,411)	\$ 14,031,961	1
2	INSTALLED DELAYED EGRESS MAGNETIC LOCK ON SOUTH								2
3	BLDG. KITCHEN EXIT DOOR	2023	3,525		27.5	75	75	331	3
4	BASEMENT AREA: INSTALL NEW WATER BOILER, COOPER								4
5	PIPE, NEW ENGINES, CONECT 2 WATER PUMPS	2023	79,400		27.5	1,684	1,684	7,458	5
6	5TH FLOOR RESIDENT ROOMS, CORRIDOR, NURSES STATION:								6
7	PAINTING, DRYWALL, CARPENTRY, MILLWORK	2023	53,293		27.5	1,131	1,131	5,007	7
8	3RD FLOOR MEDICAL ROOM: INSTALL NEW COPPER PIPE	2023	4,648		27.5	98	98	434	8
9	REMOVE AND REPLACE THE RUN CAPACITOR IN KITCHEN	2023	6,399		27.5	136	136	602	9
10	CORRIDORS: CRASHRAIL, HANDRAIL AND 95 END CAPS	2023	12,025		27.5	255	255	1,129	10
11	MEN'S 4TH FLOOR AND WOMEN'S 3RD FLOOR BATH/SHOWER:								11
12	DEMO, PLUMBING, ELECTRIC, FRAMING, DRYWALL	2023	27,802		27.5	590	590	2,612	12
13	RENOVATE (10) PATIENT SHOWER ROOMS : REBUILD WALLS,								13
14	REPLACE PIPING, DRAINS, ADD BATHTUB, TILE FOR LOCKER								14
15	ROOMS	2023	323,165		27.5	6,855	6,855	18,606	15
16	FURNISH LABOR & MATERIAL TO INSTALL A NEW 100KW								16
17	GENERATOR, DIESEL GENSET, PIPE, WIRE, TESTING	2024	115,000		27.5	2,440	2,440	6,622	17
18	GENERATOR ENGINEERING: FURNISH LABOR TO PRODUCE								18
19	ENGINEERED DRAWING FOR PERMIT SUBMISSION	2024	7,500		15	292	292	792	19
20	GENERATOR & CABLES: ROLL OUT CABLES AND INSTALL								20
21	SPLICE BLOCKS, OUTAGE ON COMED'S OVERHEAD SYSTEM	2024	16,866		15	656	656	1,780	21
22	3RD & 4TH FLOOR SHOWER ROOMS: DEMOLITION, CONCRETE, DRYWALL,								22
23	CERAMIC TILE, FLOORING, PAINTING, PLUMBING, ELECTRICAL	2024	133,533		27.5	2,832	2,832	7,687	23
24	REPLACED DOMESTIC HOT WATER STORAGE TANK	2024	26,350		15	1,024	1,024	2,780	24
25	5TH FLOOR CORRIDOR: INSTALL CEILING TILE, REPAINTING								25
26	HALLWAY WALLS	2024	11,760		15	457	457	1,241	26
27	INSTALL YORK AIR COOLED CHILLER: INCLUDES ENGINEERING FOR								27
28	STRUCTURE, STRUCTURAL STEEL, NEW PUMPS, ELECTRICAL PIPING,								28
29	CHILLER AUTOMATION CONTROLS	2024	981,492		27.5	20,819	20,819	56,509	29
30	EMERGENCY ROOM- DRYWALL, PATCH AND PAINT	2024	5,100		15	198	198	538	30
31	EMERGENCY KITCHEN- DRYWALL, SEAL, PAINT AND PRIME	2024	19,400		15	754	754	2,047	31
32	INSTALL NEW HM DOORS AND FRAME	2024	20,188		15	785	785	2,130	32
33	GENERATOR ENGINEERING: IDPH PLAN REVIEW FUND	2024	2,400		15	93	93	253	33
34	TOTAL (lines 1 thru 33)		\$ 22,582,295	\$ 754,263		\$ 472,025	\$ (282,238)	\$ 14,150,518	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$22,582,295	\$754,263		\$472,025	\$(282,238)	\$14,150,518	1
2	DAMPERS AND CONTROL VALVES FOR BASEMENT AND								2
3	7TH FLOOR AHU	2024	94,941		27.5	2,014	2,014	5,466	3
4	RISER PERLACEMENT: DEMOLITION, CARPENTRY, DRYWALL,								4
5	PAINTING, PLUMBING	2024	63,894		27.5	1,355	1,355	3,678	5
6	INSTALLED NEW RELIEF VALVES AND VARIABLE DRIVE								6
7	CONTROL TO CIRCULATING PUMP	2024	10,631		15	413	413	1,121	7
8	INSTALLED CHILLER AUTOMATION CONTROLS	2024	13,912		15	541	541	1,468	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19				41,587			(41,587)		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)		\$22,765,673	\$795,850		\$476,348	\$(319,502)	\$14,162,251	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	\$ 697,940	\$	\$ 69,794	\$ 69,794	5-10	\$ 496,000	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY	25,981	3,250	3,250				74
75	TOTALS	\$ 723,921	\$ 3,250	\$ 73,044	\$ 69,794		\$ 496,000	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	FACILITY		202	\$ 52,240	\$	\$	\$	5	\$ 52,240	76
77										77
78										78
79										79
80	TOTALS			\$ 52,240	\$	\$	\$		\$ 52,240	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)	\$ 25,041,834	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 799,100	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 549,392	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (249,708)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,710,491	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		\$
13.		\$
14.		\$

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: \$ 39,659 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			\$	\$	17
18	FACILITY	2024 FORD E450 BUS	#####	23,862	18
19			799.00	9,109	19
20					20
21	TOTAL		\$ #####	\$ 32,971	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.

