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: 0034678

Facility Name: BRIA OF BELLEVILLE

Address: 150 N 27TH STREET (Number) BELLEVILLE (City) 62226 (Zip Code)

County: ST CLAIR

Telephone Number: (618) 235-6600 **Fax #** (618) 235-7555

HFS ID Number:

Date of Initial License for Current Owners: 09/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			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) MARTIN WEISS
(Title) PRESIDENT

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 BELLEVILLE # 0034678 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	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	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			6,996	6,996	8
9	SNF/PED					9
10	ICF	34,848	1,874	1,526	38,248	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,848	1,874	8,522	45,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.55%

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 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 6,996

Medicare Intermediary ADMINISTAR

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 BELLEVILLE # 0034678 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,334	16,700	290,813	427,847		427,847	2,412	430,259			1
2	Food Purchase		131,290		131,290		131,290	(127)	131,163			2
3	Housekeeping	61,665	14,055	168,645	244,365		244,365		244,365			3
4	Laundry	16,715	16,837	112,785	146,337		146,337		146,337			4
5	Heat and Other Utilities			173,477	173,477		173,477	142	173,619			5
6	Maintenance	107,151	69,340	18,934	195,425		195,425	336	195,761			6
7	Other (specify):*			47,435	47,435		47,435		47,435			7
8	TOTAL General Services	305,865	248,222	812,089	1,366,176		1,366,176	2,763	1,368,939			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	2,639,154	248,814	9,870	2,897,838		2,897,838	45,654	2,943,492			10
10a	Therapy			47,151	47,151		47,151		47,151			10a
11	Activities	127,320	7,030	1,655	136,005		136,005		136,005			11
12	Social Services	55,901	2,342	1,655	59,898		59,898		59,898			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,822,375	258,186	85,331	3,165,892		3,165,892	45,654	3,211,546			16
	C. General Administration											
17	Administrative	102,424		505,000	607,424		607,424	(220,982)	386,442			17
18	Directors Fees											18
19	Professional Services			620,217	620,217		620,217	(397,257)	222,960			19
20	Dues, Fees, Subscriptions & Promotions			81,535	81,535		81,535	(49,470)	32,065			20
21	Clerical & General Office Expenses	189,190	23,686	95,242	308,118		308,118	20,310	328,428			21
22	Employee Benefits & Payroll Taxes			723,407	723,407		723,407		723,407			22
23	Inservice Training & Education			10,548	10,548		10,548	519	11,067			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			26,264	26,264		26,264	2,387	28,651			25
26	Insurance-Prop.Liab.Malpractice			171,897	171,897		171,897	19,816	191,713			26
27	Other (specify):*			240,000	240,000		240,000	(203,257)	36,743			27
28	TOTAL General Administration	291,614	23,686	2,474,110	2,789,410		2,789,410	(827,934)	1,961,476			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,419,854	530,094	3,371,530	7,321,478		7,321,478	(779,517)	6,541,961			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 BELLEVILLE **#0034678** **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	8,143	
	REPAIRS & MAINTENANCE		1,890	
	DIETARY-SERVICE CONTRACTS		280,780	290,813
3	**HOUSEKEEPING**			
	HOUSEKKEEPING SERVICE CONTRACTS		168,645	
				168,645
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		713	
	CONTRACTED LAUNDRY SERVICES		112,072	112,785
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		18,659	
	ELECTRICITY		84,754	
	WATER		67,962	
	CABLE TV - LOBBY		2,102	
				173,477
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,287	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,550	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		7,097	
				18,934
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		47,435	
	SECURITY SERVICE		0	
				47,435
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	25,000	25,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	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	2,620	
	PHARMACY CONSULTANT	XVIII B 39-2	7,250	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				9,870
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	17,010	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	17,102	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	5,473	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	7,566	
				47,151
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,655	
				1,655
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,655	
	SOCIAL WORKER	XVIII B 45-2	0	
				1,655
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIA OF BELLEVILLE **#0034678** **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		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	505,000	505,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,323	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	92,900	
	BOOKKEEPING/ADMINISTRATIVE SERVICE		515,994	620,217
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	47,762	
	EMPLOYEE WANT ADS	XIX F	4,994	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	11,109	
	LICENSES & PERMITS	XIX F	3,560	
	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	7,230	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,565	
	PATIENT BACKGROUND CHECKS	XIX F	3,315	
				81,535
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,063	
	EQUIPMENT REPAIR & MAINTENANCE		68,051	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	441	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,968	
	MESSENGER SERVICE		4,719	
				95,242

