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: 0048629

Facility Name: Bryan Manor

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

County: Marion

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2024 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) 11/25/2025 (Date)
(Type or Print Name) Gina Higgins
(Title) Administrator

Paid Preparer

(Signed) 11/25/2025 (Date)
(Print Name and Title) Emily Masching, CFO
(Firm Name & Address) CSI, PO Box 1946, Centralia, IL 62801
(Telephone) 618-533-9633 x 6 Fax # 618-533-6345

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

Facility Name & ID Number Bryan Manor # 0048629 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD			34,191					34,191	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS			34,191					34,191	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 93.67%

D. How many bed reserve days during this year were paid by the Department?
75pd, 433 unpd (Do not include bed reserve days in Section B.)

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

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

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

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 7/1/24-6/30/25 Fiscal Year: 7/1/24-6/30/25

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	674,654	39,148	45,650	759,452		759,452		759,452			1
2	Food Purchase		572,589		572,589		572,589		572,589			2
3	Housekeeping	656,730	104,596		761,326		761,326		761,326			3
4	Laundry	256,468	45,673	179,893	482,034		482,034		482,034			4
5	Heat and Other Utilities			225,970	225,970		225,970		225,970			5
6	Maintenance	283,255	59,732	56,144	399,131		399,131		399,131			6
7	Other (specify):*											7
8	TOTAL General Services	1,871,107	821,738	507,657	3,200,502		3,200,502		3,200,502			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	9,022,280	755,224	80,226	9,857,730		9,857,730		9,857,730			10
10a	Therapy			10,034	10,034		10,034		10,034			10a
11	Activities	479,064	36,458		515,522		515,522		515,522			11
12	Social Services	81,005			81,005		81,005		81,005			12
13	CNA Training											13
14	Program Transportation			46,718	46,718	(34,354)	12,364		12,364			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,582,349	791,682	151,978	10,526,009	(34,354)	10,491,655		10,491,655			16
	C. General Administration											
17	Administrative	423,849			423,849		423,849		423,849			17
18	Directors Fees											18
19	Professional Services			747,465	747,465		747,465		747,465			19
20	Dues, Fees, Subscriptions & Promotions			463,086	463,086		463,086		463,086			20
21	Clerical & General Office Expenses	223,546	177,985	20,621	422,152		422,152		422,152			21
22	Employee Benefits & Payroll Taxes			3,408,384	3,408,384		3,408,384		3,408,384			22
23	Inservice Training & Education			690	690		690		690			23
24	Travel and Seminar			89,578	89,578		89,578		89,578			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,372	93,372		93,372		93,372			26
27	Other (specify):*											27
28	TOTAL General Administration	647,395	177,985	4,823,196	5,648,576		5,648,576		5,648,576			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,100,851	1,791,405	5,482,831	19,375,087	(34,354)	19,340,733		19,340,733			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

C. General and Admin
Inservice Training and Education

Vendor	Cost	Description
Re:Purpose Development LLC	$ 300.00	Inserivce Training Room Rental
Catchall Services, Inc	$ 390.22	Leadership Development

Facility Name & ID Number Bryan Manor #0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			214,151	214,151		214,151	191,698	405,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							129,763	129,763			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			432,447	432,447		432,447	(432,447)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bad Debt & Fines**			29,278	29,278		29,278		29,278			36
37	**TOTAL Ownership**			675,876	675,876		675,876	(110,986)	564,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,382,993	1,382,993		1,382,993		1,382,993			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,382,993	1,382,993		1,382,993		1,382,993			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	12,100,851	1,791,405	7,541,700	21,433,956	(34,354)	21,399,602	(110,986)	21,288,616			45

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	29,278	36-3		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 29,278		$	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)	(110,986)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (110,986)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,708)		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.			$ 34,354	14-5	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 34,354		47

Schedule V Reclassification

All transportion cost costs go into program transportation. $29,278 was reclassifed as medically necessary based on the mileage driven for those trips.

