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: 0048645

Facility Name: BRIA OF CAHOKIA

Address: 3354 JEROME LANE (Number) CAHOKIA (City) 62206 (Zip Code)

County: ST CLAIR

Telephone Number: (618) 337-9400 **Fax #** (618) 332-1811

HFS ID Number:

Date of Initial License for Current Owners: 05/01/00

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) MARTIN WEISS
(Title) MEMBER

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 CAHOKIA # 0048645 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	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	133	TOTALS	133	48,545	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			4,167	4,167	8
9	SNF/PED					9
10	ICF	38,582	1,202	13	39,797	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,582	1,202	4,180	43,964	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.56%

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 05/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 4,167

Medicare Intermediary MUTUAL OF OMANA

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 CAHOKIA # 0048645 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	177,208	22,659	19,836	219,703		219,703	2,344	222,047			1
2	Food Purchase		262,892		262,892		262,892	(60)	262,832			2
3	Housekeeping	190,924	34,990		225,914		225,914		225,914			3
4	Laundry	111,870	18,160	1,277	131,307		131,307		131,307			4
5	Heat and Other Utilities			118,972	118,972		118,972	138	119,110			5
6	Maintenance	95,346	47,154	21,838	164,338		164,338	327	164,665			6
7	Other (specify):*			21,450	21,450		21,450		21,450			7
8	TOTAL General Services	575,348	385,855	183,373	1,144,576		1,144,576	2,749	1,147,325			8
	B. Health Care and Programs											
9	Medical Director			20,100	20,100		20,100		20,100			9
10	Nursing and Medical Records	2,038,663	253,446	9,749	2,301,858		2,301,858	44,363	2,346,221			10
10a	Therapy			32,619	32,619		32,619		32,619			10a
11	Activities	89,845	3,155	1,242	94,242		94,242		94,242			11
12	Social Services	168,695	891	2,208	171,794		171,794		171,794			12
13	CNA Training											13
14	Program Transportation			955	955		955		955			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,297,203	257,492	66,873	2,621,568		2,621,568	44,363	2,665,931			16
	C. General Administration											
17	Administrative	75,673		235,000	310,673		310,673	40,982	351,655			17
18	Directors Fees											18
19	Professional Services			583,684	583,684		583,684	(355,123)	228,561			19
20	Dues, Fees, Subscriptions & Promotions			54,934	54,934		54,934	(25,364)	29,570			20
21	Clerical & General Office Expenses	161,821	19,771	82,819	264,411		264,411	13,111	277,522			21
22	Employee Benefits & Payroll Taxes			521,466	521,466		521,466		521,466			22
23	Inservice Training & Education			10,187	10,187		10,187	505	10,692			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			11,474	11,474		11,474	3,494	14,968			25
26	Insurance-Prop.Liab.Malpractice			121,444	121,444		121,444	2,810	124,254			26
27	Other (specify):*			25,925	25,925		25,925	9,778	35,703			27
28	TOTAL General Administration	237,494	19,771	1,646,933	1,904,198		1,904,198	(309,807)	1,594,391			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,110,045	663,118	1,897,179	5,670,342		5,670,342	(262,695)	5,407,647			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 CAHOKIA **#0048645** **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	16,992	
	REPAIRS & MAINTENANCE		2,844	
				19,836
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,277	
				1,277
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		8,926	
	ELECTRICITY		68,743	
	WATER		37,956	
	CABLE TV - LOBBY		3,347	
				118,972
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,664	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		964	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		14,210	
				21,838
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		21,450	
	SECURITY SERVICE		0	
				21,450
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	20,100	20,100

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	2,709	
	PHARMACY CONSULTANT	XVIII B 39-2	7,040	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				9,749
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	16,788	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	12,206	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	104	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	3,521	
				32,619
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,242	
				1,242
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,208	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,208
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIA OF CAHOKIA **#0048645** **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		955	
				955
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	235,000	235,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	10,447	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	119,555	
	BOOKKEEPING/ ADMINISTRATIVE SERVICE		453,682	583,684
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24,164	
	EMPLOYEE WANT ADS	XIX F	7,106	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	10,173	
	LICENSES & PERMITS	XIX F	845	
	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	6,564	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	6,082	
				54,934
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		742	
	EQUIPMENT REPAIR & MAINTENANCE		51,203	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	9,374	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,287	
	MESSENGER SERVICE		5,213	
				82,819