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	257,841	
	UNEMPLOYMENT COMPENSATION	XIX D	133,132	
	WORKERS COMPENSATION INSURANC	XIX D	204,539	
	HOSPITALIZATION INSURANCE	XIX D	108,333	
	EMPLOYEE BENEFITS - OTHER	XIX D	19,562	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
				723,407
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,548	
				10,548
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		26,264	
				26,264
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		171,897	
				171,897
27	**OTHER**			
	BAD DEBTS	VI 24	240,000	
				240,000

GRAND TOTAL COLUMN 3 OTHER **3,371,530**

BRIA OF BELLEVILLE
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	131,290
LESS SALES TAX	(127)
NET FOOD	131,163
TOTAL PATIENT CENSUS	45,244
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	135,732
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	135,732
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	135,732
NET FOOD	131,163
DIVIDE TOTAL MEALS/YEAR	135,732
COST PER MEAL	0.97
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number BRIA OF BELLEVILLE #0034678 **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			36,767	36,767		36,767	184,832	221,599			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,778	54,778		54,778	169,248	224,026			32
33	Real Estate Taxes			5,355	5,355		5,355	56,826	62,181			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(479,642)	358			34
35	Rent-Equipment & Vehicles			23,107	23,107		23,107	13,233	36,340			35
36	Other (specify):*							24,922	24,922			36
37	**TOTAL Ownership**			600,007	600,007		600,007	(30,581)	569,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		255,117	1,308,353	1,563,470		1,563,470		1,563,470			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			319,234	319,234		319,234		319,234			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		255,117	1,627,587	1,882,704		1,882,704		1,882,704			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,419,854	785,211	5,599,124	9,804,189		9,804,189	(810,098)	8,994,091			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 BELLEVILLE # 0034678 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	20,204	30		9
10	Interest and Other Investment Income	(6,060)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(127)	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	(441)	21		18
19	Entertainment		20		19
20	Contributions	(7,230)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(3,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240,000)	27		24
25	Fund Raising, Advertising and Promotional	(47,762)	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	(47,399)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (332,315)		$	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)	(477,783)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (477,783)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (810,098)		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