Bryan Manor

ID# 0048629

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				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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bryan Manor # 0048629 **Report Period Beginning:** 07/01/2024 **Ending:** 06/30/2025

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	191,698	0	0	0	0	0	0	0	0	0	191,698	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	129,763	0	0	0	0	0	0	0	0	0	129,763	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(432,447)	0	0	0	0	0	0	0	0	0	(432,447)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(110,986)	0	0	0	0	0	0	0	0	0	(110,986)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(110,986)	0	0	0	0	0	0	0	0	0	(110,986)	45

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building Lease	$ 432,447	Adult Comprehensive Human Services, Inc		$	$ (432,447)	1
2	V	30	Depreciation		Adult Comprehensive Human Services, Inc		191,698	191,698	2
3	V	32	Interest		Adult Comprehensive Human Services, Inc		129,763	129,763	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 432,447			$ 321,461	$ * (110,986)	14

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

STATE OF ILLINOIS **Ownership Listing-1**

Bryan Manor

ID# **0048629**

Report Period Beginning: **07/01/2024**

Ending: **06/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Pat		Bronson						1
2	Shelly		Heimann						2
3	Linda		O'Rourke						3
4	Karissa		Neudecker						4
5	Glen		Masterson						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Bryan Manor

ID# **0048629**

Report Period Beginning: **07/01/2024**

Ending: **06/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
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142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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								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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	PNB/SEIDA		X	Mortgage/Bonds	$36,037.25	12/26/06	$ 6,120,000	$ 2,388,578	12/22/2031		$ 129,763	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$36,037.25		$ 6,120,000	$ 2,388,578			$ 129,763	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,120,000	$ 2,388,578			$ 129,763	15

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

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

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 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.		$	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bryan Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0048629

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule 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:

A. Land.

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		2008	2008	$ 7,667,922	$ 191,698	40	$ 191,698	$	$ 3,226,917	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Painting & Wall Repairs Room 101-113, 201-203, 205			2014	19,096	955	20	955		10,503	11
12	207, 301-312, 402-413 & 4 Park tub rooms										12
13	Painting & Wall Repairs 100 wing hallway, family room			2015	31,187	1,559	20	1,559		15,594	13
14	and office in main corridor										14
15	Painting & Wall Repairs 400 wing rooms, center hub restroom,			2016	56,104	2,805	20	2,805		25,247	15
16	housekeeping offices, offices in main corridor, 300 wing,										16
17	dining room, breakroom, and 100 wing										17
18	2016 Addition			2016	367,197	14,688	25	14,688		137,087	18
19	Painting and Wall Repairs in main office, family room, north			2017	25,509	1,275	20	1,275		10,203	19
20	and south halls, 100 wing, 200 wing, 5 bathrooms and exterior										20
21	sign										21
22	Carpet/Flooring in main building			2017	15,374	769	20	769		5,957	22
23	Light Poles			2018	9,396	470	20	470		3,406	23
24	Carpeting in main building			2018	5,200	260	20	260		1,798	24
25	Painting and wall repairs in family area, kitchen hall, 100 and			2019	4,672	234	20	234		1,460	25
26	300 wings, and nurses station										26
27	Countertops at nurses station			2019	4,951	248	20	248		1,461	27
28	Cafeteria cabinet and sinks			2023	6,097	305	20	305		610	28
29	Water Heater			2020	8,500	425	20	425		2,125	29
30	Painting and wall repairs main entrance, room 202-204, room			2020	30,034	1,502	20	1,502		7,884	30
31	4017 and 413, family area, 100, 200, and 300 wing, bathrooms in										31
32	100, 200, and 300 wings, laundry room										32
33	Cafeteria Remodel			2020	6,097	305	20	305		1,473	33
34	Parking Lot Improvement			2020	9,525	476	20	476		2,223	34
35	Living Room Flooring			2022	3,660	183	20	183		549	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 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 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	Water Heater	2022	$ 9,200	$ 460	20	$ 460	$	$ 1,342	37
38	Healthcare Equipment	2022	25,273	1,264	20	1,264		3,686	38
39	Wall Protection System	2022	5,100	255	20	255		701	39
40	Water Heater	2023	9,200	460	20	460		958	40
41	Storage Shed	2024	36,244	1,812	20	1,812		2,114	41
42	Door Lock System	2025	6,156	77	20	77		77	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,361,694	$ 222,485		$ 222,485	$	$ 3,463,375	70

