

Facility Name & ID Number BRIA OF FOREST EDGE

0052035 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	90,927		4,184	95,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	90,927		4,184	95,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.44%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 3,953

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number **BRIA OF FOREST EDGE** # **0052035** Report Period Beginning: **01/01/2018** Ending: **12/31/2018**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary			1,263,722	1,263,722		1,263,722		1,263,722		1
2	Food Purchase										2
3	Housekeeping		5,455	589,890	595,345		595,345		595,345		3
4	Laundry		42,971	399,493	442,464		442,464		442,464		4
5	Heat and Other Utilities			360,615	360,615		360,615		360,615		5
6	Maintenance	102,212	71,856	228,099	402,167		402,167	1,688	403,855		6
7	Other (specify):*	389,056		50,831	439,887		439,887	267	440,154		7
8	TOTAL General Services	491,268	120,282	2,892,650	3,504,200		3,504,200	1,955	3,506,155		8
	B. Health Care and Programs										
9	Medical Director			36,900	36,900		36,900		36,900		9
10	Nursing and Medical Records	5,227,844	225,398	49,850	5,503,092		5,503,092	41,328	5,544,420		10
10a	Therapy			86,627	86,627		86,627		86,627		10a
11	Activities	235,467	13,843	3,040	252,350		252,350		252,350		11
12	Social Services	468,837	19,876	882	489,595		489,595		489,595		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,932,148	259,117	177,299	6,368,564		6,368,564	41,328	6,409,892		16
	C. General Administration										
17	Administrative	216,011		920,000	1,136,011		1,136,011	(909,000)	227,011		17
18	Directors Fees										18
19	Professional Services			183,127	183,127		183,127	21,038	204,165		19
20	Dues, Fees, Subscriptions & Promotions			96,973	96,973		96,973	(33,925)	63,048		20
21	Clerical & General Office Expenses	344,216	37,853	330,668	712,737		712,737	(87,950)	624,787		21
22	Employee Benefits & Payroll Taxes			1,027,018	1,027,018		1,027,018		1,027,018		22
23	Inservice Training & Education			15,808	15,808		15,808	1,376	17,184		23
24	Travel and Seminar							6,479	6,479		24
25	Other Admin. Staff Transportation			13,264	13,264		13,264	(4,045)	9,219		25
26	Insurance-Prop.Liab.Malpractice			406,713	406,713		406,713	52,777	459,490		26
27	Other (specify):*			287,147	287,147		287,147	(249,680)	37,467		27
28	TOTAL General Administration	560,227	37,853	3,280,718	3,878,798		3,878,798	(1,202,930)	2,675,868		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,983,643	417,252	6,350,667	13,751,562		13,751,562	(1,159,647)	12,591,915		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	
	REPAIRS & MAINTENANCE	
	DIETARY - SERVICE CONTRACTS	1,263,722
3	HOUSEKEEPING	
	HOUSEKEEPING SERVICE - CONTRACT	589,890
		589,890
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,000
	LAUNDRY SERVICES CONTRACT	398,493
		399,493
5	HEAT & OTHER UTILITIES	
	GAS HEAT	102,809
	ELECTRICITY	157,741
	WATER	98,608
	CABLE TV - LOBBY	1,457
		360,615
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,465
	PAINTING & DECORATING	
	BUILDING REPAIRS	
	MAINTENANCE TRAVEL	
	EQUIPMENT MAINTENANCE & REPAIR	2,910
	ELEVATOR MAINTENANCE & REPAIR	
	OUTSIDE LABOR	
	EXTERMINATING SERVICE	
	FIRE SERVICE	22,804
	BUILDING & EQUIPMENT MAINTENANCE	198,920
		228,099
7	OTHER	
	SCAVENGER	50,831
	SECURITY SERVICE	
		50,831
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	36,900
		36,900

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	6,247
	LABORATORY & XRAY EXPENSE	
	PURCHASED SERVICES	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	22,450
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	
	PHARMACY CONSULTANT XVIII B 39-2	21,153
	UTILIZATION REVIEW FEES XVIII B __-2	
	PHYSICIANS XVIII B __-2	
	PSYCHIATRIC XVIII B -2	
	RN CONSULTANT XVIII B 38-2	
		49,850
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	39,013
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	30,317
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	12,335
	SPEECH THERAPY CONSULTANT XVIII B 43-2	4,962
		86,627
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,040
		3,040
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	882
	SOCIAL WORKER XVIII B 45-2	
		882
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	920,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,943
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	163,184
		183,127
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	13,028
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	14,769
	CONTRIBUTIONS VI 20 XIX F	300
	DUES & SUBSCRIPTIONS XIX F	24,216
	LICENSES & PERMITS XIX F	3,685
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	32,860
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	8,115
	PATIENT BACKGROUND CHECKS XIX F	
		96,973
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,886
	EQUIPMENT REPAIR & MAINTENANCE	
	OUTSIDE CLERICAL SERVICES	170,000
	PENALTIES / OVERDRAFT CHARGES VI 18	16,324
	HOME OFFICE EXPENSE	
	THEFT & DAMAGE LOSS	
	TELEPHONE	17,310
	MESSANGER SERVICE	2,612
	SOFTWARE MAINTENANCE	119,536
		330,668

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	531,771
	UNEMPLOYMENT COMPENSATION XIX D	72,530
	WORKERS COMPENSATION INSURANCE XIX D	124,827
	HOSPITALIZATION INSURANCE XIX D	278,331
	EMPLOYEE BENEFITS - OTHER XIX D	18,149
	EMPLOYEE PHYSICAL EXAMS XIX D	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	1,410
		1,027,018
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	15,808
		15,808
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	13,264
		13,264
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	406,713
		406,713
27	OTHER	
	BAD DEBTS VI 24	270,714
	LEGAL SETTLEMENT	16,433
		287,147