STATE OF ILLINOIS **Page 5A**

BRIA OF BELLEVILLE

ID# **0034678**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (45,868)	21	1
2	TRANSPORTATION STAFF-MARKETING	(1,531)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(47,399)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	2,412	0	0	0	0	0	0	0	2,412	1
2	Food Purchase	(127)	0	0	0	0	0	0	0	0	0	0	(127)	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	142	0	0	0	0	0	0	0	142	5
6	Maintenance	0	0	0	336	0	0	0	0	0	0	0	336	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(127)	0	0	2,890	0	0	0	0	0	0	0	2,763	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	45,654	0	0	0	0	0	0	0	45,654	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	45,654	0	0	0	0	0	0	0	45,654	16
	C. General Administration													
17	Administrative	0	0	(220,982)	0	0	0	0	0	0	0	0	(220,982)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,500)	10,460	(297,706)	(106,511)	0	0	0	0	0	0	0	(397,257)	19
20	Fees, Subscriptions & Promotions	(54,992)	0	109	5,413	0	0	0	0	0	0	0	(49,470)	20
21	Clerical & General Office Expenses	(46,309)	0	50,035	16,584	0	0	0	0	0	0	0	20,310	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	519	0	0	0	0	0	0	0	519	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,531)	0	486	3,432	0	0	0	0	0	0	0	2,387	25
26	Insurance-Prop.Liab.Malpractice	0	16,923	2,547	346	0	0	0	0	0	0	0	19,816	26
27	Other (specify):*	(240,000)	0	24,650	12,093	0	0	0	0	0	0	0	(203,257)	27
28	**TOTAL General Administration**	(346,332)	27,383	(440,861)	(68,124)	0	0	0	0	0	0	0	(827,934)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(346,459)	27,383	(440,861)	(19,580)	0	0	0	0	0	0	0	(779,517)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	20,204	161,331	2,510	787	0	0	0	0	0	0	0	184,832	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,060)	175,009	0	299	0	0	0	0	0	0	0	169,248	32
33	Real Estate Taxes	0	56,051	0	775	0	0	0	0	0	0	0	56,826	33
34	Rent-Facility & Grounds	0	(480,000)	0	358	0	0	0	0	0	0	0	(479,642)	34
35	Rent-Equipment & Vehicles	0	0	11,382	1,851	0	0	0	0	0	0	0	13,233	35
36	Other (specify):*	0	24,922	0	0	0	0	0	0	0	0	0	24,922	36
37	**TOTAL Ownership**	14,144	(62,687)	13,892	4,070	0	0	0	0	0	0	0	(30,581)	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)**	(332,315)	(35,304)	(426,969)	(15,510)	0	0	0	0	0	0	0	(810,098)	45

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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

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		34	RENT	$ 480,000	LINCOLN ASSOCIATES, L.P.		$	$ (480,000)	1
2	V		30	DEPRECIATION				161,331	161,331	2
3	V		32	INTEREST EXPENSE				171,708	171,708	3
4	V		32	AMORT LOAN COST				3,301	3,301	4
5	V		33	REAL ESTATE TAXES				56,051	56,051	5
6	V		36	MIP INSURANCE				24,922	24,922	6
7	V		26	INSURANCE				16,923	16,923	7
8	V		19	PROFESSIONAL FEES				10,460	10,460	8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 480,000			$ 444,696	$ * (35,304)	14

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	$ 505,000	WEISS MANAGEMENT GROUP, INC.		$	$ (505,000)	15
16	V	19	ADMIN./BKKP. FEES	300,000				(300,000)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATIVE SALARIES				284,018	284,018	19
20	V	19	PROFESSIONAL FEES				2,294	2,294	20
21	V	20	LICENSES & PERMITS				109	109	21
22	V	21	OFFICE EXPENSES				50,035	50,035	22
23	V	25	TRANSPORTATION STAFF				486	486	23
24	V	26	INSURANCE				2,547	2,547	24
25	V	27	EMPLOYEE BENEFITS				24,650	24,650	25
26	V	30	DEPRECIATION (SL)				2,510	2,510	26
27	V	35	AUTO LEASE				11,382	11,382	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			$ 805,000			$ 378,031	$ * (426,969)	39

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	19	BKKPNG/ADMIN SERVICES	$ 182,200	BRIA HEALTH SERVICES, LLC		$	$ (182,200)	15
16	V								16
17	V								17
18	V								18
19	V	1	DIETARY SALARIES				2,412	2,412	19
20	V	5	UTILITIES				142	142	20
21	V	6	REPAIR/MAINT				336	336	21
22	V	10	NURSING CONSULTING FEE				1,478	1,478	22
23	V	10	NURSING SALARIES				44,176	44,176	23
24	V	19	PROFESSIONAL FEES				75,689	75,689	24
25	V	20	WANT ADS, LICENSES				5,413	5,413	25
26	V	21	TOTAL OFFICE				16,584	16,584	26
27	V	23	SEMINARS				519	519	27
28	V	25	TRANSPORTATION				3,432	3,432	28
29	V	26	INSURANCE				346	346	29
30	V	27	EMPLOYEE BENEFITS				12,093	12,093	30
31	V	30	DEPRECIATION (SL)				787	787	31
32	V	32	INTEREST				299	299	32
33	V	33	RE TAX				775	775	33
34	V	34	OFFICE RENT				358	358	34
35	V	35	PUBLIC STORAGE				390	390	35
36	V	35	AUTO LEASE				1,461	1,461	36
37	V								37
38	V								38
39	Total			$ 182,200			$ 166,690	$ * (15,510)	39

