FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0052035

Facility Name: BRIA OF FOREST EDGE

Address: 8001 S WESTERN AVE (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/12

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 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) _____ (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,695	171	9,285	36,151	8
9	SNF/PED					9
10	ICF	58,425	356	73	58,854	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	85,120	527	9,358	95,005	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.36%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold 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 [ ] NO [X]

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 9,285

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	148,123	16,776	647,503	812,402		812,402	5,066	817,468			1
2	Food Purchase		217,512		217,512	(15,549)	201,963	(304)	201,659			2
3	Housekeeping	96,067	30,720	379,137	505,924		505,924		505,924			3
4	Laundry	40,821	32,789	246,623	320,233		320,233		320,233			4
5	Heat and Other Utilities			367,971	367,971		367,971	1,241	369,212			5
6	Maintenance	108,033	50,060	182,982	341,075		341,075	3,132	344,207			6
7	Other (specify):* SECURITY	266,785		22,649	289,434		289,434	246	289,680			7
8	TOTAL General Services	659,829	347,857	1,846,865	2,854,551	(15,549)	2,839,002	9,381	2,848,383			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	3,843,563	200,636	37,820	4,082,019		4,082,019	95,866	4,177,885			10
10a	Therapy	23,944		23,800	47,744		47,744		47,744			10a
11	Activities	213,787	35,143		248,930		248,930		248,930			11
12	Social Services	250,486		8,713	259,199		259,199		259,199			12
13	CNA Training											13
14	Program Transportation			8,474	8,474		8,474		8,474			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,331,780	235,779	86,807	4,654,366		4,654,366	95,866	4,750,232			16
	C. General Administration											
17	Administrative	118,698		992,500	1,111,198		1,111,198	(970,362)	140,836			17
18	Directors Fees											18
19	Professional Services			162,303	162,303		162,303	166,369	328,672			19
20	Dues, Fees, Subscriptions & Promotions			74,428	74,428		74,428	(31,669)	42,759			20
21	Clerical & General Office Expenses	265,974	36,316	67,716	370,006		370,006	(10,985)	359,021			21
22	Employee Benefits & Payroll Taxes			890,328	890,328	15,549	905,877	(640)	905,237			22
23	Inservice Training & Education							1,090	1,090			23
24	Travel and Seminar			4,537	4,537		4,537		4,537			24
25	Other Admin. Staff Transportation			13,091	13,091		13,091	1,515	14,606			25
26	Insurance-Prop.Liab.Malpractice			307,828	307,828		307,828	46,960	354,788			26
27	Other (specify):*			329,436	329,436		329,436	(292,334)	37,102			27
28	TOTAL General Administration	384,672	36,316	2,842,167	3,263,155	15,549	3,278,704	(1,090,056)	2,188,648			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,376,281	619,952	4,775,839	10,772,072		10,772,072	(984,809)	9,787,263			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.

Facility Name & ID#: BRIA OF FOREST EDGE **#0052035** **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,926	
	REPAIRS & MAINTENANCE		0	
	OUTSIDE SERVICE		640,577	647,503
3	**HOUSEKEEPING**			
	CONTRACTED BUILDING MAINT.		379,137	
				379,137
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICE		246,623	246,623
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		157,766	
	ELECTRICITY		128,063	
	WATER		77,891	
	CABLE TV - LOBBY		4,251	
				367,971
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,270	
	PAINTING & DECORATING		46,240	
	BUILDING REPAIRS		5,915	
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		44,747	
	ELEVATOR MAINTENANCE & REPAIR		53,824	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		9,077	
	FIRE SERVICE		17,909	
				182,982
7	**OTHER**			
	SCAVENGER		20,924	
	SECURITY SERVICE		1,725	
				22,649
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,000	8,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		12,756	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	20,664	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	500	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,900	
				37,820
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		23,800	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				23,800
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		8,713	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				8,713
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIA OF FOREST EDGE **#0052035** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		8,474	
				8,474
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	992,500	992,500
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	28,370	
	ADMINISTRATIVE CONSULTANTS	XIX C	10,414	
	PROFESSIONAL FEES	XIX C	123,519	
				162,303
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	31,408	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	149	
	DUES & SUBSCRIPTIONS	XIX F	21,996	
	LICENSES & PERMITS	XIX F	4,400	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	13,460	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,015	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				74,428
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,573	
	EQUIPMENT REPAIR & MAINTENANCE		1,014	
	OUTSIDE CLERICAL SERVICES		42,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	385	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,744	
	MESSENGER SERVICE		0	
				67,716

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	406,155	
	UNEMPLOYMENT COMPENSATION	XIX D	117,662	
	WORKERS COMPENSATION INSURANC	XIX D	123,044	
	HOSPITALIZATION INSURANCE	XIX D	221,810	
	EMPLOYEE BENEFITS - OTHER	XIX D	19,925	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	640	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	1,092	
				890,328
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	4,537	
	TRAVEL	XIX G	0	
				4,537
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,091	
				13,091
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		307,828	
				307,828
27	**OTHER**			
	BAD DEBTS	VI 24	329,436	
				329,436