GRAND TOTAL COLUMN 3 OTHER **6,350,667**

**BRIA OF FOREST EDGE
SCHEDULES
12/31/2018**

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

TOTAL FOOD PURCHASE	0
LESS SALES TAX	0
NET FOOD	<u>0</u>

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

TOTAL PATIENT CENSUS	95,111
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	<u>285,333</u>

ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	79,570
TOTAL EMPLOYEE MEALS	<u>0</u>

PATIENT MEALS	285,333
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	<u>285,333</u>

NET FOOD	0
DIVIDE TOTAL MEALS/YEAR	<u>285,333</u>

COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFIC	<u><u>0</u></u>

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			121,468	121,468		121,468	645,149	766,617			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			118,491	118,491		118,491	637,641	756,132			32
33	Real Estate Taxes							533,281	533,281			33
34	Rent-Facility & Grounds			2,290,022	2,290,022		2,290,022	(2,290,022)				34
35	Rent-Equipment & Vehicles			22,047	22,047		22,047	4,385	26,432			35
36	Other (specify):* RENT OFFICE			26,400	26,400		26,400	79,978	106,378			36
37	TOTAL Ownership			2,578,428	2,578,428		2,578,428	(389,588)	2,188,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,493	753,803	885,296		885,296		885,296			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			731,100	731,100		731,100		731,100			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		131,493	1,484,903	1,616,396		1,616,396		1,616,396			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,983,643	548,745	10,413,998	17,946,386		17,946,386	(1,549,235)	16,397,151			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(81,130)	30		9
10	Interest and Other Investment Income	(52,478)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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	(33,160)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(270,714)	27		24
25	Fund Raising, Advertising and Promotional	(13,028)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(137,137)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (587,647)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(961,588)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (961,588)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,549,235)		37

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

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

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

BRIA OF FOREST EDGE

ID# 0052035

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (111,773)	21	1
2	BANK CHARGE	(4,886)	21	2
3	MARKETING TRAVEL	(4,045)	25	3
4	LAWSUIT	(16,433)	27	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	(137,137)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF FOREST EDGE# 0052035

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	1,688	0	0	0	0	0	0	0	0	1,688	6
7	Other (specify):*	0	0	267	0	0	0	0	0	0	0	0	267	7
8	TOTAL General Services	0	0	1,955	0	0	0	0	0	0	0	0	1,955	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	41,328	0	0	0	0	0	0	0	0	41,328	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	41,328	0	0	0	0	0	0	0	0	41,328	16
	C. General Administration													
17	Administrative	0	0	(909,000)	0	0	0	0	0	0	0	0	(909,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	8,338	12,700	0	0	0	0	0	0	0	21,038	19
20	Fees, Subscriptions & Promotions	(46,188)	0	12,263	0	0	0	0	0	0	0	0	(33,925)	20
21	Clerical & General Office Expenses	(116,659)	0	28,709	0	0	0	0	0	0	0	0	(87,950)	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	1,376	0	0	0	0	0	0	0	0	1,376	23
24	Travel and Seminar	0	0	6,479	0	0	0	0	0	0	0	0	6,479	24
25	Other Admin. Staff Transportation	(4,045)	0	0	0	0	0	0	0	0	0	0	(4,045)	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,023	47,754	0	0	0	0	0	0	0	52,777	26
27	Other (specify):*	(287,147)	0	37,467	0	0	0	0	0	0	0	0	(249,680)	27
28	TOTAL General Administration	(454,039)	0	(809,345)	60,454	0	(1,202,930)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(454,039)	0	(766,062)	60,454	0	(1,159,647)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF FOREST EDGE

0052035

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(81,130)	0	7,629	718,650	0	0	0	0	0	0	0	645,149	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(52,478)	0	57,908	632,211	0	0	0	0	0	0	0	637,641	32
33	Real Estate Taxes	0	0	0	533,281	0	0	0	0	0	0	0	533,281	33
34	Rent-Facility & Grounds	0	0	0	(2,290,022)	0	0	0	0	0	0	0	(2,290,022)	34
35	Rent-Equipment & Vehicles	0	0	4,385	0	0	0	0	0	0	0	0	4,385	35
36	Other (specify):*	0	0	0	79,978	0	0	0	0	0	0	0	79,978	36
37	TOTAL Ownership	(133,608)	0	69,922	(325,902)	0	(389,588)	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)	(587,647)	0	(696,140)	(265,448)	0	(1,549,235)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 920,000	BRIA HEALTH SERVICES		\$	\$ (920,000)
16	V	21 OUTSIDE CLERICAL	170,000				(170,000)
17	V	17 CFO SALARY-A.WEINFELD				11,000	11,000
18	V	10 SALARIES-MEDICARE/NURSING				40,003	40,003
19	V	21 SALARIES-PURCHASING D.SEGAL				38,951	38,951
20	V	21 SALARIES-CLERICAL RELATED PARTIES				6,353	6,353
21	V	21 SALARIES-CLERICAL				123,506	123,506
22	V	6 MAINTENANCE				1,688	1,688
23	V	7 SCAVENGER				267	267
24	V	10 NURSING CONSULTANT				1,325	1,325
25	V	19 PROFESSIONAL FEES				8,338	8,338
26	V	20 DUES,FEES,SUBSCRIPTIONS				12,263	12,263
27	V	21 OFFICE EXPENSE				29,899	29,899
28	V	23 SEMINARS				1,376	1,376
29	V	24 TRAVEL				6,479	6,479
30	V	26 INSURANCE				5,023	5,023
31	V	27 EMPLOYEE BENEFITS				37,467	37,467
32	V	30 DEPRECIATION				7,629	7,629
33	V	32 INTEREST				57,908	57,908
34	V	35 AUTO LEASE				2,384	2,384
35	V	35 EQUIPMENT RENTAL				2,001	2,001
36	V						
37	V						
38	V						
39	Total		\$ 1,090,000			\$ 393,860	\$ * (696,140)