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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								1
2	MARTIN J. WEISS	45.10	BRIA OF CAHOKIA	CAHOKIA	WEISS MGMT	LINCOLNWOOD		2
3	DANIEL WEISS	12.31			GROUP, INC			3
4	GARY WEINTRAUB	14.45	BRIA OF FOREST EDGE	CHICAGO				4
5	ILANA FINN	4.69			BRIA HEALTH	LINCOLNWOOD		5
6	CATHLENE WEISS	5.88	BRIA OF GENEVA	GENEVA	SERVICES, LLC			6
7	SUZANNE KOENIG	9.18						7
8	NATAN WEISS	8.39	LAKE PARK CENTER	WAUKEGAN	LINCOLN ASSO-	LINCOLNWOOD		8
9					CIATES, L.P.			9
10			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				10
11				HEIGHTS				11
12								12
13			BRIA OF PALOS HILLS	PALOS HILLS				13
14								14
15			BRIA OF RIVER OAKS	BURNHAM				15
16								16
17								17
18			BRIA OF WESTMONT	WESTMONT				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 BELLEVILLE # 0034678 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	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIO	45.10	SEE	10	22.22	SALARY	101,435	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	SCHEDULE	15	13.04	SALARY	81,148	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	8.39		10	13.51	SALARY	101,435	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 284,018		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 BELLEVILLE # 0034678 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: WEISS MANAGEMENT GROUP, INC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5794
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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	89,208	2	$ 560,000	$ 560,000	45,244	$ 284,018	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	89,208	2	4,523		45,244	2,294	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	89,208	2	214		45,244	109	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	89,208	2	98,655	95,083	45,244	50,035	4
5	25	TRANSPORTATION STAFF	PATIENT CENSUS	89,208	2	959		45,244	486	5
6	26	INSURANCE	PATIENT CENSUS	89,208	2	5,021		45,244	2,547	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	89,208	2	48,602		45,244	24,650	7
8	30	DEPRECIATION (SL)	PATIENT CENSUS	89,208	2	4,949		45,244	2,510	8
9	35	AUTO LEASE	PATIENT CENSUS	89,208	2	22,442		45,244	11,382	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					$ 745,365	$ 655,083		$ 378,031	25

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	PATIENT CENSUS	421,649	8	$ 22,482	$ 22,482	45,244	$ 2,412	1
2	5	UTILITIES	PATIENT CENSUS	421,649	8	1,327		45,244	142	2
3	6	REPAIR/MAINT	PATIENT CENSUS	421,649	8	3,134		45,244	336	3
4	10	NURSING CONSULTING FEE	PATIENT CENSUS	421,649	8	13,770		45,244	1,478	4
5	10	NURSING SALARIES	PATIENT CENSUS	421,649	8	411,700	411,700	45,244	44,176	5
6	19	PROFESSIONAL FEES	PATIENT CENSUS	421,649	8	705,381	100,000	45,244	75,689	6
7	20	WANT ADS, LICENSES	PATIENT CENSUS	421,649	8	50,442		45,244	5,413	7
8	21	TOTAL OFFICE	PATIENT CENSUS	421,649	8	154,551	71,971	45,244	16,584	8
9	23	SEMINARS	PATIENT CENSUS	421,649	8	4,839		45,244	519	9
10	25	TRANSPORTATION	PATIENT CENSUS	421,649	8	31,980		45,244	3,432	10
11	26	INSURANCE	PATIENT CENSUS	421,649	8	3,220		45,244	346	11
12	27	EMPLOYEE BENEFITS	PATIENT CENSUS	421,649	8	112,698		45,244	12,093	12
13	30	DEPRECIATION (SL)	PATIENT CENSUS	421,649	8	7,337		45,244	787	13
14	32	INTEREST	PATIENT CENSUS	421,649	8	2,787		45,244	299	14
15	33	RE TAX	PATIENT CENSUS	421,649	8	7,222		45,244	775	15
16	34	OFFICE RENT	PATIENT CENSUS	421,649	8	3,338		45,244	358	16
17	35	PUBLIC STORAGE	PATIENT CENSUS	421,649	8	3,634		45,244	390	17
18	35	AUTO LEASE	PATIENT CENSUS	421,649	8	13,620		45,244	1,461	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,553,462	$ 606,153		$ 166,690	25