GRAND TOTAL COLUMN 3 OTHER **4,775,839**

BRIA OF FOREST EDGE
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	217,512
LESS SALES TAX	(304)
NET FOOD	217,208
TOTAL PATIENT CENSUS	95,005
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	285,015
ADD # EMPLOYEE MEALS/DAY	60
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	21,900
PATIENT MEALS	285,015
ADD EMPLOYEE MEALS	21,900
TOTAL MEALS/YEAR	306,915
NET FOOD	217,208
DIVIDE TOTAL MEALS/YEAR	306,915
COST PER MEAL	0.71
TIMES EMPLOYEE MEALS	21,900
EMPLOYEE MEAL RECLASSIFICATION	**15,549**

Facility Name & ID Number BRIA OF FOREST EDGE #0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,467	81,467		81,467	716,987	798,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,699	73,699		73,699	678,912	752,611			32
33	Real Estate Taxes							412,614	412,614			33
34	Rent-Facility & Grounds			2,466,000	2,466,000		2,466,000	(2,465,248)	752			34
35	Rent-Equipment & Vehicles			76,127	76,127		76,127	7,681	83,808			35
36	Other (specify):* OFFICE RENT			26,400	26,400		26,400	59,454	85,854			36
37	TOTAL Ownership			2,723,693	2,723,693		2,723,693	(589,600)	2,134,093			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,169	848,996	974,165		974,165		974,165			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			691,232	691,232		691,232		691,232			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		125,169	1,540,228	1,665,397		1,665,397		1,665,397			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,376,281	745,121	9,039,760	15,161,162		15,161,162	(1,574,409)	13,586,753			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 BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(71,216)	30		9
10	Interest and Other Investment Income	(12,961)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(304)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(385)	21		18
19	Entertainment		20		19
20	Contributions	(13,609)	20		20
21	Owner or Key-Man Insurance	(640)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(329,436)	27		24
25	Fund Raising, Advertising and Promotional	(31,408)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(81,588)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (541,547)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,032,862)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,032,862)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,574,409)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			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: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (57,624)	21	1
2	BANK CHARGE	(7,573)	21	2
3	NONALLOWABLE TRAVEL	(5,977)	25	3
4	ADMINISTRATIVE CONSULTANT	(10,414)	19	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**	(81,588)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF FOREST EDGE **#** 0052035 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	5,066	0	0	0	0	0	0	0	0	5,066	1
2	Food Purchase	(304)	0	0	0	0	0	0	0	0	0	0	(304)	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	942	299	0	0	0	0	0	0	0	0	1,241	5
6	Maintenance	0	2,224	706	202	0	0	0	0	0	0	0	3,132	6
7	Other (specify):*	0	0	0	246	0	0	0	0	0	0	0	246	7
8	**TOTAL General Services**	(304)	3,166	6,071	448	0	0	0	0	0	0	0	9,381	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	95,866	0	0	0	0	0	0	0	0	95,866	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	95,866	0	0	0	0	0	0	0	0	95,866	16
	C. General Administration													
17	Administrative	0	0	(992,500)	22,138	0	0	0	0	0	0	0	(970,362)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,414)	145	158,935	1,203	16,500	0	0	0	0	0	0	166,369	19
20	Fees, Subscriptions & Promotions	(45,017)	42	11,365	1,941	0	0	0	0	0	0	0	(31,669)	20
21	Clerical & General Office Expenses	(65,582)	44	34,823	19,730	0	0	0	0	0	0	0	(10,985)	21
22	Employee Benefits & Payroll Taxes	(640)	0	0	0	0	0	0	0	0	0	0	(640)	22
23	Inservice Training & Education	0	0	1,090	0	0	0	0	0	0	0	0	1,090	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(5,977)	0	7,206	286	0	0	0	0	0	0	0	1,515	25
26	Insurance-Prop.Liab.Malpractice	0	206	726	260	45,768	0	0	0	0	0	0	46,960	26
27	Other (specify):*	(329,436)	0	25,393	11,709	0	0	0	0	0	0	0	(292,334)	27
28	**TOTAL General Administration**	(457,066)	437	(752,962)	57,267	62,268	0	0	0	0	0	0	(1,090,056)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(457,370)	3,603	(651,025)	57,715	62,268	0	0	0	0	0	0	(984,809)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(71,216)	2,521	1,653	190	783,839	0	0	0	0	0	0	716,987	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,961)	1,977	628	0	689,268	0	0	0	0	0	0	678,912	32
33	Real Estate Taxes	0	5,125	1,627	0	405,862	0	0	0	0	0	0	412,614	33
34	Rent-Facility & Grounds	0	0	752	0	(2,466,000)	0	0	0	0	0	0	(2,465,248)	34
35	Rent-Equipment & Vehicles	0	2,579	3,888	1,214	0	0	0	0	0	0	0	7,681	35
36	Other (specify):*	0	(26,400)	0	0	85,854	0	0	0	0	0	0	59,454	36
37	TOTAL Ownership	(84,177)	(14,198)	8,548	1,404	(501,177)	0	0	0	0	0	0	(589,600)	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)	(541,547)	(10,595)	(642,477)	59,119	(438,909)	0	0	0	0	0	0	(1,574,409)	45