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	$ 801,176	$ 136,909	$ 136,909	$	5-10 years	$ 467,551	71
72	Current Year Purchases	306,593	40,351	40,351		5 years	40,351	72
73	Fully Depreciated Assets	821,389				5-10 years	821,389	73
74								74
75	TOTALS	$ 1,929,158	$ 177,260	$ 177,260	$		$ 1,329,291	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	Patinet/Admin	2017 Ford Transit	2017	$ 45,757	$	$	$	5	$ 45,757	76
77	Patinet/Admin	2017 E350 Braun Van	2017	25,198				5	25,198	77
78	Patinet/Admin	Van/Buses	various	227,837	6,104	6,104		5	197,928	78
79										79
80	TOTALS			$ 298,792	$ 6,104	$ 6,104	$		$ 268,883	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)	$ 10,889,951	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 405,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 405,849	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)	$ 5,061,549	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Improvements	$ 400,391	$	$ 400,391	86
87	06 Mazda	11,176		11,176	87
88					88
89					89
90					90
91	TOTALS	$ 411,567	$	$ 411,567	91

G. Construction-in-Progress

	Description	Cost	
92	Cabinets and Countertops	$ 19,275	92
93	Nurse Call System	187,081	93
94			94
95		$ 206,356	95

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

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Bryan Manor # 0048629 **Report Period Beginning:** 07/01/2024 **Ending:** 06/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2025 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,742,680	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,377,834		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,148		6
7	Other Prepaid Expenses	132,527		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Right-Of-Use Asset - Bldg Lease	318,420		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 21,580,609	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	367,197		14
15	Leasehold Improvements, at Historical Cost	746,240		15
16	Equipment, at Historical Cost	2,331,903		16
17	Accumulated Depreciation (book methods)	(2,039,757)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	183,668		21
22	Other Long-Term Assets (spe Right-Of-Use Asset - I	2,071,267		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,660,518	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 25,241,127	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 444,633	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,654		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,524		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	121,050		36
37	Current Portion of Operating Lease Liabil	318,420		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,190,281	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Operating Lease Liability	2,071,267		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,071,267	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,261,548	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 21,979,579	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 25,241,127	$	48

***(See instructions.)**

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,216,219	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,216,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,763,360	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)**	$ 5,763,360	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)**	$ 21,979,579	24 *

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

Facility Name & ID Number Bryan Manor # 0048629 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 26,440,449	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 26,440,449	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	263,830	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)**	$ 263,830	23
	D. Non-Operating Revenue		
24	Contributions	1,096	24
25	Interest and Other Investment Income***	444,646	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 445,742	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	4,372	27
28	Transportation	31,415	28
28a	Miscellaneous	11,508	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 47,295	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 27,197,316	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,200,502	31
32	Health Care	10,526,009	32
33	General Administration	5,648,576	33
	B. Capital Expense		
34	Ownership	675,876	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	1,382,993	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,433,956	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,763,360	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,763,360	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 25,100,271.00	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) Hospice	105,985.00	50
51	Other-(specify) Social Security	1,234,193.00	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)	$ 26,440,449	56

Section 1 Revenue
Other Revenue

Activity Account Income	$ 5,758.00
Sale of Assets	$ 3,000.00
Rebates	$ 2,495.16
Medical Records	$ 20.00
Refunds	$ 35.00
Other Misc. Income	$ 200.00
	$11,508.16