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

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 22,115	\$		\$ 22,115	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,039			1,039	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			33,377			33,377	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				16,833		16,833	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	39-2					4,664		4,664	13
	Other (specify): IV THERAPY, RENTAL	39-2					1,843		1,843	
14	TOTAL			\$		\$ 56,531	\$ 23,340		\$ 79,871	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	\$	\$ 88,947	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,382)	4,644,867	4,644,867	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		112,165	6
7	Other Prepaid Expenses	1,703,566	1,703,566	7
8	Accounts Receivable (owners or related parties)	225,810	405,810	8
9	Other(specify): ESCROW, REPL RESERVE	74,979	1,414,134	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,649,222	\$ 8,369,489	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,633,931	13
14	Buildings, at Historical Cost		14,153,640	14
15	Leasehold Improvements, at Historical Cost	2,500,813	2,500,813	15
16	Equipment, at Historical Cost	794,063	2,434,063	16
17	Accumulated Depreciation (book methods)	(857,364)	(2,604,946)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) CONSTRUCTION	600,000	1,200,000	22
23	Other(specify): LOAN COST-NET		117,869	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,037,512	\$ 19,435,370	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,686,734	\$ 27,804,859	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,360,261	\$ 5,364,459	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	736,948	1,168,507	29
30	Accrued Salaries Payable	270,263	270,263	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,191,624	32
33	Accrued Interest Payable		43,687	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PA LOAN	1,549,200	1,549,200	36
37	DUE TO RELATED PARTY	2,530,250	4,668,518	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,446,922	\$ 14,256,258	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,840,371	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)	\$	\$ 12,840,371	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,446,922	\$ 27,096,629	46
47	TOTAL EQUITY(page 18, line 24)	\$ (760,188)	\$ 708,230	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,686,734	\$ 27,804,859	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 334,622	1
2	Restatements (describe):		2
3	ROUNDING		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 334,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,094,810)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,094,810)	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)	\$ (760,188)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF FOREST EDGE

0052035

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 19,255,031	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,255,031	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,391	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 216,391	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,998	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,998	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	2,301,029	28
28a	SETTLEMENT	(1,540)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,299,489	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,788,909	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,469,862	31
32	Health Care	8,402,880	32
33	General Administration	5,774,275	33
	B. Capital Expense		
34	Ownership	3,350,500	34
	C. Ancillary Expense		
35	Special Cost Centers	79,871	35
36	Provider Participation Fee	724,558	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,801,946	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,013,037)	41
42	Income Taxes	(81,773)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,094,810)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,342,685.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	15,651,362.00	45
46	MMAI-Medicaid is the Primary Payer	742,128.00	46
47	MMAI-Medicare is the Primary Payer	53,519.00	47
48	Private Pay	113,400.00	48
49	Medicare Part A	1,146,224.00	49
50	Other-(specify) HOSPICE	176,981.00	50
51	Other-(specify) INSURANCE	28,732.00	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)	\$ 19,255,031	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	1,952	2,256	\$ 179,982	\$ 79.78	1
2	Assistant Director of Nursing	4,120	4,352	234,374	53.85	2
3	Registered Nurses	21,282	22,736	1,049,344	46.15	3
4	Licensed Practical Nurses	33,516	37,064	1,604,170	43.28	4
5	CNAs & Orderlies	136,158	148,672	3,788,401	25.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,369	20,535	291,602	14.20	8
9	Activity Director					9
10	Activity Assistants	5,754	6,320	146,154	23.13	10
11	Social Service Workers	15,264	17,824	433,525	24.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,246	8,831	223,449	25.30	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	5,208	5,472	374,202	68.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,200	20,788	632,983	30.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: <u>Care Plan Coord</u>	7,806	8,422	382,967	45.47	32
33	Other(specify) <u>Security</u>	22,190	23,961	486,975	20.32	33
34	TOTAL (lines 1 - 33)	299,065	327,233	\$ 9,828,128 *	\$ 30.03	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	M	\$ 57,233	1-3	35
36	Medical Director	O	31,334	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	12,032	10-3	39
40	Physical Therapy Consultant	L	8,835	10A-3	40
41	Occupational Therapy Consultant	Y	11,240	10A-3	41
42	Respiratory Therapy Consultant		0	10A-3	42
43	Speech Therapy Consultant	F	216	10A-3	43
44	Activity Consultant	E	1,945	11-3	44
45	Social Service Consultant	E	2,025	12-3	45
46	Other(specify) <u>S</u>				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 124,860		49