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 SUPP						

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. [X] 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	36	OFFICE RENT	$ 26,400	IME REALTY CORP.		$	$ (26,400)	1
2	V	5	UTILITIES				942	942	2
3	V	6	REPAIRS/MAINT				2,224	2,224	3
4	V	19	ACCOUNTING FEES				145	145	4
5	V	20	LICENSES & PERMITS				42	42	5
6	V	21	OFFICE EXPENSE				44	44	6
7	V	26	INSURANCE				206	206	7
8	V	30	DEPRECIATION (SL)				2,521	2,521	8
9	V	32	INTEREST				1,977	1,977	9
10	V	33	REAL ESTATE TAX				5,125	5,125	10
11	V	35	STORAGE FEES				2,579	2,579	11
12	V								12
13	V								13
14	Total			$ 26,400			$ 15,805	$ * (10,595)	14

*** 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: 01/01/2014 Ending: 12/31/2014

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. [X] 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	17	MANAGEMENT FEES	$ 992,500	BRIA HEALTH SERVICES , LLC		$	$ (992,500)	15
16	V	1	DIETARY SALARIES				5,066	5,066	16
17	V	5	UTILITIES				299	299	17
18	V	6	REPAIRS & MAINTENANCE				706	706	18
19	V	10	NURSE CONSULT FEES				3,103	3,103	19
20	V	10	NURSING SALARIES				92,763	92,763	20
21	V	19	PROFESSIONAL FEES				158,935	158,935	21
22	V	20	WANT ADS, LICENSES, DUES				11,365	11,365	22
23	V	21	TOTAL OFFICE				34,823	34,823	23
24	V	23	SEMINARS				1,090	1,090	24
25	V	25	TRANSPORTATION				7,206	7,206	25
26	V	26	INSURANCE				726	726	26
27	V	27	EMPLOYEE BENEFITS				25,393	25,393	27
28	V	30	DEPRECIATION (SL)				1,653	1,653	28
29	V	32	INTEREST				628	628	29
30	V	33	REAL ESTATE TAX				1,627	1,627	30
31	V	34	OFFICE RENT				752	752	31
32	V	35	PUBLIC STORAGE				819	819	32
33	V	35	AUTO LEASE				3,069	3,069	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 992,500			$ 350,023	$ * (642,477)	39

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [X] 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	21	OUTSIDE CLERICAL	$ 42,000	EKS MANAGEMENT CO.		$	$ (42,000)	15
16	V	6	CLEANING SUPPLIES				202	202	16
17	V	7	SCAVENGER				246	246	17
18	V	17	CFO SALARY-A.WEINFELD				22,138	22,138	18
19	V	19	PROFESSIONAL FEES				1,203	1,203	19
20	V	20	WANT ADS/BACKGR CKS				1,941	1,941	20
21	V	21	TOTAL OFFICE				61,730	61,730	21
22	V	25	TRAVEL				286	286	22
23	V	26	INSURANCE				260	260	23
24	V	27	EMPLOYEE BENEFITS				11,709	11,709	24
25	V	30	DEPRECIATION (SL)				190	190	25
26	V	35	EQUIPMENT RENTAL				1,214	1,214	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			$ 42,000			$ 101,119	$ * 59,119	39

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [X] 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	34	RENT	$ 2,466,000	PRESIDENTIAL PAVILION LLC		$	$ (2,466,000)	15
16	V	34	RENT				1,866,000	1,866,000	16
17	V	30	DEPREC S.L -IMP				33,431	33,431	17
18	V								18
19	V								19
20	V	34	RENT	1,866,000	BEVERLY PAVILION LLC			(1,866,000)	20
21	V	19	PROFESSIONAL FEES				16,500	16,500	21
22	V	26	INSURANCE - PROPERTY				45,768	45,768	22
23	V	30	DEPR S.L BUILDING & IMP				672,851	672,851	23
24	V	30	DEPR S.L. - EQUIP & FURN				77,557	77,557	24
25	V	32	INTERST				689,268	689,268	25
26	V	33	REAL ESTATE TAXES				405,862	405,862	26
27	V	36	M.I.P. INSURANCE				85,854	85,854	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			$ 4,332,000			$ 3,893,091	$ * (438,909)	39

