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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0051136

Facility Name: BRIA OF PALOS HILLS

Address: 10426 SOUTH ROBERTS (Number) PALOS HILLS (City) 60465 (Zip Code)

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: 07/01/10

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 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) 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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,398	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	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			7,402	7,402	8
9	SNF/PED					9
10	ICF	38,513	1,994	1,680	42,187	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,513	1,994	9,082	49,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.74%

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 07/01/201

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 7,402

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		13,134	968,978	982,112		982,112		982,112			1
2	Food Purchase		810		810		810		810			2
3	Housekeeping		60,648	408,133	468,781		468,781		468,781			3
4	Laundry		40,842	272,871	313,713		313,713		313,713			4
5	Heat and Other Utilities			178,944	178,944		178,944		178,944			5
6	Maintenance	144,582	102,119	81,481	328,182		328,182		328,182			6
7	Other (specify):*			31,013	31,013		31,013		31,013			7
8	**TOTAL General Services**	144,582	217,553	1,941,420	2,303,555		2,303,555		2,303,555			8
	B. Health Care and Programs											
9	Medical Director			47,500	47,500		47,500		47,500			9
10	Nursing and Medical Records	3,973,617	401,005	128,019	4,502,641		4,502,641		4,502,641			10
10a	Therapy			150,830	150,830		150,830		150,830			10a
11	Activities	126,650	6,886	2,992	136,528		136,528		136,528			11
12	Social Services	138,139	6,304	624	145,067		145,067		145,067			12
13	CNA Training											13
14	Program Transportation			2,553	2,553		2,553		2,553			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,238,406	414,195	332,518	4,985,119		4,985,119		4,985,119			16
	C. General Administration											
17	Administrative	165,536			165,536		165,536		165,536			17
18	Directors Fees											18
19	Professional Services			132,260	132,260		132,260	3,500	135,760			19
20	Dues, Fees, Subscriptions & Promotions			456,712	456,712		456,712	(401,613)	55,099			20
21	Clerical & General Office Expenses	526,380	60,819	208,999	796,198		796,198	(152,109)	644,089			21
22	Employee Benefits & Payroll Taxes			727,645	727,645		727,645	(1,959)	725,686			22
23	Inservice Training & Education			3,011	3,011		3,011		3,011			23
24	Travel and Seminar			10,524	10,524		10,524		10,524			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			309,544	309,544		309,544		309,544			26
27	Other (specify):*			130,302	130,302		130,302	(130,302)				27
28	**TOTAL General Administration**	691,916	60,819	1,978,997	2,731,732		2,731,732	(682,483)	2,049,249			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,074,904	692,567	4,252,935	10,020,406		10,020,406	(682,483)	9,337,923			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 PALOS HILLS **#0051136** **Report Period Beginning: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		2,324	
	CONTRACTED DIETARY SERVICES		966,654	968,978
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		408,133	
				408,133
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		272,871	272,871
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		28,270	
	ELECTRICITY		88,697	
	WATER		55,833	
	CABLE TV - LOBBY		6,144	
				178,944
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		53,383	
	PAINTING & DECORATING		3,443	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		24,655	
				81,481
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICES		31,013	
	SECURITY SERVICE		0	
				31,013
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	47,500	47,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	62,247	
	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	720	
	PHARMACY CONSULTANT	XVIII B 39-2	16,153	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	6,000	
	RN CONSULTANT	XVIII B 38-2	42,899	
				128,019
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	45,270	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	34,339	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	57,349	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	13,872	
				150,830
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,992	
				2,992
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	624	
	SOCIAL WORKER	XVIII B 45-2	0	
				624
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIA OF PALOS HILLS **#0051136** **Report Period Beginning: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,553	
				2,553
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,566	
	ADMINISTRATIVE CONSULTANTS	XIX C	118,694	
	PROFESSIONAL FEES	XIX C	0	
				132,260
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	394,914	
	EMPLOYEE WANT ADS	XIX F	29,443	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	15,036	
	LICENSES & PERMITS	XIX F	5,685	
	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	6,699	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,100	
	PATIENT BACKGROUND CHECKS	XIX F	3,835	
				456,712
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,627	
	EQUIPMENT REPAIR & MAINTENANCE		137,085	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,192	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		57,890	
	MESSENGER SERVICE		5,205	
				208,999

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	376,101	
	UNEMPLOYMENT COMPENSATION	XIX D	111,630	
	WORKERS COMPENSATION INSURANCI	XIX D	156,891	
	HOSPITALIZATION INSURANCE	XIX D	64,752	
	EMPLOYEE BENEFITS - OTHER	XIX D	18,271	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				727,645
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,011	
				3,011
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	10,524	
				10,524
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF			
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		309,544	
				309,544
27	**OTHER**			
	BAD DEBTS	VI 24	130,302	
				130,302

GRAND TOTAL COLUMN 3 OTHER **4,252,935**

BRIA OF PALOS HILLS
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	810
LESS SALES TAX	0
NET FOOD	810
TOTAL PATIENT CENSUS	49,589
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	148,767
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	54,900
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	148,767
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	148,767
NET FOOD	810
DIVIDE TOTAL MEALS/YEAR	148,767
COST PER MEAL	0.01
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

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

Facility Name & ID Number BRIA OF PALOS HILLS #0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			60,465	60,465		60,465	700,772	761,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,644	24,644		24,644	515,977	540,621			32
33	Real Estate Taxes							451,888	451,888			33
34	Rent-Facility & Grounds			730,800	730,800		730,800	(720,000)	10,800			34
35	Rent-Equipment & Vehicles			41,147	41,147		41,147		41,147			35
36	Other (specify):*											36
37	**TOTAL Ownership**			857,056	857,056		857,056	948,637	1,805,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		448,201	1,022,606	1,470,807		1,470,807		1,470,807			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			363,050	363,050		363,050		363,050			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		448,201	1,385,656	1,833,857		1,833,857		1,833,857			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,074,904	1,140,768	6,495,647	12,711,319		12,711,319	266,154	12,977,473			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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(4,572)	30		9
10	Interest and Other Investment Income	(959)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(6,192)	21		18
19	Entertainment		20		19
20	Contributions	(6,699)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130,302)	27		24
25	Fund Raising, Advertising and Promotional	(394,914)	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 SEE PG 5A	(147,876)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (691,514)		$	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)	957,668		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 957,668		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 266,154		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 PALOS HILLS

ID# 0051136

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (145,917)	21	1
2	CHICAGO BULLS TICKETS	(1,959)	22	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**	(147,876)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,500	0	0	0	0	0	0	0	0	0	3,500	19
20	Fees, Subscriptions & Promotions	(401,613)	0	0	0	0	0	0	0	0	0	0	(401,613)	20
21	Clerical & General Office Expenses	(152,109)	0	0	0	0	0	0	0	0	0	0	(152,109)	21
22	Employee Benefits & Payroll Taxes	(1,959)	0	0	0	0	0	0	0	0	0	0	(1,959)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(130,302)	0	0	0	0	0	0	0	0	0	0	(130,302)	27
28	**TOTAL General Administration**	(685,983)	3,500	0	0	0	0	0	0	0	0	0	(682,483)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(685,983)	3,500	0	0	0	0	0	0	0	0	0	(682,483)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,572)	705,344	0	0	0	0	0	0	0	0	0	700,772	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(959)	516,936	0	0	0	0	0	0	0	0	0	515,977	32
33	Real Estate Taxes	0	451,888	0	0	0	0	0	0	0	0	0	451,888	33
34	Rent-Facility & Grounds	0	(720,000)	0	0	0	0	0	0	0	0	0	(720,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,531)	954,168	0	0	0	0	0	0	0	0	0	948,637	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)**	(691,514)	957,668	0	0	0	0	0	0	0	0	0	266,154	45

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 720,000	PM NURSING & REHAB		$	$ (720,000)	1
2	V	30	DEPRECIATION				705,344	705,344	2
3	V	32	INTEREST EXPENSE				516,936	516,936	3
4	V	19	PROFESSIONAL FEES				3,500	3,500	4
5	V	33	REAL ESTATE TAXES				451,888	451,888	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 720,000			$ 1,677,668	$ * 957,668	14

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	DANIEL WEISS	16.67	BRIA OF CAHOKIA	CAHOKIA	WEISS MGMT		MANAGEMENT/	2
3	NATAN WEISS	16.67			GROUP, INC	LINCOLNWOOD	CLERICAL	3
4	AVRUM WEINFELD	16.67	BRIA OF BELLEVILLE	BELLEVILLE				4
5	DEANNA KAPLAN	49.99			BRIA HEALTH		MANAGEMENT	5
6			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO	SERVICES, LLC	LINCOLNWOOD	SERVICES	6
7				HEIGHTS				7
8					PM NURSING &		REAL ESTATE	8
9			BRIA OF FOREST EDGE	CHICAGO	REHAB	LINCOLNWOOD		9
10								10
11			BRIA OF GENEVA	GENEVA				11
12								12
13			LAKE PARK CENTER	WAUKEGAN				13
14								14
15			BRIA OF RIVER OAKS	BURNHAM				15
16								16
17			BRIA OF WESTMONT	WESTMONT				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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	DANIEL WEISS	SHAREHOLDER	ADMINISTRATIV	16.67		10	9.52		$		1
2					SEE						2
3	NATAN WEISS	CFO	FINANCE/MGMT	16.67	ATTACHED	10	11.24				3
4					SCHEDULE						4
5	AVRUM WEINDFELD	SHAREHOLDER	ADMINISTRATIV	16.67		15	12.60				5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: PM NURSING & REHAB						$	$			$	1
2	THE PRIVATE BANK	X		LOAN				20,054,204		PRIME+	516,936	2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	08/01/10	750,000	637,604		PRIME+	20,263	6
7		X		INSURANCE FINANCE							4,381	7
8												8
9	TOTAL Facility Related						$ 750,000	$ 20,691,808			$ 541,580	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 750,000	$ 20,691,808			$ 541,580	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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 442,935	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.)		$ 445,186	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,251	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 449,637	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** $ 200 **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.		$ 451,888	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	30,535	8
	2012	352,284	9
	2013	350,701	10
	2014	413,236	11
	2015	445,186	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 2015 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF PALOS HILLS COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051136

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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-14-224-001-0000	NURSING HOME	$ 2,546.04	$ 2,546.04
2.	23-14-224-002-0000	NURSING HOME	$ 2,634.23	$ 2,634.23
3.	23-14-224-003-0000	NURSING HOME	$ 7,572.37	$ 7,572.37
4.	23-14-224-004-0000	NURSING HOME	$ 7,572.37	$ 7,572.37
5.	23-14-224-009-0000	NURSING HOME	$ 7,830.84	$ 7,830.84
6.	23-14-224-010-0000	NURSING HOME	$ 11,378.72	$ 11,378.72
7.	23-14-224-011-0000	NURSING HOME	$ 7,531.14	$ 7,531.14
8.	23-14-224-012-0000	NURSING HOME	$ 9,130.34	$ 9,130.34
9.	23-14-224-017-0000	NURSING HOME	$ 388,989.54	$ 388,989.54
10.			$	$
		TOTALS	$ 445,185.59	$ 445,185.59

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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		2012	$ 812,700	1
2	NURSING HOME		2016	637,703	2
3	TOTALS			$ 1,450,403	3

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	203		2012		$ 1,636,707	$ 41,967	27.5	$ 41,967	$	$ 166,119	4
5			2016		18,665,735	311,096	27.5	311,096		311,096	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF TOP AIR CONDITION			2010	9,124		5			9,124	9
10	LOBBY: MILLWORK,CROWN MOLDING,REPLACE OUTLETS,										10
11	WALLCOVERING										11
12	CORRIDOR #1:CEILING TILE,HANDRAILS,PAINTING WALLS,										12
13	MILLWORK										13
14	CORRIDOR #2:CEILING TILE,HANDRAILS,MILLWORK,LIGHT										14
15	FIXTURE										15
16	THERAPY AND RESIDENT ROOMS;CEILING TILE,WINDOW										16
17	TREATMENTS,FLOORING,WALLCOVERING, LIGHT FIXTURES,										17
18	INSTALL NEW VCT AND COVE BASE			2010	60,347	2,194	27.5	2,194		13,528	18
19	SOUTH HALL, NORTH/DINING, BEATY SHOP-PAINTING			2011	12,000	692	5	692		12,000	19
20	PHONE ROOM AREA-INSTALL NEW WIREGLASS WINDOW;										20
21	DINING ROOM-CEILING TILE,WALLCOVERING,CHAIR RAIL'										21
22	BUILD TWO NEW WALLS;										22
23	THERAPY ROOM-INSTALL NEW DOOR,PAINT WALLS;										23
24	RESIDENT BATHROOMS-PAINT,CEILINGS, COVE BASE;										24
25	RECETTION AREA-DEMOLISH TWO WALLS,INSTALL NEW										25
26	COUNTERTOP, PAINT;										26
27	ADMISSION OFFICE-BUID NEW WALL,WALLCOVERING ,PAINT										27
28	INSTALLATION OF WINDOW TREATMENTS,ROLLER SHADES,										28
29	CUBICLE CURTAINS			2011	35,514	1,291	27.5	1,291		7,477	29
30	NORTH HALL, FRONT HALL-PAINTING			2011	13,350	769	5	769		13,350	30
31	INSTALL ANTI-FREEZE SYSTEM BELOW CANOPY			2011	5,135	187	27.5	187		1,114	31
32	INSTALL INTELLIGENT PHOTO DETECTOR			2011	7,998	291	27.5	291		1,734	32
33	LOBBY-INSTALL NEW CERAMIC TILE, MILLWORK, GROUT			2011	8,537	310	27.5	310		1,718	33
34	PARKING LOT-PAVED WITH 1.5" OF NEW ASPHALT			2011	29,850	1,990	15	1,990		10,779	34
35	INSTALL FIVE DELAYED EGRESS LOCKS-DOUBLE & SINGLE			2011	8,368	304	27.5	304		1,609	35
36				2011	2,622	95	27.5	95		487	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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	REROOFED PROPERTY USING SINGLE PLY MODIFIED		$	$		$	$	$	37
38	BITUMEN; INSTALL 6 NEW RETRO FIT DRAINS	2011	35,700	1,298	27.5	1,298		6,544	38
39	INSTALLATION AND WIRING FOR WAP'S	2012	4,730	172	27.5	172		839	39
40	CORRIDOR-HANDRAILS, CORNER GUARDS	2012	5,225	190	27.5	190		910	40
41	REPLACEMENT OF A/C SOUTHEAST UNIT COMPRESSOR	2012	2,618	151	5	151		2,543	41
42	APPLIED A PATCH TO THE FIELD OR WALL FLASHINGS	2012	2,800	102	27.5	102		438	42
43	NURSES STATION; 2 BATHROOMS; NOTRH, WEST, SOUTH								43
44	CORRIDORS; CAFETERIA-INSTALL NEW CERAMIC TILE,								44
45	VCT AND MILLWORK	2013	36,893	1,342	27.5	1,342		5,312	45
46	APPLIED A PATCH TO THE FIELD USING SPMB OR WALL								46
47	FLASHING-EAST, SOUTH WING	2013	3,650	133	27.5	133		460	47
48	TUB ROOM; TRAINING TOILET; 2 SMALL SHOWER ROOMS								48
49	INSTALLATION OF CERAMIC FLOOR TILE	2013	18,583	676	27.5	676		2,225	49
50	FIRE SPRINKLER SYSTEM REPAIR-LABOT AND MATERIAL								50
51	TO COMPLETE WORK	2013	10,120	368	27.5	368		1,211	51
52	ALZHEIMERS DINING ROOM; SOUTH CORRIDOR; NORTH								52
53	SHOWER ROOM-INSTALL NEW VCT & MILLWORK	2013	26,867	977	27.5	977		3,135	53
54	REROOFED PROPERTY USING SINGLE PLY MODIFIED								54
55	BITUMEN ON FRONT PORTION OF THE CENTER AND								55
56	SOUTH WING	2013	79,040	2,874	27.5	2,874		9,221	56
57	REPLACEMENT OF A/C UNIT IN NORTH DIALYSIS ROOM	2013	8,602	313	27.5	313		1,004	57
58	INSTALL NEW FIRE ALARM SYSTEM; SMOKE DETECTOR								58
59	BASE	2013	24,108	877	27.5	877		2,814	59
60	REPLACE WITH NEW PIPE AND FITTINGS OF THE SEWER								60
61	LINE' TWO SEPARATE TRENCH EXCAVATIONS	2013	8,425	306	27.5	306		956	61
62	INSTALLED NEW WHITE GRANULATED SPMB FLASHING								62
63	AND GRAVEL STOP-REMOVED EXISTING ROOF	2014	10,150	369	27.5	369		1,030	63
64	NORTHEAST DINING ROOM-INSTALLATION OF BUMPER								64
65	GUARD & CHAIR RAIL	2014	3,428	125	27.5	125		349	65
66	INSTALL CONCRETE PAD DEMO; SPOT TUCKPOINT AND								66
67	RESET SILLS AROUD BLDG	2014	16,636	1,109	15	1,109		3,050	67
68	REMODEL 5 SHOWERS ROOMS: NEW TILE, WALLS,								68
69	LIGHT FIXTURES, PAINT CEILINGS, NEW FIRE DOOR	2014	44,975	1,635	27.5	1,635		4,292	69
70	TOTAL (lines 4 thru 69)		$ 20,837,837	$ 374,203		$ 374,203	$	$ 596,468	70

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 20,837,837	$ 374,203		$ 374,203	$	$ 596,468	1
2	INSTALLED NEW CONDENSING UNIT ON ROOF	2014	6,300	229	27.5	229		563	2
3	INSTALL ACCUTECH DEPARTURE ALERT SYSTEM FOR								3
4	FRONT & BACK DOOR; DELAY LOCKS ON DOUBLE DOOR	2014	11,599	422	27.5	422		967	4
5	WIRE UP 10 ROOMS	2015	3,500	127	27.5	127		238	5
6	INSTALLATION OF THE FIRE DOORS COMING FROM								6
7	THE KITCHEN	2015	3,835	139	27.5	139		203	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)		$ 20,863,071	$ 375,120		$ 375,120	$	$ 598,439	34

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 243,217	$ 14,095	$ 31,709	$ 17,614	3-10	$ 131,866	71
72	Current Year Purchases	40,522	24,313	2,127	(22,186)	8-10	2,127	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		352,281	352,281				74
75	TOTALS	$ 283,739	$ 390,689	$ 386,117	$ (4,572)		$ 133,993	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,597,213	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 765,809	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 761,237	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,572)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 732,432	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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 ☒ NO

16. Rental Amount for movable equipment: $ 33,144 Description: SEE ATTACHED SCHEDULE
(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	FACILITY	2016 FORD TRANSIT	$ #######	$ 8,003	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 8,003	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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$		$ 423,708	$		$ 423,708	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			126,360			126,360	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			472,538			472,538	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				352,959		352,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					46,295		46,295	12
13	MEDICAL SUPPLIES, RENTALS, Other (specify): I.V.THERAPY	39-2					48,947		48,947	13
14	TOTAL			$		$ 1,022,606	$ 448,201		$ 1,470,807	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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 244,622	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,000)	5,014,693		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	241,049		6
7	Other Prepaid Expenses	74,764		7
8	Accounts Receivable (owners or related parties)	47,533		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,622,661	$	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	560,630		15
16	Equipment, at Historical Cost	283,739		16
17	Accumulated Depreciation (book methods)	(372,533)		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)**	$ 471,836	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,094,497	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,694,710	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	637,604		29
30	Accrued Salaries Payable	386,513		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,947		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	DUE TO D. WEISS	595,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,352,774	$	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 PM NURSING & REHAB	821,255		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 821,255	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,174,029	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 920,468	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,094,497	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,935,258	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,935,258	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,014,790)	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)**	$ (1,014,790)	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)**	$ 920,468	24 *

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 11,695,570	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,695,570	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***	959	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 959	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)**	$ 11,696,529	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,303,555	31
32	Health Care	4,985,119	32
33	General Administration	2,731,732	33
	B. Capital Expense		
34	Ownership	857,056	34
	C. Ancillary Expense		
35	Special Cost Centers	1,470,807	35
36	Provider Participation Fee	363,050	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,711,319	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,014,790)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,014,790)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,023,331	44
45	Private Pay - Net Inpatient Revenue	354,130	45
46	Medicare - Net Inpatient Revenue	4,173,834	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	379,673	47
48	Other-(specify) MANAGED CARE	764,602	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,695,570	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 PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	3,608	3,680	$ 149,919	$ 40.74	1
2	Assistant Director of Nursing	4,520	4,544	160,904	35.41	2
3	Registered Nurses	22,175	22,523	910,451	40.42	3
4	Licensed Practical Nurses	33,625	34,571	927,595	26.83	4
5	CNAs & Orderlies	114,538	118,405	1,608,380	13.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,507	10,174	126,650	12.45	10
11	Social Service Workers	6,878	7,130	138,139	19.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9,537	9,875	144,582	14.64	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,880	2,960	165,536	55.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,832	22,390	526,380	23.51	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	3,426	3,521	49,952	14.19	31
32	Other Health C: Care Plan Coord	4,503	4,801	166,416	34.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	237,029	244,574	$ 5,074,904 *	$ 20.75	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	$ 0	1-3	35
36	Medical Director	O	47,500	9-3	36
37	Medical Records Consultant	N	720	10-3	37
38	Nurse Consultant	T	42,899	10-3	38
39	Pharmacist Consultant	H	16,153	10-3	39
40	Physical Therapy Consultant	L	45,270	10a-3	40
41	Occupational Therapy Consultant	Y	34,339	10a-3	41
42	Respiratory Therapy Consultant		57,349	10a-3	42
43	Speech Therapy Consultant	F	13,872	10a-3	43
44	Activity Consultant	E	2,992	11-3	44
45	Social Service Consultant	E	624	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 261,718		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	640	$ 41,626	10-3	50
51	Licensed Practical Nurses	286	13,931	10-3	51
52	Certified Nurse Assistants/Aides	238	6,690	10-3	52
53	TOTAL (lines 50 - 52)	1,164	$ 62,247		53

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MATTHEW GIDLEY	ADMINISTRATOR	0	$ 134,767
ISSAC PURE	ADMINISTRATOR	0	30,769
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 165,536

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 10,769
NATIONAL DATACARE	DATA PROCESSING	2,797
KBKB, LTD	ACCOUNTING FEES	17,700
RICHARD PEELO & ASSOCIAT.	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	UC CONSULTANT	2,856
IMPG RISK MGMT SERVICES	LIABILITY/REGULATORY	3,333
EARTHWISE ENVIRONMENTAL	LEGIONELLA TESTING	4,500
LEGAL FEES	SEE SCHEDULE	85,805
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 132,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 156,891
Unemployment Compensation Insurance	111,630
FICA Taxes	376,101
Employee Health Insurance	64,752
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	18,271
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
CHICAGO BULLS TICKETS	(1,959)
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,686

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	$ 1,980
Advertising: Employee Recruitment	29,443
Health Care Worker Background Check	1,100
(Indicate # of checks performed 110)	
Patient Background Checks 237	3,835
TRUST/FRANCHISE/CONTRIB/ETC	6,699
MARKETING/ADV/PROMO	394,914
LICENSES/DUES/SUBSCRIPTIONS	18,741
TRUST/FRANCHISE/CONTRIB/ETC	(6,699)
Less: Public Relations Expense	(0)
Non-allowable advertising	(394,914)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,099

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	10,524
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,524

* Attach copy of IMRF notifications

**See instructions.

BRIA OF PALOS HILLS
SCHEDULE-LEGAL
12/31/2016

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
1/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	428
2/29/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	614
3/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	688
4/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,459
5/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	448
6/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	2,078
7/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,024
8/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,021
9/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	808
10/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
11/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
12/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	623
2/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	354
2/19/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING LINE OF CREDIT	1,641
5/2/2016	GARY A. WEINTRAUB,P.C.	GENERAL COUNSELING	590
6/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	384
9/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	472
10/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	590
11/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	384
12/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	354
12/31/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	455
2/20/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	4,281
2/22/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	218
3/15/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	2,992
5/2/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	745
5/23/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	316
6/29/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	1,258
7/29/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	1,237
3/17/2016	SEYFARTH ATTORNEYS SHAW LLP	OPERATOR LOAN	2,153
8/19/2016	SEYFARTH ATTORNEYS SHAW LLP	CONSTRUCTION LOAN	6,299
9/9/2016	DUANE MORRIS	HFSRB EVALUATION	2,279
8/2/2016	CAN DEDUCTIBLE RECOVERY GROUP	SETTLEMENT	50,000
5/23/2016	SPIELBERGER LAW GROUP	SETTLEMENT	1,800
1/25/2016	FEDERAL INSURANCE COMPANY	DEFENSE COSTS	911
5/11/2016	FEDERAL INSURANCE COMPANY	DEFENSE COSTS	215
4/4/2016	HEPLERBROOM	RESIDENT ESTATE	(4,951)
TOTAL			85,805

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $13,601**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **36,022** 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 fo
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
PALOS HILLS EXTENDED CARE LLC, IDPH #0046029 07/01/2010

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **363,050**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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
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