C. CONTRACT NURSES

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

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

** See instructions.

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	
ABAYOMI ADEBOGUN	Administrator	0	\$ 155,642	Workers' Compensation Insurance	\$	187,841	IDPH License Fee	\$ 2,035	
ROSEMARY OLANREWAJU	Administrator	0	129,804	Unemployment Compensation Insurance		174,181	Advertising: Employee Recruitment	7,000	
TUBOR OJOMALADE	Assistant admin	0	88,756	FICA Taxes		747,702	Health Care Worker Background Check		
				Employee Health Insurance		342,871	(Indicate # of checks performed)	6,274	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	20,329	
				EMPLOYEE BENEFITS - OTHER		26,573	TRUST/FRANCHISE/CONTRIB/ETC	500	
				EMPLOYEE PHYSICAL EXAMS			MARKETING/ADV/PROMO	10,065	
				PENSION/PROFIT SHARING PLANS			LICENSES/DUES/SUBSCRIPTIONS	7,639	
				INSURANCE - EXECUTIVE LIFE			MGMT CO ALLOC	10,654	
							Less: Public Relations Expense (		
							PAC and Lobbying payments	(16,737)	
							All non-allowable advertising	(10,065)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 374,202	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,479,168	TOTAL (agree to Sch. V, line 20, col. 8)	
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			\$ 996,436			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 996,436				MARKETING TRAVEL		
C. Professional Services							MGMT CO ALLOC	5,580	
Vendor/Payee	Type		Amount				Seminar Expense		
			\$						
SEE ATTACHED SCHEDULE			877,948						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 877,948	TOTAL			\$	Entertainment Expense (	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 5,580	

* Attach copy of IMRF notifications

**See instructions.

BRIA OF FOREST EDGE
LEGAL EXPENSES
1/1/2025-12/31/2025

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/3/2025	BRIAN A. STINES	COLLECTION	500
2/1/2025	BRIAN A. STINES	REVIEW IVD NOTICE	80
3/30/2025	BRIAN A. STINES	REVIEW FILE AND ADDITIONAL IVD	140
5/2/2025	BRIAN A. STINES	REVIEW UPDATE IVD	110
6/1/2025	BRIAN A. STINES	EMAIL CORRESPONDENCES RE STATUS OF ISSUED IVD	40
7/31/2025	BRIAN A. STINES	REVIEW IVD NOTICE FROM FACILITY	100
1/31/2025	HINSHAW & CULBERTSON	APPEARED & ATTENDED IDPH STATUS HEARING	972
2/28/2025	HINSHAW & CULBERTSON	REVIEW AND ANALYSIS OF IDPH PREHEARING NOTICE	416
3/31/2025	HINSHAW & CULBERTSON	APPEARED & ATTENDED IDPH STATUS HEARING	350
5/1/2025	HINSHAW & CULBERTSON	APPEARED & ATTENDED IDPH STATUS HEARING	70
5/31/2025	HINSHAW & CULBERTSON	DEVELOPED SETTLEMENT RECOMMENDATION	569
6/23/2025	HINSHAW & CULBERTSON	APPEARED & ATTENDED IDPH STATUS HEARING	105
1/31/2025	JACKSON LEWIS P.C.	ANALYZE PLAINTIFF'S SETTLEMENT DEMAND	4,697
2/1/2025	JACKSON LEWIS P.C.	REVIEW ORDER ON SETTLEMENT	4,102
3/1/2025	JACKSON LEWIS P.C.	ANALYZE SETTLEMENT PROPOSAL	8,429
4/16/2025	JACKSON LEWIS P.C.	ANALYZE STRATEGY REGARDING SETTLEMENT	3,034
5/5/2025	JACKSON LEWIS P.C.	PREPARE REVISIONS TOPROPOSED ORDER	3,618
6/10/2025	JACKSON LEWIS P.C.	PREPARE STRATEGY REGARDING SETTLEMENT	425
7/18/2025	JACKSON LEWIS P.C.	PREPARE REVISIONS TO DRAFT	933
1/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,650
1/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	4,320
4/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,735
7/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,735
7/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,735
7/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,625
7/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,735
7/1/2025	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,735
2/1/2025	MUCH SHELIST	REVIEW DRAFT SETTLEMENT ORDER	987
2/1/2025	MUCH SHELIST P.C.	REVIEW COURT ORDER	141
1/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
2/28/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
3/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
4/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
5/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
6/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
7/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
TOTAL			51,988

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

YES
- (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

HEALTH CARE COUNCIL OF IL (HCCI)

Amount

3,592

3,592

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.

HEALTH CARE COUNCIL OF IL (HCCI)

16,737

16,737

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)

20,329

20,329

Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$

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.

\$

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.

\$

N/A

Has any meal income been offset against
related costs?

Indicate the amount.

\$
- (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?

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?

27%

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?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$

N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (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?

YES

See page 39 of the instructions for details.

Attach invoices and a summary of services for all architect and appraisal fees.