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			BRIA OF CAHOKIA	COHOKIA	EKS MANAGEMENT	LINCOLNWOOD	HOME OFFICE	1
2	AVRUM WEINFELD	23.75						2
3			BRIA OF RIVER OAKS	BURNHAM	IME REALTY CORP	LINCOLNWOOD	MGMT CONSULT	3
4	DANIEL WEISS	23.75						4
5			BRIA OF BELLEVILLE	BELLEVILLE				5
6	NATAN WEISS	23.75						6
7			BRIA OF GENEVA	GENEVA	BRIA HEALTH		MANAGEMENT	7
8	FRED BERKOVITS	23.75			SERVICES, LLC	LINCOLNWOOD		8
9			BRIA OF WESTMONT	WESTMONT				9
10	DOV SEGAL	5			BEVERLY PAVILION		REAL ESTATE	10
11			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO	LLC	LINCOLNWOOD		11
12				HEIGHTS				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: 01/01/2014 Ending: 12/31/2014

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	ALLOCATIOM FR BRIA HEALTH SERVICES				See Attached				$		1
2	DOV SEGAL	Purchasing Consult	consulting	5.00	Schedule	10.63	13.00	SALARY & FEE	41,458	19-7	2
3											3
4	FRED BERKOVITS	Administrative Cons.	consulting	23.75		45	53.00	FEES	45,064	19-7	4
5											5
6											6
7	ALLOCATION FR EKS MANAGEMENT :										7
8											8
9	AVRUM WEINFELD	CFO	FINANCIAL	23.75		15	14.00	SALARY	22,138	17-7	9
10											10
11	FLORA WEISS(ARM ENTEI	O/S CONSULT	CLERICAL	0.00				consult fee	5,411	21-7	11
12											12
13								TOTAL	$ 114,071		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: 01/01/2014 Ending: 2/31/2014

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 [x] NO [ ]

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

Name of Related Organization: IME REALTY
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD IL. 60712
Phone Number: (847)674-5795
Fax Number: (847) 674-5794

	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	5	UTILITIES	RENTAL INCOME	131,400	6	$ 4,687	$	26,400	$ 942	1
2	6	REPAIRS/MAINT	RENTAL INCOME	131,400	6	11,070		26,400	2,224	2
3	19	ACCOUNTING FEES	RENTAL INCOME	131,400	6	724		26,400	145	3
4	20	LICENSES & PERMITS	RENTAL INCOME	131,400	6	210		26,400	42	4
5	21	OFFICE EXPENSE	RENTAL INCOME	131,400	6	221		26,400	44	5
6	26	INSURANCE	RENTAL INCOME	131,400	6	1,026		26,400	206	6
7	30	DEPRECIATION(SL)	RENTAL INCOME	131,400	6	12,550		26,400	2,521	7
8	32	INTEREST	RENTAL INCOME	131,400	6	9,842		26,400	1,977	8
9	33	REAL ESTATE TAX	RENTAL INCOME	131,400	6	25,509		26,400	5,125	9
10	35	STORAGE FEES	RENTAL INCOME	131,400	6	12,837		26,400	2,579	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					$ 78,676	$		$ 15,805	25

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X] NO [ ]

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

Name of Related Organization: BRIA HEALTH SERVICES LLC
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 5795
Fax Number: (847) 674 - 5794

	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	DIETARY SALARIES	CENSUS DAYS	421,649	8	$ 22,482	$ 22,482	95,005	$ 5,066	1
2	5	UTILITIES	CENSUS DAYS	421,649	8	1,327		95,005	299	2
3	6	REPAIRS & MAINTENANCE	CENSUS DAYS	421,649	8	3,134		95,005	706	3
4	10	NURSE CONSULT FEES	CENSUS DAYS	421,649	8	13,770		95,005	3,103	4
5	10	NURSING SALARIES	CENSUS DAYS	421,649	8	411,700	411,700	95,005	92,763	5
6	19	PROFESSIONAL FEES	CENSUS DAYS	421,649	8	705,381	100,000	95,005	158,935	6
7	20	WANT ADS, LICENSES, DUES	CENSUS DAYS	421,649	8	50,442		95,005	11,365	7
8	21	TOTAL OFFICE	CENSUS DAYS	421,649	8	154,551	71,971	95,005	34,823	8
9	23	SEMINARS	CENSUS DAYS	421,649	8	4,839		95,005	1,090	9
10	25	TRANSPORTATION	CENSUS DAYS	421,649	8	31,980		95,005	7,206	10
11	26	INSURANCE	CENSUS DAYS	421,649	8	3,220		95,005	726	11
12	27	EMPLOYEE BENEFITS	CENSUS DAYS	421,649	8	112,698		95,005	25,393	12
13	30	DEPRECIATION (SL)	CENSUS DAYS	421,649	8	7,337		95,005	1,653	13
14	32	INTEREST	CENSUS DAYS	421,649	8	2,787		95,005	628	14
15	33	REAL ESTATE TAX	CENSUS DAYS	421,649	8	7,222		95,005	1,627	15
16	34	OFFICE RENT	CENSUS DAYS	421,649	8	3,338		95,005	752	16
17	35	PUBLIC STORAGE	CENSUS DAYS	421,649	8	3,634		95,005	819	17
18	35	AUTO LEASE	CENSUS DAYS	421,649	8	13,620		95,005	3,069	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,553,462	$ 606,153		$ 350,023	25

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X] NO [ ]

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

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LICOLNWOOD IL 60712
Phone Number: (847) 674 - 5795
Fax Number: (847) 674 - 5794

	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	6	CLEANING SUPPLIES	CENSUS DAYS	293,675	4	$ 623	$	95,005	$ 202	1
2	7	SCAVENGER	CENSUS DAYS	293,675	4	759		95,005	246	2
3	17	CFO SALARY-A.WEINFELD	CENSUS DAYS	293,675	4	68,433	102,650	95,005	22,138	3
4	19	PROFESSIONAL FEES	CENSUS DAYS	293,675	4	3,720		95,005	1,203	4
5	20	WANT ADS/BACKGR CKS	CENSUS DAYS	293,675	4	6,000		95,005	1,941	5
6	21	TOTAL OFFICE	CENSUS DAYS	293,675	4	190,816	141,933	95,005	61,730	6
7	25	TRAVEL	CENSUS DAYS	293,675	4	886		95,005	287	7
8	26	INSURANCE	CENSUS DAYS	293,675	4	802		95,005	259	8
9	27	EMPLOYEE BENEFITS	CENSUS DAYS	293,675	4	36,193		95,005	11,709	9
10	30	DEPRECIATION (SL)	CENSUS DAYS	293,675	4	586		95,005	190	10
11	35	EQUIPMENT RENT	CENSUS DAYS	293,675	4	3,753		95,005	1,214	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					$ 312,571	$ 244,583		$ 101,119	25

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 17,048,051	05/01/43/	0.0395	$ 678,300	1
2	WEDGEWOOD		X	MORTGAGE	$15,000.00	/	1,525,600	165,928	12/01/15	0.0375	10,968	2
3	MEMBERS -BYB	X		WORKING CAPITAL	$5,000.00	11/12	250,000	148,155	8/17	0.0550	9,661	3
4	S.SEGAL	X		WORKING CAPITAL	$1,590.00	11/12	150,000	124,629	11/22	0.0500	6,573	4
5	B.WEINFELD	X		WORKING CAPITAL	$2,500.00	11/12	200,000	195,623	11/22	0.1409	27,739	5
	Working Capital											
6				INSURANCE POLICIES FIN							3,701	6
7				L.O.C.				300,000	revolv		26,025	7
8	RELATED IME & BRIA										2,605	8
9	TOTAL Facility Related				$103,093.00		$ 19,847,100	$ 17,982,386			$ 765,572	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 19,847,100	$ 17,982,386			$ 765,572	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ N/A** **Line #** **36**

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

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 461,188	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.)		$ 474,181	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,993	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 467,429	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** $ 67,808 **For** 2011 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (67,808)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 412,614	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	560,054	8
	2010	584,436	9
	2011	582,005	10
	2012	467,084	11
	2013	474,181	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2013 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 SANFORD BOKOR

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-31-108-044-0000	NURSING HOME	$ 467,428.97	$ 467,428.97
2.		OFFICE - ALLOCATION - BRIA	$ 1,627.00	$ 1,627.00
3.		OFFICE - ALLOCATION - IME	$ 5,125.00	$ 5,125.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 474,180.97	$ 474,180.97

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	328		2005		$ 17,449,000	$ 634,509	27.5	$ 634,509	$	$ 6,212,901	4
5											5
6											6
7	BRIA ALLOC				20,230	519		519			7
8	IME ALLOC				75,472	2,430		2,430			8
	Improvement Type**										
9	AWNINGS			2001	10,500	382	27.5	382		5,014	9
10	FENCE			2001	2,100	140	15	140		1,838	10
11	ELEVATOR			2001	18,340	667	27.5	667		8,754	11
12	ALARM			2001	5,686	207	27.5	207		2,717	12
13	WINDOWS			2001	4,149	151	27.5	151		1,982	13
14	BOILER			2001	3,000	109	27.5	109		1,213	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953		5			12,953	15
16	KITCHEN SINK & DRAIN			2001	2,525	92	27.5	92		1,207	16
17	DOORS			2001	15,100	549	27.5	549		7,195	17
18	ELEVATOR			2002	222,811	8,102	27.5	8,102		105,326	18
19	FENCE			2002	3,100	207	15	207		2,588	19
20	DOORS & LOCKS			2002	21,741	791	27.5	791		10,184	20
21	SHOWER ROOMS			2002	4,669	170	27.5	170		2,090	21
22	ALARM AND SPRINKLER			2002	11,881	432	27.5	432		5,309	22
23	EJECTOR & SEWEGE PUMP			2002	14,604	531	27.5	531		6,527	23
24	ROOF DRAIN			2002	3,100	113	27.5	113		1,417	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494		5			91,494	25
26	ELEVATIR			2003	110,562	4,020	27.5	4,020		47,403	26
27	PARKING LOT			2003	64,182	4,279	15	4,279		49,209	27
28	FIRE ALARM SYSTEM			2003	25,000	909	27.5	909		10,491	28
29	ROOF			2003	26,500	964	27.5	964		11,046	29
30	EXTERIOR WALL			2003	9,796	356	27.5	356		4,050	30
31	SINKS			2003	3,146	114	27.5	114		1,316	31
32	BUILT IN WARDROBE			2003	19,398	705	27.5	705		7,961	32
33	REBUILD A/C & HEATING RETURN FAN			2004	4,700	171	27.5	171		1,860	33
34	FIRE ALARM SYSTEM			2004	13,201	480	27.5	480		5,180	34
35	BUILT IN WARDROBE			2004	21,807	793	27.5	793		8,360	35
36	MASONRY REPAIRS			2004	61,620	2,241	27.5	2,241		23,064	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2004	$ 2,995	$ 109	27.5	$ 109	$	$ 1,113	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		2,068	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		2,526	39
40	FLOOR TILING	2004	5,326	194	27.5	194		1,948	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		2,109	41
42	DOORS	2005	4,506	164	27.5	164		1,565	42
43	FLOOR TILING	2005	1,536	56	27.5	56		534	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		33,469	44
45	CONCRETE PATIO	2005	3,015	201	15	201		1,935	45
46	SHOWER	2006	3,040	111	27.5	111		948	46
47	DUCT WORK	2006	5,600	204	27.5	204		1,743	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		3,612	48
49	FIRE ALARM - BEVERLY	2007	273,534	9,946	27.5	9,946		74,596	49
50	COOLING TOWERS - BEVERLY	2007	121,905	4,433	27.5	4,433		33,247	50
51	SHOWERS - BEVERLY	2007	12,160	442	27.5	442		3,315	51
52	AIR CLEANERS - BEVERLY	2007	10,851	395	27.5	395		2,962	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		1,480	53
54	SHOWERS - BEVERLY	2008	9,120	333	27.5	333		2,242	54
55	DOORS - BEVERLY	2008	4,520	164	27.5	164		1,141	55
56	BOLIER - BEVERLY	2008	5,295	193	27.5	193		1,246	56
57	FLOORS - BEVERLY	2008	6,260	228	27.5	228		1,435	57
58	ROOFING - BEVERLY	2008	3,800	138	27.5	138		857	58
59	EXTERIOR WALL - BEVERLY	2008	20,000	727	27.5	727		4,392	59
60	ROOFING - BEVERLY	2009	10,333	375	27.5	375		2,134	60
61	CAULK JOINTS - BEVERLY	2010	28,450	1,035	27.5	1,035		4,701	61
62	MECHANICAL ROOM - BEVERLY	2010	19,450	707	27.5	707		3,034	62
63	WELDING - BEVERLY	2010	3,587	130	27.5	130		536	63
64	ROOF - BEVERLY	2010	2,925	106	27.5	106		437	64
65	STEEL DOOR - BEVERLY	2011	1,275	46	27.5	46		174	65
66	CONTROLLE R- ANNUNCIATOR - BEVERLY	2011	6,649	242	27.5	242		918	66
67	CONCRETE - SIDEWALK - BEVERLY	2011	2,375	86	27.5	86		333	67
68	BACKFLOW REPAIR - BEVERLY	2011	4,550	165	27.5	165		529	68
69	ELECTRICAL - BEVERLY	2012	4,347	158	27.5	158		454	69
70	TOTAL (lines 4 thru 69)		$ 19,064,565	$ 691,123		$ 691,123	$	$ 6,844,382	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 19,064,565	$ 691,123		$ 691,123	$	$ 6,844,382	1
2	VINYL FENCE AND GATE	2012	7,400	269	27.5	269		706	2
3	SOUTH ROOF FLASHING - BEVERLY	2012	4,350	158	27.5	158		402	3
4	KITCHEN IMPROVEMENT - BEVERLY	2012	2,640	96	27.5	96		236	4
5	SIDEWALK - BEVERLY	2012	2,150	78	27.5	78		192	5
6	NORTH ROOF FLASHING - BEVERLY	2012	1,950	71	27.5	71		175	6
7	SPRINKLER MODIFICATIONS	2012	17,530	637	27.5	637		1,407	7
8	FIRE DAMPERS, CEILING, ELECTRICAL WORK - BEVERLY	2012	49,679	1,807	27.5	1,807		3,990	8
9	COMPLETE REBUILD OF CHILLER - BEVERLY	2013	42,700	1,553	27.5	1,553		2,912	9
10	WIRING FOR SATELLITE - BEVERLY	2013	13,325	485	27.5	485		829	10
11	FIRE SPRINKLERS - BEVERLY	2013	16,686	607	27.5	607		986	11
12	BOILER REBUILD - BEVERLY	2013	8,550	311	27.5	311		454	12
13	INSTALL DOOR PACKAGE ON 3 ELEVATORS - BEVERLY	2013	36,000	1,309	27.5	1,309		1,582	13
14	WALK IN FREEZER NEW CONDENSING UNIT - BEVERLY	2013	7,307	266	27.5	266		321	14
15									15
16	COMM AWNING WITH NAME	2013	9,200	1,127	7	1,314	187	2,628	16
17									17
18									18
19	REPLACE ELEVATOR ENCODER & MACHINE BEARINGS	2014	18,060	465	27.5	465		465	19
20									20
21	1ST FLOOR DAY RM - GLASS WALLS , DOORS & GUARDS	2014	9,998	258	27.5	258		258	21
22	1ST FLOOR - REMOVE VCT AND INSTALL CARPET TILE	2014	20,810	536	27.5	536		536	22
23	LOBBY - REMOVE WALL AND INSTALL NEW GLASS								23
24	WALL , DOORS AND ACOUSTICAL CEILING	2014	87,162	2,245	27.5	2,245		2,245	24
25	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								25
26	AND CORRIDOR - PAINT ,WALL COVERING & SIGNAGE	2014	21,335	550	27.5	550		550	26
27	1ST FLR VESTIBULE,RECEPTION SECURITY STATION								27
28	AND CORRIDOR - MILL WORK,ELCTRICAL	2014	10,083	260	27.5	260		260	28
29	ELEVATOR - WALLCOVERING AND NEW CEILING	2014	24,569	633	27.5	633		633	29
30	REFRESHMENT STAND	2014	2,500	64	27.5	64		64	30
31	GUEST BATHRMS & SMOKING PATIO - DOORS & FRAME	2014	8,657	223	27.5	223		223	31
32	2ND FLOOR - REBUILD 2 TUB ROOMS	2014	30,531	694	27.5	694		694	32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,517,737	$ 705,825		$ 706,012	$ 187	$ 6,867,130	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 19,517,737	$ 705,825		$ 706,012	$ 187	$ 6,867,130	1
2	SMOKING PATIO - REMOVE OLD FLR AND WALL AND								2
3	INSTALL NEW FLOOR AND WALLS	2014	5,037	130	27.5	130		130	3
4	NURSES STATION - NURSES STATION , ELECTRICAL ,								4
5	BUILT IN CABINETS AND COUNTER TOPS	2014	27,118	698	27.5	698		698	5
6	2ND FLOOR CORRIDOR & GREAT ROOM - NEW								6
7	ACOUSTICAL CEILING & LIGHTING	2014	26,708	688	27.5	688		688	7
8	2ND FLOOR GREAT ROOM - REMOVE OLD GLASS WALL								8
9	INSTALL NEW STUD WALL	2014	5,700	147	27.5	147		147	9
10	2ND FLOOR CORRIDOR & GREAT ROOM - WALL								10
11	COVERINGS	2014	25,444	655	27.5	655		655	11
12	2ND FLOOR - VCT AND COVE BASE REMOVAL AND								12
13	OF NEW FLOORING AND CHAIR RAILS	2014	45,077	1,161	27.5	1,161		1,161	13
14	3RD FLOOR - DEMOLISH & REBUILD THE SHOWER	2014	16,540	326	27.5	326		326	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	328	27.5	328		328	17
18	FIRE SPRINKLERS - ELEVATOR AND SECOND FLOOR	2014	8,600	65	27.5	65		65	18
19	18 SMOKE DETECT ELEVATOR & VARIOUS LOCATION	2014	3,191	34	27.5	34		34	19
20	CONCRETE PILLARS	2014	6,800	51	27.5	51		51	20
21	INSTALL 2 DAMPERS ON THE MAIN AIR SUPPLY AND	2014	5,480	41	27.5	41		41	21
22	RETURN DUCTS								22
23	INSTALL NEW BOILER SECTIONS	2014	11,724	53	27.5	53		53	23
24	4 TH FLOOR TUB ROOM REMOVE OLD FLOOR AND	2014	4,430	47	27.5	47		47	24
25	DRAIN INSTALL NEW								25
26	AWNING	2014	6,520	109	27.5	109		109	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,746,986	$ 710,358		$ 710,545	$ 187	$ 6,871,663	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: 01/01/2014 Ending: 12/31/2014

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	$ 25,867	$ 4,139	$ 2,587	$ (1,552)		$ 3,880	71
72	Current Year Purchases	127,001	76,201	6,350	(69,851)		6,350	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	775,564	78,972	78,972				74
75	TOTALS	$ 928,432	$ 159,312	$ 87,909	$ (71,403)		$ 10,230	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)	$ 22,175,418	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 869,670	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 798,454	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (71,216)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,881,893	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 38,232 Description: SEE SCHEDULE ATTACHED
    (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	SEE ATTACHED SCHEDULE			37,895	18
19					19
20					20
21	TOTAL		$	$ 37,895	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 BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 415,930	$		$ 415,930	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			31,470			31,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			401,596			401,596	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				125,169		125,169	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			$		$ 848,996	$ 125,169		$ 974,165	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 BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 464,700	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (360,000))	3,443,008		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	199,344		6
7	Other Prepaid Expenses	50,699		7
8	Accounts Receivable (owners or related parties)	304,329		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,462,080	$	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	162,068		16
17	Accumulated Depreciation (book methods)	(102,245)		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): Due From Presidential	581,274		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 641,097	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,103,177	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,365,953	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	368,926		29
30	Accrued Salaries Payable	271,707		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,551		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		399,481		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,452,618	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,452,618	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,650,559	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,103,177	$	48