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,808	2,080	$ 151,241	$ 72.71	1
2	Assistant Director of Nursing	1,830	2,127	124,782	58.67	2
3	Registered Nurses	10,408	11,357	664,608	58.52	3
4	Licensed Practical Nurses	35,441	38,161	1,942,752	50.91	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,288	20,174	796,972	39.50	8
9	Activity Director	2,003	2,417	97,444	40.32	9
10	Activity Assistants	13,510	14,400	381,620	26.50	10
11	Social Service Workers	1,793	2,100	81,005	38.57	11
12	Dietician					12
13	Food Service Supervisor	2,126	2,321	69,320	29.87	13
14	Head Cook	3,466	3,874	93,686	24.18	14
15	Cook Helpers/Assistants	21,339	22,071	503,648	22.82	15
16	Dishwashers	418	460	8,000	17.39	16
17	Maintenance Workers	7,334	8,407	283,255	33.69	17
18	Housekeepers	25,281	27,352	656,730	24.01	18
19	Laundry	10,465	11,345	256,468	22.61	19
20	Administrator	1,800	2,080	167,406	80.48	20
21	Assistant Administrator					21
22	Other Administrative	7,630	8,345	256,443	30.73	22
23	Office Manager					23
24	Clerical	5,344	6,063	223,546	36.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	8,041	9,208	294,552	31.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	187,324	195,617	5,047,373	25.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	365,649	389,959	$ 12,100,851 *	$ 31.03	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	830	$ 45,650	1-3	35
36	Medical Director	150	15,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,686	10-3	39
40	Physical Therapy Consultant	134	10,034	10a-3	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) Dental, Vision, Podiatry		9,188	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,150	$ 83,558		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		67,352	10-3	52
53	TOTAL (lines 50 - 52)		$ 67,352		53

Facility Name & ID Number Bryan Manor # 0048629 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
G. Higgins	Administrator		$ 168,265
C. Stallard	Admin Asst		64,394
A. Davis	Direct Care Coord.		103,135
P. Rockett	Admin Asst		3,159
A. Feig	Admin Asst		344
C. Brown	Staff Development Coord.		84,552
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 423,849

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
CSI	Mgmt	$ 605,688
Crain, Miller, & Wernsman	Legal	6,583
Creative Systems, Inc	IT	79,015
Glass & Shuffett, Ltd	Audit	11,500
Wipfli LLP	PS Audit	27,560
Correll Co	TPA	5,471
KLA Consulting	Admin	5,500
Franco & Moroney LLC	Legal	4,848
Community Resource Center	Legal Consult	1,300
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 747,465

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 118,723
Unemployment Compensation Insurance	34,820
FICA Taxes	917,839
Employee Health Insurance	1,211,039
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Physicals, Vaccines, Testing, Retirement, etc	1,125,963
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,408,384

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	3,500
Health Care Worker Background Check	607
(Indicate # of checks performed 26)	
Patient Background Checks 3	54
Association Dues (total from pg 22, #4)	25,480
License & Fees	6,246
Promotions	425,000
Dues	2,199
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 463,086

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	624
Seminar Expense	88,954
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 89,578

* Attach copy of IMRF notifications

**See instructions.

Section C
Legal Invoices

Invoice Date	Law Firm	Allowable Amount	Unallowable Amount	Description of Services
8/1/2024	Crain, Miller, & Wernsman	$1,481.69		Guardianships
7/31/2024	Franco & Moroney, LLC	$4,438.50		Teel vs PG
9/3/2024	Crain, Miller, & Wernsman	$ 547.07		Guardianships
10/1/2024	Crain, Miller, & Wernsman	$ 141.44		Guardianships
10/31/2024	Franco & Moroney, LLC	$ 273.00		Teel vs PG
11/1/2024	Crain, Miller, & Wernsman	$ 62.69		Guardianships
12/2/2024	Crain, Miller, & Wernsman	$1,256.70		Guardianships
1/3/2025	Crain, Miller, & Wernsman	$ 373.94		Guardianships
1/31/2025	Franco & Moroney, LLC	$ 78.00		Teel vs PG
3/3/2025	Crain, Miller, & Wernsman	$ 264.88		Guardianships
4/3/2025	Crain, Miller, & Wernsman	$ 547.91		Guardianships
5/1/2025	Crain, Miller, & Wernsman	$ 894.69		Guardianships
4/30/2025	Franco & Moroney, LLC	$ 58.50		Teel vs PG
6/4/2025	Crain, Miller, & Wernsman	$ 714.00		Guardianships
7/1/2025	Crain, Miller, & Wernsman	$ 297.88		Guardianships

Date	Seminar	Cost	Staff Attended
7/1/2024 to 12/31/2024	IARFuture	$ 2,800.00	M. Swagler
7/13/2024 and 7/14/2024	Contemporary Life Sa	$ 950.00	C. Brown and K. Keeley
7/8/2024	Crisis Prevention Insti	$ 200.00	
8/28/2024 to 8/30/2024	IARF Conference and	$ 700.00	G. Higgins and M. Swagler
8/28/2024 to 8/30/2024	IARF Conference and	$ 850.00	S. Jones and B. Boldt
7/30/2024	Mometrix - Certified D	$ 46.74	C. Berry
8/28/2024 to 8/30/2024	Marriott	$ 3,219.00	G. Higgins and M. Swagler
			S. Jones and B. Boldt
10/29/2024	QBS, LLC	$20,500.00	10 various staff
10/17/2024	Contemporary Life Sa	$ 130.00	13 various staff
11/14/2024	Contemporary Life Sa	$ 70.00	Marshall and Brown
11/16/2024 and 11/17/2024	Contemporary Life Sa	$ 950.00	Brown and Whalen
10/31/2024	Vital StimPlus - NMES	$ 250.00	B. Boldt
10/31/2024	ASHA	$ 278.00	B. Boldt
11/18/2024	CDM Credentialing Ex	$ 425.00	C. Berry
		$ 181.10	
12/3/2024	Contemporary Life Sa	$ 338.28	50 various staff
11/18/2024	Contemporary Life Sa	$ 86.00	Sauter
Various	UKG Conference, SH	$10,855.10	Admin Staff
12/6/2024	Contemporary Life Sa	$ 70.00	7 staff
12/2/2024	Contemporary Life Sa	$ 396.00	12 staff
1/2/2025	Contemporary Life Sa	$ 297.00	9 staff
1/15/2025	Contemporary Life Sa	$ 297.00	9 staff
2/25/2025	Office Supplies for Tra	$ 38.88	
2/6/2025	Contemporary Life Sa	$ 495.00	15 staff
2/6/2025	Contemporary Life Sa	$ 396.00	12 staff
2/14/2025	Contemporary Life Sa	$ 165.00	5 staff
3/10/2025	NFPT - Pathway 1	$ 525.00	C. Berry
3/10/2025	Nutrition Fundamenta	$ 273.00	C. Berry
2/27/2025	QBS, LLC	$ 216.00	A. Feig and C. Brown
3/13/2025	Contemporary Life Sa	$ 693.00	12 staff
7/21/2025	ANCOR Retreat	$ 1,968.73	Admin Staff
4/2/2025	IL Public Health Infect	$ 100.00	G. Higgins
Various	IMPACT/Medicar Trai	$ 1,200.00	6 staff
4/10/2025	Contemporary Life Sa	$ 627.00	19 staff
4/17/2025	Contemporary Life Sa	$ 132.00	4 staff
11/24/2024	Contemporary Life Sa	$ 184.00	7 staff
4/20/2025	Supplies for training	$ 8.93	
Various	QBS, LLC	$ 324.00	C. Brown
5/20/2025	QBS, LLC	$18,392.00	8 staff
5/20/2025	QBS, LLC	$ 2,299.00	1 staff
5/7/2025	Contemporary Life Sa	$ 33.00	Wilkins
5/7/2025	Contemporary Life Sa	$ 363.00	11 staff
5/13/2025	QBS, LLC	$ 48.00	Brown
6/6/2025	Contemporary Life Sa	$ 429.00	13 staff
6/17/2025	Contemporary Life Sa	$ 33.00	Stedlin
Various	AHLA, ANCOR, Thera	$15,731.40	Admin Staff
Various	QBS, LLC	$ 390.00	Brown

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
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	25,480
	25,480 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.

ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	
	Total

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

ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	25,480
	25,480 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ **142,235** 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. $ **1,382,993**
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? **N/A** Indicate the amount. $ **N/A**

(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. $ **31,415**

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained? **YES**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(13) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **GLASS AND SHUFFETT**

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