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC						$	$			$	1
2	BEECH STREET CAPITAL		X	MORTGAGE	$33,742.90	09/01/13	4,528,900	4,387,712	04/01/39	3.8700	171,708	2
3	AMORT LOAN COST		X	AMORT OVER LIFE			84,735	80,334			3,301	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND			937,919		PRIME+	48,947	6
7		X		INSURANCE FINANCING							5,831	7
8	RELATED PARTY ALLOCATION										299	8
9	TOTAL Facility Related				$33,742.90		$ 4,613,635	$ 5,405,965			$ 230,086	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,613,635	$ 5,405,965			$ 230,086	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 24,922 **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 BELLEVILLE # 0034678 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.**	$ 56,762	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.)		$ 61,481	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,719	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,285	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 60,004	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	53,890	8
	2010	59,552	9
	2011	61,492	10
	2012	61,563	11
	2013	61,481	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 BELLEVILLE COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0034678

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.	08-20.0-204-015	NURSING HOME	$ 2,995.96	$ 2,995.96
2.	08-20.0-210-029	NURSING HOME	$ 54,737.64	$ 54,737.64
3.	08-20.0-207-025	NURSING HOME	$ 1,142.88	$ 1,142.88
4.	08-20.0-210-028	NURSING HOME	$ 245.28	$ 245.28
5.	08-20.0-204-014	NURSING HOME	$ 2,358.74	$ 2,358.74
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,480.50	$ 61,480.50

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 BELLEVILLE # 0034678 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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	NURSING HOME	3+ACRES	1987	$ 148,649	1
2	PARKING LOT	2+ACRES	2005	50,000	2
3	TOTALS	#VALUE!		$ 198,649	3

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	152			1988	$ 2,011,351	$ 63,852	31.5	$ 63,852	$	$ 1,653,245	4
5				2003	1,249,221	45,426	27.5	45,426		520,506	5
6											6
7											7
8	RELATED PARTY ALLOCATION				9,635	247		247			8
	Improvement Type**										
9	VARIOUS			1990	11,158	354	31.5	354		8,590	9
10	VARIOUS			1993	6,676	171	39	171		4,463	10
11	VARIOUS			1994	7,797	200	39	200		5,058	11
12	VARIOUS			1995	13,072	335	39	335		7,597	12
13	CARPET			1996	907	23	39	23		466	13
14	BILLBOARD			1996	900	23	39	23		469	14
15	SMOKE DETECTORS			1996	602	15	39	15		310	15
16	PARKING LOT			1996	8,006	205	39	205		4,280	16
17	AWNING			1996	905	23	39	23		484	17
18	CARPETING			1996	1,512	39	39	39		833	18
19	DOOR LOCKS			1997	2,100	54	39	54		1,030	19
20	WALL PAPER			1997	2,012	52	39	52		1,002	20
21	HANDRAIL			1997	3,217	83	39	83		1,523	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		5,059	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	236	39	236		4,013	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		1,307	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		475	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD			1999	6,144	158	39	158		2,138	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	1,446	39	1,446		19,516	27
28	WALLPAPER			2000	14,896	382	39	382		6,093	28
29	SEWER LINE REPAIR			2000	11,743	301	39	301		4,358	29
30	AIR CONDITIONING UNITS			2000	8,848	227	39	227		3,286	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	69	39	69		1,002	31
32	NEW NURSES STATION			2000	20,379	522	39	522		7,579	32
33	FIRE ALARM SYSTEM			2000	1,826	47	39	47		682	33
34	HOT WATER SYSTEM			2000	3,849	99	20	99		2,450	34
35	TILED FLOORS			2000	54,185	1,389	39	1,389		20,150	35
36	REMODELOING OF BATHROOMS			2000	18,490	474	39	474		6,871	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 BELLEVILLE # 0034678 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	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	$ 13,369	$	20	$ 668	$ 668	$ 12,010	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		17,632	38
39	ROOF	2001	47,500	1,727	27.5	1,727		23,315	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		4,508	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		5,994	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		5,575	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		26,770	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		18,442	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159		20	1,558	1,558	20,254	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		3,165	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		7,867	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTR	2002	7,245	263	27.5	263		3,342	48
49	LANDSCAPING	2004	7,759		15	517	517	5,364	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	18,073	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	3,454	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250		20	5,263	5,263	57,893	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		1,097	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		870	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		10,462	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		3,253	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		2,894	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		13,582	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		6,422	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906		5			17,906	60
61	AIR CONDITIONERS	2007	7,968		5			7,968	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	2,084	27.5	2,084		15,543	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		2,479	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		1,059	64
65	PAINTING	2007	9,986		5			9,986	65
66	GARDEN	2007	60,172	2,188	15	4,012	1,824	27,992	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		1,282	67
68	PAINTING - 30 ROOMS	2008	2,550		5			2,550	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		713	69
70	TOTAL (lines 4 thru 69)		$ 4,274,881	$ 134,695		$ 146,482	$ 11,787	$ 2,654,551	70

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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		$ 4,274,881	$ 134,695		$ 146,482	$ 11,787	$ 2,654,551	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		662	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		1,126	3
4	WALL AIR CONDITIONS	2009	5,187	298	5	298		5,187	4
5	INSTALL NEW COMPRESSOR,CRANK CASE HEATER	2009	3,195	116	27.5	116		653	5
6	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		1,624	6
7	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		23,394	7
8	WALLCOVERING, CARPET, PAINTING, BLINDS, CURTAINS	2009	29,344	1,690	5	1,691	1	29,344	8
9	WALL AIR CONDITIONS	2010	4,581	265	5	265		4,451	9
10	INSTALL STEEL DOOR	2010	10,694	389	27.5	389		1,702	10
11	FIRE PROTECTION WORK-SPRINKLERS PHASE 1	2010	97,653	3,551	27.5	3,551		14,648	11
12	FIRE PROTECTION WORK-SPRINKLERS PHASE 2	2011	97,652	3,551	27.5	3,551		11,097	12
13	WING CORRIDORS-FLOORING,WALLCOVERING,	2011	67,587	2,458	27.5	2,458		9,730	13
14	HANDRAILS,BUNPER GUARDS,SIGNAGE,WALL PROTECTION								14
15	INSTALL NEW CARRIER RTU	2011	4,517	164	27.5	164		581	15
16	PAINTING-100 & 200 HALL, LODGING, NURSES STATION	2011	44,405	6,075	5	6,075		35,293	16
17	WALL AIR CONDITIONS	2011	7,698		5	1,540	1,540	6,160	17
18	WALL AIR CONDITIONS	2012	4,194	327	5	327		3,703	18
19	REPLACED ROOF TOP UNIT & 5 TON CONDENSING UNIT	2012	9,995	363	27.5	363		892	19
20	INSTALL NEW PLASTIC CEMENT, CAP,COTTON MEMBRA-								20
21	NE ON EPDM ROOF	2012	2,595	94	27.5	94		270	21
22	PARKING LOT IMPROVMENTS; CONCRETE PATIO AND								22
23	DRAINAGE	2012	72,786	4,852	15	4,852		10,108	23
24	INSTALLED A 240CFM EXHAUST FAN ON A CURB OVER								24
25	THE NURSES STATION	2013	3,044	111	27.5	111		217	25
26	LOBBY; OFFICES-CARPET INSTALLATION; WALL BASE								26
27	INSTALLATION	2013	7,824	285	27.5	285		487	27
28	SEAL COAT PARKING LOT AND STRIPE PARKING SPACES	2013	3,000	200	15	200		333	28
29	100, 200, 300, 400 WINGS- CORRIDOR, RESIDENT ROOMS,								29
30	RESIDENT BATHSROOMS-FLOORING	2013	164,523	5,983	27.5	5,983		6,232	30
31	INSTALLATION OF NURSING STATION; AREA BETWEEN 100								31
32	& 200 WINGS;CORRIDOR, RESIDENT ROOM IN CENTER-								32
33	CUSTOM PVT INSTALLATION	2014	75,482	1,487	27.5	1,487		1,487	33
34	TOTAL (lines 1 thru 33)		$ 5,119,406	$ 171,674		$ 185,002	$ 13,328	$ 2,823,932	34

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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		$ 5,119,406	$ 171,674		$ 185,002	$ 13,328	$ 2,823,932	1
2	100 & 200 WINGS RESIDENT BATHS-INSTALLATION OF								2
3	CERAMIC TILE; ACTIVITY ROOM-COVE BASE & PVT INS-								3
4	TALLATION; BUILD 2 NEW WALLS WITH METAL	2014	51,277	699	27.5	699		699	4
5	INSTALL A FIRESTONE TPO ROOFING SYSTEM, GRAVE								5
6	GUARD,ROOF FLASHING OVER THE TOP FLANGE	2014	23,186	246	27.5	246		246	6
7	INSTALL NEW SIGN & CABINET TO EXISTING STRUCTURE	2014	5,737	96	15	96		96	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	TOTAL (lines 1 thru 33)		$ 5,199,606	$ 172,715		$ 186,043	$ 13,328	$ 2,824,973	34

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	$ 318,596	$ 18,072	$ 31,437	$ 13,365	3-10	$ 156,586	71
72	Current Year Purchases	12,071	7,243	754	(6,489)	8	754	72
73	Fully Depreciated Assets	118,491					118,491	73
74	RELATED PARTY SL DEPRECIATION		3,365	3,365				74
75	TOTALS	$ 449,158	$ 28,680	$ 35,556	$ 6,876		$ 275,831	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2005 FORD ECONOCARE	2005	$ 41,500	$	$	$		$ 41,500	76
77										77
78										78
79										79
80	TOTALS			$ 41,500	$	$	$		$ 41,500	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)	$ 5,888,913	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,395	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 221,599	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,204	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,142,304	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 BELLEVILLE # 0034678 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: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 23,107 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			N/A		18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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.

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$		$ 566,257	$		$ 566,257	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			167,517			167,517	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			574,579			574,579	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				166,104		166,104	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					29,686		29,686	12
13	MEDICAL SUPPLY Other (specify): I.V.THERAPY	39-2					28,200 31,127		28,200 31,127	13
14	TOTAL			$		$ 1,308,353	$ 255,117		$ 1,563,470	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.