* 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	34 RENT	\$ 2,290,022	PRESIDENTIAL PAVILION LLC		\$	(2,290,022)
16	V	34 RENT				1,690,023	1,690,023
17	V	30 DEPREC S.L -IMP				30,941	30,941
18	V						
19	V						
20	V	34 RENT	1,690,023	BEVERLY PAVILION LLC			(1,690,023)
21	V	19 PROFESSIONAL FEES				12,700	12,700
22	V	26 INSURANCE - PROPERTY				47,754	47,754
23	V	30 DEPR S.L BUILDING & IMP				687,709	687,709
24	V	32 INTERST				632,211	632,211
25	V	33 REAL ESTATE TAXES				533,281	533,281
26	V	36 M.I.P. INSURANCE				79,978	79,978
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,980,045			\$ 3,714,597	\$ * (265,448)

* 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:

01/01/2018

Ending:

12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	AVRUM WEINFELD	23.75	BRIA OF CAHOKIA	COHOKIA				1
2								2
3	DANIEL WEISS	23.75	BRIA OF RIVER OAKS	BURNHAM	IME REALTY CORP	SKOKIE	MGMT CONSULT	3
4								4
5	NATAN WEISS	23.75	BRIA OF BELLEVILLE	BELLEVILLE				5
6								6
7	FRED BERKOVITS	23.75	BRIA OF GENEVA	GENEVA	BRIA HEALTH SERVICES, LLC	SKOKIE	MANAGEMENT	7
8								8
9	DOV SEGAL	5	BRIA OF WESTMONT	WESTMONT				9
10					BEVERLY PAVILION		REAL ESTATE	10
11			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO HEIGHTS	LLC	SKOKIE		11
12					LLC			12
13								13
14			BRIA OF PALOS HEIGHTS	PALOS HILLS				14
15								15
16			LAKE PARK	WAUKEGAN				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

BRIA OF FOREST EDGE

#

0052035

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FR BRIA HEALTH SERVICES								\$		1
2	DOV SEGAL	Purchasing Consult	consulting	5.00	SEE	4	10.00	SALARY	11,000	17-7	2
3	AVRUM WEINFELD	CFO	ADMINISTRATIV	23.75	ATTACHED	4	10.00	SALARY	38,951	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,951		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:

01/01/2018

Ending: 2/31/2018

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 BRIA OF FOREST EDGE

0052035

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	CFO SALARY-A.WEINFELD	wghtd avr hours	9	\$ 99,000	\$ 99,000		\$ 11,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	516,944	217,425	217,425	95,111	40,003	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours	9	148,012	148,012		38,951	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours	9	41,826	41,826		6,353	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	516,944	671,273	671,273	95,111	123,506	5
6	6	MAINTENANCE	CENSUS DAYS	516,944	9,177		95,111	1,688	6
7	7	SCAVENGER	CENSUS DAYS	516,944	1,451		95,111	267	7
8	10	NURSING CONSULTANT	CENSUS DAYS	516,944	7,200		95,111	1,325	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	516,944	45,319		95,111	8,338	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	516,944	66,654		95,111	12,263	10
11	21	OFFICE EXPENSE	CENSUS DAYS	516,944	162,507		95,111	29,899	11
12	23	SEMINARS	CENSUS DAYS	516,944	7,477		95,111	1,376	12
13	24	TRAVEL	CENSUS DAYS	516,944	35,214		95,111	6,479	13
14	26	INSURANCE	CENSUS DAYS	516,944	27,300		95,111	5,023	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	516,944	203,639		95,111	37,467	15
16	30	DEPRECIATION	CENSUS DAYS	516,944	41,469		95,111	7,629	16
17	32	INTEREST	CENSUS DAYS	516,944	314,739		95,111	57,908	17
18	35	AUTO LEASE	CENSUS DAYS	516,944	12,960		95,111	2,384	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	516,944	10,875		95,111	2,001	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,123,517	\$ 1,177,536		\$ 393,860	25

Facility Name & ID Number

BRIA OF FOREST EDGE

0052035

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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 - BEVERLY	X	MORTGAGE	\$79,003.00	6/01/12	\$ 17,721,500	\$ 15,860,039	05/01/43	0.0395	\$ 632,211	1									
2											2									
3											3									
4	S.SEGAL		WORKING CAPITAL	\$1,590.00	11/12	150,000	67,866	11/22	0.0500	3,810	4									
5	B.WEINFELD		WORKING CAPITAL	\$2,500.00	11/12	200,000	182,631	11/22	0.1409	26,041	5									
Working Capital																				
6			INSURANCE POLICIES FIN							6,039	6									
7	MB FINANCIAL		L.O.C.		11/12	3,000,000	2,275,000	11/18	0.0450	82,601	7									
8	RELATED PARTY ALLOCATION									57,908	8									
9	TOTAL Facility Related			\$83,093.00		\$ 21,071,500	\$ 18,385,536			\$ 808,610	9									
B. Non-Facility Related*																				
10	IRS,IDR,ETC	X	LATE FEES								10									
11											11									
12											12									
13	INTEREST INCOME									(52,478)	13									
14	TOTAL Non-Facility Related					\$	\$			\$ (52,478)	14									
15	TOTALS (line 9+line14)					\$ 21,071,500	\$ 18,385,536			\$ 756,132	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 79,978 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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF FOREST EDGE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0052035