*(See instructions.)

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,199,894	1	
2	Restatements (describe):		2	
3	ROUNDING	4	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,199,898	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,350,661	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	(900,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,450,661	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,650,559	24	*

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 17,336,848	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,336,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	162,014	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 162,014	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,961	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,961	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)**	$ 17,511,823	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,854,551	31
32	Health Care	4,654,366	32
33	General Administration	3,263,155	33
	B. Capital Expense		
34	Ownership	2,723,693	34
	C. Ancillary Expense		
35	Special Cost Centers	974,165	35
36	Provider Participation Fee	691,232	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,161,162	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,350,661	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,350,661	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,948,836	44
45	Private Pay - Net Inpatient Revenue	83,229	45
46	Medicare - Net Inpatient Revenue	4,278,788	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	25,995	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,336,848	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: 01/01/2014 Ending: 12/31/2014

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	1,967	2,071	$ 152,407	$ 73.59	1
2	Assistant Director of Nursing	1,386	1,692	63,818	37.72	2
3	Registered Nurses	13,151	14,177	377,155	26.60	3
4	Licensed Practical Nurses	57,872	63,199	1,409,656	22.31	4
5	CNAs & Orderlies	131,762	140,637	1,463,144	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,156	2,301	23,944	10.41	8
9	Activity Director	651	694	7,466	10.76	9
10	Activity Assistants	18,010	19,171	206,321	10.76	10
11	Social Service Workers	17,067	18,120	250,486	13.82	11
12	Dietician					12
13	Food Service Supervisor	576	618	6,126	9.91	13
14	Head Cook	13,342	14,311	141,997	9.92	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,920	7,570	108,033	14.27	17
18	Housekeepers	9,496	10,171	96,067	9.45	18
19	Laundry	3,778	4,204	40,821	9.71	19
20	Administrator	1,901	1,901	118,698	62.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,248	18,166	265,974	14.64	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	4,048	4,259	48,560	11.40	31
32	Other Health Care(specify)	13,434	14,241	328,823	23.09	32
33	Other(specify) SECURITY	26,199	27,525	266,785	9.69	33
34	TOTAL (lines 1 - 33)	340,964	365,028	$ 5,376,281 *	$ 14.73	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	M	$ 6,926	1-3	35
36	Medical Director	O	8,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	20,664	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) SOCIAL REHABILI	S	8,713	12-3	46
47	PHYSICIANS		500	10-3	47
48	DENTAL		3,900	10-3	48
49	TOTAL (lines 35 - 48)		$ 48,703		49

C. CONTRACT NURSES

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

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANCY GIVEN	ADMINISTRATOR	0	$ 31,813
PHILIP BIRN	ADMINISTRATOR	0	86,885
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,698

B. Administrative - Other

Description		Amount
BRIA HEALTHCARE SERVICES	MANAGEMENT FEE	$ 992,500
TOTAL (agree to Schedule V, line 17, col. 3)		$ 992,500
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		162,303
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 162,303

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,044
Unemployment Compensation Insurance	117,662
FICA Taxes	406,155
Employee Health Insurance	221,810
Employee Meals	15,549
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	19,925
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	1,092
INSURANCE - EXECUTIVE LIFE	640
INSURANCE - EXECUTIVE LIFE VI 21	(640)
TOTAL (agree to Schedule V, line 22, col.8)	$ 905,237

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	0
Health Care Worker Background Check	3,015
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	13,609
MARKETING/ADV/PROMO	31,408
LICENSES/DUES/SUBSCRIPTIONS	26,396
MGMT CO ALLOC	13,348
TRUST/FRANCHISE/CONTRIB/ETC	(13,609)
Less: Public Relations Expense	(0)
Non-allowable advertising	(31,408)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,759

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	4,537
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,537

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIA OF FOREST EDGE # 0052035 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. **ICLTC $21,746**

(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? **NO** 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. $ **7,920** 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. $ **691,232**
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 benefits on Schedule V. $ **15,549** 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.