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	$ (64,826)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	3,737,303		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	173,950		6
7	Other Prepaid Expenses	56,476		7
8	Accounts Receivable (owners or related parties)	2,320		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,905,223	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	172,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	158,256		15
16	Equipment, at Historical Cost	490,658		16
17	Accumulated Depreciation (book methods)	(554,674)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 266,266	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,171,489	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,178,037	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	977,919		29
30	Accrued Salaries Payable	73,227		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,049		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)**	$ 2,256,232	$	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	DUE TO LINCOLN ASSOCIATES	199,815		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 199,815	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,456,047	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,715,442	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,171,489	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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**	$ 1,333,001	1
2	Restatements (describe):		2
3	REPLACEMENT TAX	(693)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,332,308	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	383,134	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 383,134	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)**	$ 1,715,442	24 *

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

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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	$ 10,181,263	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,181,263	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,060	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,060	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)**	$ 10,187,323	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,366,176	31
32	Health Care	3,165,892	32
33	General Administration	2,789,410	33
	B. Capital Expense		
34	Ownership	600,007	34
	C. Ancillary Expense		
35	Special Cost Centers	1,563,470	35
36	Provider Participation Fee	319,234	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,804,189	40
41	**Income before Income Taxes (line 30 minus line 40)****	383,134	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 383,134	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,879,742	44
45	Private Pay - Net Inpatient Revenue	317,201	45
46	Medicare - Net Inpatient Revenue	4,113,851	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	240,108	47
48	Other-(specify) MANAGED CARE	630,361	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,181,263	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 BELLEVILLE # 0034678 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	2,248	2,400	$ 78,849	$ 32.85	1
2	Assistant Director of Nursing	2,124	2,180	76,005	34.86	2
3	Registered Nurses	7,672	8,053	219,298	27.23	3
4	Licensed Practical Nurses	38,490	41,055	793,386	19.32	4
5	CNAs & Orderlies	117,844	123,930	1,280,347	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,736	14,422	127,320	8.83	10
11	Social Service Workers	3,934	4,146	55,901	13.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,340	14,582	120,334	8.25	15
16	Dishwashers					16
17	Maintenance Workers	8,780	9,325	107,151	11.49	17
18	Housekeepers	6,983	7,328	61,665	8.41	18
19	Laundry	1,660	1,739	16,715	9.61	19
20	Administrator	2,016	2,160	102,424	47.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,615	13,297	189,190	14.23	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	1,924	2,160	37,200	17.22	31
32	Other Health C: Care Plan Coord	6,072	6,598	154,069	23.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	239,438	253,375	$ 3,419,854 *	$ 13.50	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	$ 8,143	1-3	35
36	Medical Director	O	25,000	9-3	36
37	Medical Records Consultant	N	2,620	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,250	10-3	39
40	Physical Therapy Consultant	L	17,010	10a-3	40
41	Occupational Therapy Consultant	Y	17,102	10a-3	41
42	Respiratory Therapy Consultant		5,473	10a-3	42
43	Speech Therapy Consultant	F	7,566	10a-3	43
44	Activity Consultant	E	1,655	11-3	44
45	Social Service Consultant	E	1,655	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 93,474		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		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KENYA WASHINGTON	ADMINISTRATOR	0	$ 102,424
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,424

B. Administrative - Other

Description	Amount
WEISS MANAGEMENT GROUP MANAGEMENT FEES	$ 505,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 505,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		620,217
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 620,217

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 204,539
Unemployment Compensation Insurance	133,132
FICA Taxes	257,841
Employee Health Insurance	108,333
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	19,562
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 723,407

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,994
Health Care Worker Background Check	3,565
(Indicate # of checks performed 350)	
Patient Background Checks 262	3,315
TRUST/FRANCHISE/CONTRIB/ETC	7,230
MARKETING/ADV/PROMO	47,762
LICENSES/DUES/SUBSCRIPTIONS	12,679
MGMT CO ALLOC	5,522
TRUST/FRANCHISE/CONTRIB/ETC	(7,230)
Less: Public Relations Expense	(0)
Non-allowable advertising	(47,762)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,065

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 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							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $ 9,899**

(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? **NO**

(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. $ **25,136** 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 **X** 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. $ **319,234**
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. $ **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.