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	236,515	
	UNEMPLOYMENT COMPENSATION	XIX D	61,140	
	WORKERS COMPENSATION INSURANC	XIX D	113,236	
	HOSPITALIZATION INSURANCE	XIX D	91,518	
	EMPLOYEE BENEFITS - OTHER	XIX D	19,057	
	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	
				521,466
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,187	
				10,187
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,474	
				11,474
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		121,444	
				121,444
27	**OTHER**			
	BAD DEBTS	VI 24	25,925	
				25,925

GRAND TOTAL COLUMN 3 OTHER **1,897,179**

BRIA OF CAHOKIA
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	262,892
LESS SALES TAX	(60)
NET FOOD	262,832
TOTAL PATIENT CENSUS	43,964
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	131,892
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	131,892
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	131,892
NET FOOD	262,832
DIVIDE TOTAL MEALS/YEAR	131,892
COST PER MEAL	1.99
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number BRIA OF CAHOKIA #0048645 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			65,264	65,264		65,264	101,951	167,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,946	39,946		39,946	215,050	254,996			32
33	Real Estate Taxes							46,357	46,357			33
34	Rent-Facility & Grounds			520,000	520,000		520,000	(519,652)	348			34
35	Rent-Equipment & Vehicles			18,294	18,294		18,294	12,859	31,153			35
36	Other (specify):*											36
37	**TOTAL Ownership**			643,504	643,504		643,504	(143,435)	500,069			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,260	766,721	885,981		885,981		885,981			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,821	313,821		313,821		313,821			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		119,260	1,080,542	1,199,802		1,199,802		1,199,802			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,110,045	782,378	3,621,225	7,513,648		7,513,648	(406,130)	7,107,518			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 CAHOKIA # 0048645 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	1,773	30		9
10	Interest and Other Investment Income	(1,381)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(60)	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	(9,374)	21		18
19	Entertainment		20		19
20	Contributions	(6,564)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,925)	27		24
25	Fund Raising, Advertising and Promotional	(24,164)	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	(42,563)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (110,758)		$	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)	(295,372)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (295,372)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (406,130)		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 CAHOKIA

ID# 0048645

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (42,250)	21	1
2	TRANSPORTATION STAFF-MARKETING	(313)	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**	(42,563)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 **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	2,344	0	0	0	0	0	0	0	2,344	1
2	Food Purchase	(60)	0	0	0	0	0	0	0	0	0	0	(60)	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	138	0	0	0	0	0	0	0	138	5
6	Maintenance	0	0	0	327	0	0	0	0	0	0	0	327	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(60)	0	0	2,809	0	0	0	0	0	0	0	2,749	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	44,363	0	0	0	0	0	0	0	44,363	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	44,363	0	0	0	0	0	0	0	44,363	16
	C. General Administration													
17	Administrative	0	0	40,982	0	0	0	0	0	0	0	0	40,982	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,500)	0	(257,771)	(94,852)	0	0	0	0	0	0	0	(355,123)	19
20	Fees, Subscriptions & Promotions	(30,728)	0	105	5,259	0	0	0	0	0	0	0	(25,364)	20
21	Clerical & General Office Expenses	(51,624)	0	48,620	16,115	0	0	0	0	0	0	0	13,111	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	505	0	0	0	0	0	0	0	505	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(313)	0	473	3,334	0	0	0	0	0	0	0	3,494	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,474	336	0	0	0	0	0	0	0	2,810	26
27	Other (specify):*	(25,925)	0	23,952	11,751	0	0	0	0	0	0	0	9,778	27
28	**TOTAL General Administration**	(111,090)	0	(141,165)	(57,552)	0	0	0	0	0	0	0	(309,807)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,150)	0	(141,165)	(10,380)	0	0	0	0	0	0	0	(262,695)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 **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	1,773	96,974	2,439	765	0	0	0	0	0	0	0	101,951	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,381)	216,140	0	291	0	0	0	0	0	0	0	215,050	32
33	Real Estate Taxes	0	45,604	0	753	0	0	0	0	0	0	0	46,357	33
34	Rent-Facility & Grounds	0	(520,000)	0	348	0	0	0	0	0	0	0	(519,652)	34
35	Rent-Equipment & Vehicles	0	0	11,060	1,799	0	0	0	0	0	0	0	12,859	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	392	(161,282)	13,499	3,956	0	0	0	0	0	0	0	(143,435)	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)**	(110,758)	(161,282)	(127,666)	(6,424)	0	0	0	0	0	0	0	(406,130)	45

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	$ 520,000	JEROME LANE, LLC		$	$ (520,000)	1
2	V								2
3	V	30	DEPRECIATION				96,974	96,974	3
4	V	32	INTEREST EXPENSE				207,523	207,523	4
5	V	32	AMORT LOAN COST				8,617	8,617	5
6	V	33	REAL ESTATE TAXES				45,604	45,604	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 520,000			$ 358,718	$ * (161,282)	14

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	$ 235,000	WEISS MANAGEMENT GROUP		$	$ (235,000)	15
16	V	19	ADMIN./BKKP. FEES	260,000				(260,000)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATIVE SALARIES				275,982	275,982	19
20	V	19	PROFESSIONAL FEES				2,229	2,229	20
21	V	20	LICENSES & PERMITS				105	105	21
22	V	21	OFFICE EXPENSES				48,620	48,620	22
23	V	25	TRANSPORTATION STAFF				473	473	23
24	V	26	INSURANCE				2,474	2,474	24
25	V	27	EMPLOYEE BENEFITS				23,952	23,952	25
26	V	30	DEPRECIATION (SL)				2,439	2,439	26
27	V	35	AUTO LEASE				11,060	11,060	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			$ 495,000			$ 367,334	$ * (127,666)	39

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	$ 168,400	BRIA HEALTH SERVICES, LLC		$	$ (168,400)	15
16	V								16
17	V								17
18	V	1	DIETARY SALARIES				2,344	2,344	18
19	V	5	UTILITIES				138	138	19
20	V	6	REPAIR/MAINT				327	327	20
21	V	10	NURSING CONSULTING FEE				1,436	1,436	21
22	V	10	NURSING SALARIES				42,927	42,927	22
23	V	19	PROFESSIONAL FEES				73,548	73,548	23
24	V	20	WANT ADS, LICENSES				5,259	5,259	24
25	V	21	TOTAL OFFICE				16,115	16,115	25
26	V	23	SEMINARS				505	505	26
27	V	25	TRANSPORTATION				3,334	3,334	27
28	V	26	INSURANCE				336	336	28
29	V	27	EMPLOYEE BENEFITS				11,751	11,751	29
30	V	30	DEPRECIATION (SL)				765	765	30
31	V	32	INTEREST				291	291	31
32	V	33	RE TAX				753	753	32
33	V	34	OFFICE RENT				348	348	33
34	V	35	PUBLIC STORAGE				379	379	34
35	V	35	AUTO LEASE				1,420	1,420	35
36	V								36
37	V								37
38	V								38
39	Total			$ 168,400			$ 161,976	$ * (6,424)	39

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	30.00	BRIA OF BELLEVILLE	BELLEVILLE	WEISS MGMT		MANAGEMENT/	2
3	NATAN WEISS	30.00			GROUP, INC	LINCOLNWOOD	CLERICAL	3
4	DANIEL WEISS	30.00	BRIA OF GENEVA	GENEVA				4
5	GARY A. WEINTRAUB	10.00			BRIA HEALTH		MANAGEMENT	5
6			BRIA OF FOREST EDGE	CHICAGO	SERVICES, LLC	LINCOLNWOOD	SERVICES	6
7								7
8			LAKE PARK CENTER	WAUKEGAN	JEROME LANE,		REAL ESTATE	8
9					LLC	LINCOLNWOOD		9
10			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				10
11				HEIGHTS				11
12								12
13			BRIA OF WESTMONT	WESTMONT				13
14								14
15			BRIA OF PALOS HILLS	PALOS HILLS				15
16								16
17			BRIA OF RIVER OAKS	BURNHAM				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 CAHOKIA # 0048645 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	30.00	SEE	10	22.22	SALARY	98,565	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	30.00	SCHEDULE	15	13.04	SALARY	78,852	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	30.00		10	13.51	SALARY	98,565	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 275,982		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 CAHOKIA # 0048645 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
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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	89,208	2	$ 560,000	$ 560,000	43,964	$ 275,982	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	89,208	2	4,523		43,964	2,229	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	89,208	2	214		43,964	105	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	89,208	2	98,655	95,083	43,964	48,620	4
5	25	TRANSPORTATION STAFF	PATIENT CENSUS	89,208	2	959		43,964	473	5
6	26	INSURANCE	PATIENT CENSUS	89,208	2	5,021		43,964	2,474	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	89,208	2	48,602		43,964	23,952	7
8	30	DEPRECIATION (SL)	PATIENT CENSUS	89,208	2	4,949		43,964	2,439	8
9	35	AUTO LEASE	PATIENT CENSUS	89,208	2	22,442		43,964	11,060	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		$ 367,334	25

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	43,964	$ 2,344	1
2	5	UTILITIES	PATIENT CENSUS	421,649	8	1,327		43,964	138	2
3	6	REPAIR/MAINT	PATIENT CENSUS	421,649	8	3,134		43,964	327	3
4	10	NURSING CONSULTING FEE	PATIENT CENSUS	421,649	8	13,770		43,964	1,436	4
5	10	NURSING SALARIES	PATIENT CENSUS	421,649	8	411,700	411,700	43,964	42,927	5
6	19	PROFESSIONAL FEES	PATIENT CENSUS	421,649	8	705,381	100,000	43,964	73,548	6
7	20	WANT ADS, LICENSES	PATIENT CENSUS	421,649	8	50,442		43,964	5,259	7
8	21	TOTAL OFFICE	PATIENT CENSUS	421,649	8	154,551	71,971	43,964	16,115	8
9	23	SEMINARS	PATIENT CENSUS	421,649	8	4,839		43,964	505	9
10	25	TRANSPORTATION	PATIENT CENSUS	421,649	8	31,980		43,964	3,334	10
11	26	INSURANCE	PATIENT CENSUS	421,649	8	3,220		43,964	336	11
12	27	EMPLOYEE BENEFITS	PATIENT CENSUS	421,649	8	112,698		43,964	11,751	12
13	30	DEPRECIATION (SL)	PATIENT CENSUS	421,649	8	7,337		43,964	765	13
14	32	INTEREST	PATIENT CENSUS	421,649	8	2,787		43,964	291	14
15	33	RE TAX	PATIENT CENSUS	421,649	8	7,222		43,964	753	15
16	34	OFFICE RENT	PATIENT CENSUS	421,649	8	3,338		43,964	348	16
17	35	PUBLIC STORAGE	PATIENT CENSUS	421,649	8	3,634		43,964	379	17
18	35	AUTO LEASE	PATIENT CENSUS	421,649	8	13,620		43,964	1,420	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,553,462	$ 606,153		$ 161,976	25

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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: JEROM LANE, LLC						$	$			$	1
2	BANK FINANCIAL		X			12/26/13	6,280,000	6,280,000	12/26/16	3.5000	207,523	2
3	AMORT LOAN COST		X	AMORT OVER 5 YEAR			43,083	34,466			8,617	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	05/08/11	2,000,000	1,031,719		PRIME+	37,123	6
7		X		INSURANCE FINANCING							2,823	7
8	RELATED PARTY ALLOCATION										291	8
9	TOTAL Facility Related						$ 8,323,083	$ 7,346,185			$ 256,377	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,323,083	$ 7,346,185			$ 256,377	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 CAHOKIA # 0048645 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.**	$	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.)		$ 45,604	2
3. Under or (over) accrual (line 2 minus line 1).		$ 45,604	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 45,604	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	44,479	8
	2010	43,762	9
	2011	40,322	10
	2012	36,043	11
	2013	45,604	12

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 CAHOKIA COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0048645

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.	06-12.0-206-016	NURSING HOME	$ 45,604.38	$ 45,604.38
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,604.38	$ 45,604.38

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 CAHOKIA # 0048645 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,723 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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		2014	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	133		2014		$ 2,668,552	$ 68,424	27.5	$ 68,424	$	$ 68,424	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				9,362	240		240			8
	Improvement Type**										
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2006	30,000	1,091	27.5	1,091		8,928	9
10	AIR CONDITIONS			2006	947		5			947	10
11	INSTALLATION OF EXAUST SYSTEM			2007	3,340	121	27.5	121		963	11
12	AIR CONDITIONS			2007	11,065		5			11,065	12
13	INSTALLATION OF ROOFTOP UNIT			2007	4,140	151	27.5	151		1,151	13
14	CALLCARE STATION REPLACEMENT			2007	3,122	114	27.5	114		860	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIC			2007	6,870	458	15	458		3,244	15
16	INSTALLATION OF DOORS-FRONT ENTRANCE,VESTIBULE			2007	11,640	423	27.5	423		3,014	16
17	PAINTING			2007	7,587		5			7,587	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS			2007	14,027		5			14,027	18
19	BUILDING RENOVATION AND REMODELING:			2007	228,253	8,300	27.5	8,300		58,446	19
20	A,B,C,D-WINGS CORRIDOR,RISIDENT ROOMS, THERAPY										20
21	ROOM,LOBBY, RECEPTION,ACTIVITY ROOM, HALL-LIGHT										21
22	FIXTURES,FLOORING,CEILING GRID & TILE,HANDRAILS,										22
23	CORNER GUARDS,NURSES STATION B-WING CORRIDOR										23
24	D-WING RESIDENT ROOM-FLOORING			2008	34,382	1,250	27.5	1,250		8,490	24
25	SHOWER-VARIOUS DIFFERENT AREAS			2008	16,266	591	27.5	591		3,965	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2008	26,400	960	27.5	960		6,280	26
27	INSTALLED NEW OFFICE, SIDEWALK TO THE OFFICE			2008	29,175	1,061	27.5	1,061		6,941	27
28	INSTALLATION OF ALARM SYSTEM			2008	42,875	1,559	27.5	1,559		10,069	28
29	INSTALLATION OF DOORS-OXYGEN ROOM, COURTYARD			2008	6,147	224	27.5	224		1,465	29
30	AIR CONDITIONS, WATER HEATER			2008	5,513		5			5,513	30
31	REPLACE EXISTING SPRINKLER PIPING			2008	9,498	345	27.5	345		2,113	31
32	SEALING PARKING LOT			2008	2,500	167	15	167		1,058	32
33	WALL AIR CONDITIONS			2009	6,308	182	5	182		6,308	33
34	WANDERGUARD E. STANDARD, BUMPER GUARD			2009	10,612	386	27.5	386		2,010	34
35	LOUNGE,RESIDENT & ACTIVITY ROOMS-FLOORING			2010	16,410	597	27.5	597		2,960	35
36	WALL AIR CONDITIONS			2010	6,712	379	5	379		6,475	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 CAHOKIA # 0048645 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	INSTALL DOORS AND HARDWARE	2010	$ 2,966	$ 108	27.5	$ 108	$	$ 482	37
38	INSTALL ACCELERATOR, REPLACE DRY PENDENT	2010	3,218	117	27.5	117		522	38
39	RANCH STYLE GARAGE	2010	15,515	564	27.5	564		2,468	39
40	NEW LAUNDRY ROOM-INSTALL DOORS,CONCRETE SLAB	2010	28,249	1,027	27.5	1,027		4,151	40
41	FOOTING FOR PERMIT,ELECTRICAL,WIRING,WINDOW,TILE								41
42	WALL AIR CONDITIONS	2011	6,639		5	1,328	1,328	5,327	42
43	SEAL COATING PARKING LOT	2011	20,931	1,395	15	1,395		5,348	43
44	INSTALLED QUARTER BARREL STYLE AWNINGS	2011	2,955	107	27.5	107		397	44
45	RESIDENT ROOMS-CUSTOM BUILT-IN WARDROBES	2011	18,278	665	27.5	665		2,466	45
46	INSTALL RTU & DUST RUN FROM ATTIC INTO ADM OFFIC	2011	12,989	472	27.5	472		1,593	46
47	SHOWER ROOM: FOUR PIESE FIBERGLASS SHOWER;	2011	12,163	442	27.5	442		1,418	47
48	FULL PLYWOOD BACKING ON ALL WALLS; POLYESTER								48
49	GELCOAT FINISH								49
50	WALL AIR CONDITIONS	2012	12,123	1,164	5	1,164		5,529	50
51	INSTALLED 35 GALLON GREASE TRAP IN THE FLOOR	2012	13,900	505	27.5	505		1,284	51
52	REPLACED PIPE IN ATTIC , INSTALLED COMPRESSOR	2012	12,100	440	27.5	440		1,045	52
53	WALL AIR CONDITIONS	2013	6,903	1,104	5	1,104		5,246	53
54	SPRINKLERS	2013	91,610	3,331	27.5	3,331		5,413	54
55	CARPET FOR COFFICES AND LOBBY INSET; WALK-OFF								55
56	CARPET; WALL BASE	2013	5,794	1,159	5	1,159		1,739	56
57	PLASTER CEILING-INSTALL 2 EXPANSION JOINTS; ATTIC								57
58	SPACE-RE-INSULATE WITH 6" BLOWN	2013	10,338	376	27.5	376		392	58
59	WALL AIR CONDITIONS	2014	10,764	6,458	5	2,153	(4,305)	2,153	59
60	INSTALL REDUCED PRESSURE BACKFLOW PREVENTER								60
61	ON FIRE SPRINKLER SERVICE	2014	8,815	174	27.5	174		174	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,507,953	$ 106,631		$ 103,654	$ (2,977)	$ 289,450	70

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	$ 195,534	$ 6,649	$ 23,874	$ 17,225	3-10	$ 112,614	71
72	Current Year Purchases	25,349	15,210	1,477	(13,733)	8-10	1,477	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		31,514	31,514				74
75	TOTALS	$ 220,883	$ 53,373	$ 56,865	$ 3,492		$ 114,091	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	2008 FORD WAGON	208	$ 37,400	$ 1,775	$	$ (1,775)	5	$ 37,400	76
77										77
78	ADMINISTRATIVE	2007 LAND ROVER/RANGE	2010	33,484	3,663	6,696	3,033	5	33,484	78
79										79
80	TOTALS			$ 70,884	$ 5,438	$ 6,696	$ 1,258		$ 70,884	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)	$ 4,149,720	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,442	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,215	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,773	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 474,425	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 CAHOKIA # 0048645 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: $ 18,294 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					18
19			N/A		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 CAHOKIA # 0048645 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	$		$ 307,325	$		$ 307,325	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			96,516			96,516	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			362,880			362,880	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				85,840		85,840	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					10,311		10,311	12
13	I.V. THERAPY Other (specify): MEDICAL SUPPLY	39-2					19,770 3,339		19,770 3,339	13
14	TOTAL			$		$ 766,721	$ 119,260		$ 885,981	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 CAHOKIA # 0048645 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	$ 81,345	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,132,831		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,530		6
7	Other Prepaid Expenses	60,906		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,410,612	$	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	830,039		15
16	Equipment, at Historical Cost	291,767		16
17	Accumulated Depreciation (book methods)	(487,834)		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)**	$ 633,972	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,044,584	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,676,616	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,031,719		29
30	Accrued Salaries Payable	102,640		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,276		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)**	$ 2,830,251	$	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)**	$ 2,830,251	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,214,333	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,044,584	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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**	$ 967,429	1	
2	Restatements (describe):		2	
3	ROUNDING	1	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 967,430	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	246,903	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)**	$ 246,903	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)**	$ 1,214,333	24	*

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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	$ 7,759,170	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,759,170	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***	1,381	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,381	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)**	$ 7,760,551	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,144,576	31
32	Health Care	2,621,568	32
33	General Administration	1,904,198	33
	B. Capital Expense		
34	Ownership	643,504	34
	C. Ancillary Expense		
35	Special Cost Centers	885,981	35
36	Provider Participation Fee	313,821	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,513,648	40
41	**Income before Income Taxes (line 30 minus line 40)****	246,903	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 246,903	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,810,607	44
45	Private Pay - Net Inpatient Revenue	156,859	45
46	Medicare - Net Inpatient Revenue	2,430,948	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	315,714	47
48	Other-(specify) MANAGED CARE	45,042	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,759,170	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 CAHOKIA # 0048645 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	1,760	1,904	$ 62,943	$ 33.06	1
2	Assistant Director of Nursing	932	988	24,479	24.78	2
3	Registered Nurses	3,191	3,309	75,366	22.78	3
4	Licensed Practical Nurses	32,782	34,493	693,329	20.10	4
5	CNAs & Orderlies	92,007	96,558	1,016,282	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,037	9,413	89,845	9.54	10
11	Social Service Workers	15,034	15,911	168,695	10.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,744	18,675	177,208	9.49	15
16	Dishwashers					16
17	Maintenance Workers	8,345	8,924	95,346	10.68	17
18	Housekeepers	19,799	20,859	190,924	9.15	18
19	Laundry	11,882	12,594	111,870	8.88	19
20	Administrator	1,832	2,080	75,673	36.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,030	11,780	161,821	13.74	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	1,720	1,840	26,163	14.22	31
32	Other Health C: Care Plan Coord	5,879	6,375	140,101	21.98	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	232,974	245,703	$ 3,110,045 *	$ 12.66	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	$ 16,992	1-3	35
36	Medical Director	O	20,100	9-3	36
37	Medical Records Consultant	N	2,709	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,040	10-3	39
40	Physical Therapy Consultant	L	16,788	10a-3	40
41	Occupational Therapy Consultant	Y	12,206	10a-3	41
42	Respiratory Therapy Consultant		104	10a-3	42
43	Speech Therapy Consultant	F	3,521	10a-3	43
44	Activity Consultant	E	1,242	11-3	44
45	Social Service Consultant	E	2,208	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 82,910		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 CAHOKIA # 0048645 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEPHANIE BIRCH	ADMINISTRATOR	0	$ 75,673
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,673

B. Administrative - Other

Description		Amount
WEISS MGMT GROUP, INC	MANAGEMENT FEES	$ 235,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 235,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		583,684
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 583,684

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,236
Unemployment Compensation Insurance	61,140
FICA Taxes	236,515
Employee Health Insurance	91,518
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	19,057
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)	$ 521,466

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	7,106
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 505	6,082
TRUST/FRANCHISE/CONTRIB/ETC	6,564
MARKETING/ADV/PROMO	24,164
LICENSES/DUES/SUBSCRIPTIONS	11,018
MGMT CO ALLOC	5,364
TRUST/FRANCHISE/CONTRIB/ETC	(6,564)
Less: Public Relations Expense	(0)
Non-allowable advertising	(24,164)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,570

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 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 CAHOKIA # 0048645 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 $ 8,662**

(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. $ **9,646** 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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
RIVER BLUFFS OF CAHOKIA NURSING & REHAB CENTER #0042713; 05/01/2000

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **313,821**
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.