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>20-31-108-044-0000</u>	<u>NURSING HOME</u>	\$ <u>565,083.21</u>	\$ <u>565,803.21</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>565,083.21</u></u>	\$ <u><u>565,803.21</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number BRIA OF FOREST EDGE

0052035 Report Period Beginning:

01/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: 1, Use, Square Feet, 2005, \$ 1,500,000, 1. Row 2: 2, Use, Square Feet, Year Acquired, Cost, 2. Row 3: 3, TOTALS, Square Feet, Year Acquired, \$ 1,500,000, 3.

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

Report Period Beginning:

01/01/2018

Ending:

12/31/2018**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	328		2005	2005	\$ 17,449,000	\$ 634,509	27.5	\$ 634,509	\$	\$ 8,116,428	4
5											5
6											6
7	BRIA ALLOC				133,067	3,754	39	3,754			7
8											8
	Improvement Type**										
9	AWNINGS		2001		10,500	382	27.5	382		6,542	9
10	FENCE		2001		2,100		15			2,100	10
11	ELEVATOR		2001		18,340	667	27.5	667		11,422	11
12	ALARM		2001		5,686	207	27.5	207		3,545	12
13	WINDOWS		2001		4,149	151	27.5	151		2,586	13
14	BOILER		2001		3,000	109	27.5	109		1,649	14
15	FURNISHING WALLPAPER & BORDERS		2001		12,953		5			12,953	15
16	KITCHEN SINK & DRAIN		2001		2,525	92	27.5	92		1,575	16
17	DOORS		2001		15,100	549	27.5	549		9,391	17
18	ELEVATOR		2002		222,811	8,102	27.5	8,102		137,734	18
19	FENCE		2002		3,100	98	15		(98)	3,100	19
20	DOORS & LOCKS		2002		21,741	791	27.5	791		13,348	20
21	SHOWER ROOMS		2002		4,669	170	27.5	170		2,770	21
22	ALARM AND SPRINKLER		2002		11,881	432	27.5	432		7,037	22
23	EJECTOR & SEWEGE PUMP		2002		14,604	531	27.5	531		8,651	23
24	ROOF DRAIN		2002		3,100	113	27.5	113		1,869	24
25	FURNISHING - CARPETS AND DRAPERIES		2002		91,494		5			91,494	25
26	ELEVATOR		2003		110,562	4,020	27.5	4,020		63,483	26
27	PARKING LOT		2003		64,182	4,279	15	2,136	(2,143)	64,182	27
28	FIRE ALARM SYSTEM		2003		25,000	909	27.5	909		14,127	28
29	ROOF		2003		26,500	964	27.5	964		14,902	29
30	EXTERIOR WALL		2003		9,796	356	27.5	356		5,474	30
31	SINKS		2003		3,146	114	27.5	114		1,772	31
32	BUILT IN WARDROBE		2003		19,398	705	27.5	705		10,781	32
33	REBUILD A/C & HEATING RETURN FAN		2004		4,700	171	27.5	171		2,544	33
34	FIRE ALARM SYSTEM		2004		13,201	480	27.5	480		7,100	34
35	BUILT IN WARDROBE		2004		21,807	793	27.5	793		11,532	35
36			2004		61,620	2,241	27.5	2,241		32,028	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:

01/01/2018 Ending: 12/31/2018

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>DOORS</u>	2004	\$ 2,995	\$ 109	27.5	\$ 109	\$	\$ 1,549	37
38	<u>BOILER REPAIR</u>	2004	5,650	206	27.5	206		2,892	38
39	<u>HOT WATER HEATER</u>	2004	5,756	209	27.5	209		3,362	39
40	<u>FLOOR TILING</u>	2004	5,326	194	27.5	194		2,724	40
41	<u>REMODEL BATHROOM</u>	2005	6,080	221	27.5	221		2,993	41
42	<u>DOORS</u>	2005	4,506	164	27.5	164		2,221	42
43	<u>FLOOR TILING</u>	2005	1,536	56	27.5	56		758	43
44	<u>2 WATER BOILERS</u>	2005	99,047	3,602	27.5	3,602		47,877	44
45	<u>CONCRETE PATIO</u>	2005	3,015	201	15	201		2,739	45
46	<u>SHOWER</u>	2006	3,040	111	27.5	111		1,392	46
47	<u>DUCT WORK</u>	2006	5,600	204	27.5	204		2,559	47
48	<u>A/C COOLING TOWER</u>	2006	13,161	479	27.5	479		5,528	48
49	<u>FIRE ALARM - BEVERLY</u>	2007	273,534	9,946	27.5	9,946		114,380	49
50	<u>COOLING TOWERS - BEVERLY</u>	2007	121,905	4,433	27.5	4,433		50,979	50
51	<u>SHOWERS - BEVERLY</u>	2007	12,160	442	27.5	442		5,083	51
52	<u>AIR CLEANERS - BEVERLY</u>	2007	10,851	395	27.5	395		4,542	52
53	<u>CONCRETE WORK - BEVERLY</u>	2007	5,100	185	27.5	185		2,220	53
54	<u>SHOWERS - BEVERLY</u>	2008	9,120	333	27.5	333		3,574	54
55	<u>DOORS - BEVERLY</u>	2008	4,520	164	27.5	164		1,797	55
56	<u>BOLIER - BEVERLY</u>	2008	5,295	193	27.5	193		2,018	56
57	<u>FLOORS - BEVERLY</u>	2008	6,260	228	27.5	228		2,347	57
58	<u>ROOFING - BEVERLY</u>	2008	3,800	138	27.5	138		1,409	58
59	<u>EXTERIOR WALL - BEVERLY</u>	2008	20,000	727	27.5	727		7,300	59
60	<u>ROOFING - BEVERLY</u>	2009	10,333	375	27.5	375		3,634	60
61	<u>CAULK JOINTS - BEVERLY</u>	2010	28,450	1,035	27.5	1,035		8,841	61
62	<u>MECHANICAL ROOM - BEVERLY</u>	2010	19,450	707	27.5	707		5,862	62
63	<u>WELDING - BEVERLY</u>	2010	3,587	130	27.5	130		1,056	63
64	<u>ROOF - BEVERLY</u>	2010	2,925	106	27.5	106		861	64
65	<u>STEEL DOOR - BEVERLY</u>	2011	1,275	46	27.5	46		358	65
66	<u>CONTROLLE R- ANNUNCIATOR - BEVERLY</u>	2011	6,649	242	27.5	242		1,644	66
67	<u>CONCRETE - SIDEWALK - BEVERLY</u>	2011	2,375	86	27.5	86		677	67
68	<u>BACKFLOW REPAIR - BEVERLY</u>	2011	4,550	165	27.5	165		1,189	68
69	<u>ELECTRICAL - BEVERLY</u>	2012	4,347	158	27.5	158		1,086	69
70	TOTAL (lines 4 thru 69)		\$ 19,101,930	\$ 691,679		\$ 689,438	\$ (2,241)	\$ 8,959,570	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:

01/01/2018 Ending: 12/31/2018

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,101,930	\$ 691,679		\$ 689,438	\$ (2,241)	\$ 8,959,570	1
2	VINYL FENCE AND GATE	2012	7,400	269	27.5	269		1,782	2
3	SOUTH ROOF FLASHING - BEVERLY	2012	4,350	158	27.5	158		1,034	3
4	KITCHEN IMPROVEMENT - BEVERLY	2012	2,640	96	27.5	96		620	4
5	SIDEWALK - BEVERLY	2012	2,150	78	27.5	78		504	5
6	NORTH ROOF FLASHING - BEVERLY	2012	1,950	71	27.5	71		459	6
7	SPRINKLER MODIFICATIONS	2012	17,530	637	27.5	637		3,955	7
8	FIRE DAMPERS, CEILING, ELECTRICAL WORK - BEVERLY	2012	49,679	1,807	27.5	1,807		11,218	8
9	COMPLETE REBUILD OF CHILLER - BEVERLY	2013	42,700	1,553	27.5	1,553		9,124	9
10	WIRING FOR SATELLITE - BEVERLY	2013	13,325	485	27.5	485		2,769	10
11	FIRE SPRINKLERS - BEVERLY	2013	16,686	607	27.5	607		3,414	11
12	BOILER REBUILD - BEVERLY	2013	8,550	311	27.5	311		1,698	12
13	INSTALL DOOR PACKAGE ON 3 ELEVATORS - BEVERLY	2013	36,000	1,309	27.5	1,309		6,818	13
14	WALK IN FREEZER NEW CONDENSING UNIT - BEVERLY	2013	7,307	266	27.5	266		1,385	14
15									15
16	COMM AWNING WITH NAME	2013	9,200	411	7	1,314	903	7,884	16
17									17
18									18
19	REPLACE ELEVATOR ENCODER & MACHINE BEARINGS	2014	18,060	657	27.5	657		3,093	19
20									20
21	1ST FLOOR DAY RM - GLASS WALLS , DOORS & GUARDS	2014	9,998	364	27.5	364		1,714	21
22	1ST FLOOR - REMOVE VCT AND INSTALL CARPET TILE	2014	20,810	757	27.5	757		3,564	22
23	LOBBY - REMOVE WALL AND INSTALL NEW GLASS								23
24	WALL , DOORS AND ACOUSTICAL CEILING	2014	87,162	3,170	27.5	3,170		14,925	24
25	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								25
26	AND CORRIDOR - PAINT ,WALL COVERING & SIGNAGE	2014	21,335	776	27.5	776		3,654	26
27	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								27
28	AND CORRIDOR - MILL WORK,ELCTRICAL	2014	10,083	367	27.5	367		1,728	28
29	ELEVATOR - WALLCOVERING AND NEW CEILING	2014	24,569	893	27.5	893		4,205	29
30	REFRESHMENT STAND	2014	2,500	91	27.5	91		428	30
31	GUEST BATHRMS & SMOKING PATIO - DOORS & FRAME	2014	8,657	315	27.5	315		1,483	31
32	2ND FLOOR - REBUILD 2 TUB ROOMS	2014	30,531	1,110	27.5	1,110		5,134	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,555,102	\$ 708,237		\$ 706,899	\$ (1,338)	\$ 9,052,162	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:

01/01/2018 Ending: 12/31/2018

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		\$ 19,555,102	\$ 708,237		\$ 706,899	\$ (1,338)	\$ 9,052,162	1
2	SMOKING PATIO - REMOVE OLD FLR AND WALL AND								2
3	INSTALL NEW FLOOR AND WALLS	2014	5,037	183	27.5	183		862	3
4	NURSES STATION - NURSES STATION , ELECTRICAL ,								4
5	BUILT IN CABINETS AND COUNTER TOPS	2014	27,118	986	27.5	986		4,642	5
6	2ND FLOOR CORRIDOR & GREAT ROOM - NEW								6
7	ACOUSTICAL CEILING & LIGHTING	2014	26,708	971	27.5	971		4,572	7
8	2ND FLOOR GREAT ROOM - REMOVE OLD GLASS WALL								8
9	INSTALL NEW STUD WALL	2014	5,700	207	27.5	207		975	9
10	2ND FLOOR CORRIDOR & GREAT ROOM - WALL								10
11	COVERINGS	2014	25,444	925	27.5	925		4,355	11
12	2ND FLOOR - VCT AND COVE BASE REMOVAL AND								12
13	OF NEW FLOORING AND CHAIR RAILS	2014	45,077	1,639	27.5	1,639		7,717	13
14	3RD FLOOR - DEMOLISH & REBUILD THE SHOWER	2014	16,540	601	27.5	601		2,730	14
15	AREAS IN BOTH 3RD FLOOR TUB RMS.REBUILD								15
16	INCLUDES TILES, PLUMBING FIXTURES, AND TRIMS								16
17	ALL WINDOWS OF BUILDING TO BE RECAULKED	2014	30,880	1,123	27.5	1,123		4,820	17
18	FIRE SPRINKLERS - ELEVATOR AND SECOND FLOOR	2014	8,600	313	27.5	313		1,317	18
19	18 SMOKE DETECT ELEVATOR & VARIOUS LOCATION	2014	3,191	116	27.5	116		498	19
20	CONCRETE PILLARS	2014	6,800	247	27.5	247		1,039	20
21	INSTALL 2 DAMPERS ON THE MAIN AIR SUPPLY AND	2014	5,480	199	27.5	199		837	21
22	RETURN DUCTS								22
23	INSTALL NEW BOILER SECTIONS	2014	11,724	426	27.5	426		1,757	23
24	4 TH FLOOR TUB ROOM REMOVE OLD FLOOR AND	2014	4,430	161	27.5	161		691	24
25	DRAIN INSTALL NEW								25
26	AWNING	2014	6,520	237	27.5	237		1,057	26
27									27
28	1ST FLOOR THERAPY ROOM								28
29	REMOVAL OF EXISTING COVE BASE & VCT	2015	13,694	498	27.5	498		1,888	29
30	PREP & INSTALL OF NEW VINYL & CARPET								30
31	FLOORING & COVE BASE								31
32	FRAME NEW WALLS FOR VESTIBULE , STORAGE,	2015	10,992	400	27.5	400		1,516	32
33	AND WORK STATION, PROVIDE SEPARATE								33
34	TOTAL (lines 1 thru 33)		\$ 19,809,037	\$ 717,469		\$ 716,131	\$ (1,338)	\$ 9,093,435	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:

01/01/2018 Ending: 12/31/2018

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		\$ 19,809,037	\$ 717,469		\$ 716,131	\$ (1,338)	\$ 9,093,435	1
2	SWITCHING FOR VESTIBULE LIGHTING AND								2
3	6 NEW OUTLETS AND INSTALL DRYWALL ,								3
4	TAPE JOINTS, SMOOTH AND PRIME READY FOR								4
5	FINISHES								5
6	FURNISH & INSTALL NEW CEILING & LIGHTING	2015	15,140	551	27.5	551		2,089	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	399	7	653	254	2,285	9
10	MIRROR WALL 16'11"W X 8'H WITH	2015	2,640	96	27.5	96		364	10
11	CRACK ISOLATION MEMBRANE								11
12	CUSTOM CHARTING STATION WITH 4 LOCKING	2015	9,780	355	27.5	355		1,347	12
13	UPPER CABINETS , 3 PEDESTALS 2 LATERAL FILES								13
14	LAMINATED TOP WITH GRANITE TRANS TOP								14
15	FREIGHT & TAX FOR THERAPY ROOM PROJECT	2015	5,330	194	27.5	194		735	15
16	BUILD WALL WITH DOOR OPENING FOR NEW	2015	4,270	155	27.5	155		588	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	556	7	908	352	3,178	20
21	CUBICLE CURTAINS WITH SUSPENDED TRACK	2015	1,920	168	7	274	106	959	21
22	SIGNAGE ON ENTRY & THERAPY RECEPTION AREA	2015	6,796	594	7	971	377	3,398	22
23	SECURITY SYSTEM IN 2ND FLOOR TO 7TH FLOOR								23
24	STAIR WELL DOORS	2015	24,564	893	27.5	893		2,939	24
25	INSTALLED AS PER CODE ONE ROPE GRIPPER.	2016	36,711	1,335	27.5	1,335		3,727	25
26	SERVICE ELEVATOR- FURNISHED AND INSTALLED NEW ALUMINUM DIAMOND PLATE; REPAIRED PLYWOOD FLOORING IF NECESSAR								26
27	ADJUST AND RETURN CAR TO SERVICE	2016	5,300	193	27.5	193		539	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, CUBICLICE TRACKS, WALL BETWEEN BATHROOMS, CLOSETS								29
30	AND WALL BETWEEN TWO ROOMS. REMOVE AND REROUTE EXISTING ELECTRIC AFTER WALL REMOVAL. PATCH & SAND WALLS AF								30
31	AWININGS								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,932,411	\$ 722,958		\$ 722,709	\$ (249)	\$ 9,115,583	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:

01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 19,932,411	\$ 722,958		\$ 722,709	\$ (249)	\$ 9,115,583	1
2	WALLS REMOVAL. PREP FOR NEW FINISHES. NURSE CALLS BY OTHERS. FURNISH & INSTALL NEW DOOR & FRAME FOR NEW STORAC								2
3	CLOSET.	2016	14,987	545	27.5	545		1,431	3
4	MODIFY FIRE SPRINKLERS, REMOVE EXISTING LINES FOR DEMO OF THE WALL BETWEEN ROOM 212 & ROOM 214. INSTALL 6 NEW								4
5	HEADS IN THE MIDDLE OF THE ROOM. REMOVE EXISTING LINES FOR DEMO OF THE BATHROOM AND WARDROBE CLOSETS. ADD 2 N								5
6	HEADS UNDER THE SOFFIT	2016	10,332	376	27.5	376		987	6
7	ROOMS 212 AND 214- EXISTING COVE BASE AND VCT REMOVAL, PREP FLOOR AND VCT1 AND VCT2 INSTALLATION, CUSTOM PVT								7
8	INSTALLATION, MILLWORK BASE INSTALLATION	2016	3,467	126	27.5	126		331	8
9	ROOM 212 AND 214- WINDOW TREATMENTS INCLUDING 2 CORNICES & 4 ROLLER SHADES &								9
10	INSTALLATION	2016	3,094	112	27.5	112		294	10
11									11
12	AWININGS	2016	5,950	397	27.5	397		993	12
13	INSTALLED NEW CEILING TILE AND LIGHTS; REMOVE A	2016	4,677	170	27.5	170		446	13
14	REPLACE EXISTING DOOR								14
15	EXTEND WALL IN PHYSICAL THERAPY ROOM TO MEET	2016	2,540	92	27.5	92		188	15
16	THE EXTERIOR GLASS WALL.								16
17	REPLACEMENT OF SIDEWALK IN REAR PARK OF THE BU	2017	4,800	320	15	320		480	17
18	SIDEWALK REMOVAL AND REPAIR AT THE REAR OF THI	2017	5,600	373	15	373		560	18
19	REMOVE AND REPLACE REAE CONCRETE STAIRS	2017	7,950	530	15	530		795	19
20	EJECTOR PUMP REPLACEMENT; EXISTING PUMP HAS A	2017	8,900	324	27.5	324		500	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	450	15	450		450	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,018,208	\$ 726,773		\$ 726,524	\$ (249)	\$ 9,123,038	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	\$ 342,527	\$ 25,882	\$ 34,253	\$ 8,371	10 YRS	\$ 117,622	71
72	Current Year Purchases	93,950	93,950	4,698	(89,252)	10 YRS	4,698	72
73	Fully Depreciated Assets	775,564					775,564	73
74	MGMT ALLOC		3,875	3,875		8-10 YRS		74
75	TOTALS	\$ 1,212,041	\$ 123,707	\$ 42,826	\$ (80,881)		\$ 897,884	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 22,730,249	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 850,480	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 769,350	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (81,130)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,020,922	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

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,661 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	<u>FACILITY VAN</u>	<u>2015 FORD TRANSIT</u>	\$ <u>847.77</u>	\$ <u>10,173</u>	17
18					18
19		<u>17 Jeep Grand Cherokee</u>	<u>655.73</u>	<u>7,213</u>	19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>17,386</u>	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 328,306	\$		\$ 328,306	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			82,225			82,225	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			343,272			343,272	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				72,116		72,116	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): MED SUPPLIES	39-2					59,377		59,377	13
14	TOTAL			\$		\$ 753,803	\$ 131,493		\$ 885,296	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	\$ 59,107	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 625,000)	4,814,157		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	188,419		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	256,484		8
9	Other(specify):	12,183		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,330,350	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	465,316		16
17	Accumulated Depreciation (book methods)	(420,833)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	664,125		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 708,608	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,038,958	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,640,752	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,295,605		29
30	Accrued Salaries Payable	181,555		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,277		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,145,189	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	229,891		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 229,891	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,375,080	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,663,878	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,038,958	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,719,570	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,719,570	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(55,692)	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) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (55,692)	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)	\$ 1,663,878	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 17,467,391	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,467,391	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	389,283	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 389,283	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***	52,478	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,478	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,909,152	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,504,200	31
32	Health Care	6,368,564	32
33	General Administration	3,878,798	33
B. Capital Expense			
34	Ownership	2,578,428	34
C. Ancillary Expense			
35	Special Cost Centers	885,296	35
36	Provider Participation Fee	731,100	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,946,386	40
41	Income before Income Taxes (line 30 minus line 40)**	(37,234)	41
42	Income Taxes	(18,458)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (55,692)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 14,839,797	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	2,291,699	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	335,895	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 17,467,391	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

0052035

Report Period Beginning: **01/01/2018**

Ending:

12/31/2018

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	1,543	1,675	\$ 96,832	\$ 57.81	1
2	Assistant Director of Nursing	1,517	1,581	60,450	38.24	2
3	Registered Nurses	17,557	18,049	631,177	34.97	3
4	Licensed Practical Nurses	54,756	57,685	1,660,758	28.79	4
5	CNAs & Orderlies	160,769	171,421	2,225,048	12.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	17,852	19,285	235,467	12.21	10
11	Social Service Workers	26,458	27,401	468,837	17.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,117	6,810	102,212	15.01	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	4,102	4,478	216,011	48.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,453	16,592	344,216	20.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	18,268	19,236	553,579	28.78	32
33	Other(specify) <u>Security</u>	29,056	30,927	389,056	12.58	33
34	TOTAL (lines 1 - 33)	353,448	375,140	\$ 6,983,643 *	\$ 18.62	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	36,900	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	22,450	10-3	38
39	Pharmacist Consultant	H	21,153	10-3	39
40	Physical Therapy Consultant	L	39,013	10a-3	40
41	Occupational Therapy Consultant	Y	30,317	10a-3	41
42	Respiratory Therapy Consultant		12,335	10a-3	42
43	Speech Therapy Consultant	F	4,962	10a-3	43
44	Activity Consultant	E	3,040	11-3	44
45	Social Service Consultant	E	882	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 171,052		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

**BRIA OF FOREST EDGE
LEGAL EXPENSES
12/31/2018**

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/31/2018	CARDEN & SAX	DEFENSE OF LIABILITY SUIT	100.00
1/31/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	195.00
3/31/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	940.00
3/31/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	(1,287.50)
4/30/2018	LANER MUCHIN , LTD	UNION NEGOTIATIONS	276.25
4/30/2018	LANER MUCHIN , LTD	HEALTHCARE REFORM	585.00
4/30/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	3,985.00
5/31/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	2,162.57
6/30/2018	LANER MUCHIN , LTD	UNION NEGOTIATIONS	471.25
6/30/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	985.00
8/31/2018	LANER MUCHIN , LTD	PAYROLL AUDIT	200.00
10/31/2018	LANER MUCHIN , LTD	SEIU NEGOTIATIONS	271.25
1/31/2018	FEDERAL INSURANCE COMPANY	EMPLOYMENT PRACTISES LEGAL REPRESENTATION	817.00
3/31/2018	FEDERAL INSURANCE COMPANY	EMPLOYMENT PRACTISES LEGAL REPRESENTATION	64.50
5/31/2018	FEDERAL INSURANCE COMPANY	EMPLOYMENT PRACTISES LEGAL REPRESENTATION	21.50
1/31/2018	VANEK LARSON & KOLB LLC	GUARDIANSHIP	240.69
3/31/2018	VANEK LARSON & KOLB LLC	GUARDIANSHIP	240.69
3/31/2018	VANEK LARSON & KOLB LLC	GUARDIANSHIP	3.95
4/30/2018	VANEK LARSON & KOLB LLC	GUARDIANSHIP	39.57
4/30/2018	VANEK LARSON & KOLB LLC	GUARDIANSHIP	3.95
10/31/2018	VANEK LARSON & KOLB LLC	GUARDIANSHIP	46.10
1/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
2/28/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
3/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
4/30/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
5/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
6/30/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
7/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
8/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
9/30/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
10/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
11/30/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
12/31/2018	STONE MCGUIRE & SIEGEL	COMPLIANCE MEETINGS & EDUCATION	700.00
2/28/2018	PRETZEL & STOUFFER ,CHARTERED	DEFENDING LAWSUIT	11,233.06
4/30/2018	PRETZEL & STOUFFER ,CHARTERED	DEFENDING LAWSUIT	9,522.90
4/30/2018	PRETZEL & STOUFFER ,CHARTERED	DEFENDING LAWSUIT	4,244.04
4/30/2018	PRETZEL & STOUFFER ,CHARTERED	DEFENDING LAWSUIT	5,912.61
3/31/2018	THOMPSON COBURN LLP	REVOLVING LINE LOAN DOCUMENTATION	800.00
6/30/2018	ALLEGRO RECORD SOLUTIONS	MEDICAL PROCESSING FEE	73.50
6/30/2018	ALLEGRO RECORD SOLUTIONS	MEDICAL PROCESSING FEE	73.50
8/31/2018	ALLEGRO RECORD SOLUTIONS	MEDICAL PROCESSING FEE	73.50
8/31/2018	ALLEGRO RECORD SOLUTIONS	MEDICAL PROCESSING FEE	73.50
8/31/2018	ALLEGRO RECORD SOLUTIONS	MEDICAL PROCESSING FEE	73.50
6/30/2018	MCCABE KIRSHNER	DEFENSE OF LIABILITY SUIT	6,580.50
8/31/2018	MCCABE KIRSHNER	DEFENSE OF LIABILITY SUIT	9,900.00
8/31/2018	MUCH SHELIST	GENERAL COUNSELING	78.00
10/31/2018	GARY WEINTRAUB, P.C.	IDPH APPEAL	617.50
12/31/2018	SYOUT ,RISIUS,ROSS INC	DEFENSE OF LIABILITY SUIT	5,516.26
12/31/2018	ANDERSON RASOR & PARTNERS LLP	DEFENSE OF LIABILITY SUIT	1,629.79
1/31/2018	SKIDELSKY & ASSOCIATES	REAL ESTATE TAX REDUCTION	250.00
9/30/2018	SKIDELSKY & ASSOCIATES	REAL ESTATE TAX REDUCTION	23,804.00
11/30/2018	CLASS ACTION	CLASS ACTION LAWSUIT	(39.25)
12/31/2018	LEGAL SERVICES	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	425.00
2/28/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	171.00
2/28/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	550.00
3/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
3/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
4/30/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
4/30/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
5/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
5/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.66
6/30/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	505.71
6/30/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
7/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
7/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
8/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
8/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
9/30/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
9/30/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
10/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
10/31/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	172.50

TOTAL LEGAL FEES

105,669.57

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. HEALTH CARE COUNCIL OF ILL \$22,416
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,104 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 731,100
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees