FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

I. IDPH License ID Number: 0050120

Facility Name: BRIA OF WESTMONT

Address: 6501 S. CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

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

HFS ID Number:

Date of Initial License for Current Owners: 09/03/08

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 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid Preparer

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

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,504	6,504	8
9	SNF/PED					9
10	ICF	50,518	3,214	2,358	56,090	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,518	3,214	8,862	62,594	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.76%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/03/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/03/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 125 and days of care provided 6,504

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	388,258	59,166	99,995	547,419		547,419		547,419			1
2	Food Purchase		511,871		511,871		511,871	(962)	510,909			2
3	Housekeeping		20,633	379,328	399,961		399,961		399,961			3
4	Laundry		8,966	350,466	359,432		359,432		359,432			4
5	Heat and Other Utilities			297,910	297,910		297,910	1,453	299,363			5
6	Maintenance	132,423	155,381	39,241	327,045		327,045	4,627	331,672			6
7	Other (specify):*			16,724	16,724		16,724	347	17,071			7
8	**TOTAL General Services**	520,681	756,017	1,183,664	2,460,362		2,460,362	5,465	2,465,827			8
	B. Health Care and Programs											
9	Medical Director			57,000	57,000		57,000		57,000			9
10	Nursing and Medical Records	4,203,795	305,988	63,399	4,573,182		4,573,182	44,221	4,617,403			10
10a	Therapy			30,038	30,038		30,038		30,038			10a
11	Activities	184,656	4,322	2,908	191,886		191,886		191,886			11
12	Social Services	85,836	5,603	1,636	93,075		93,075		93,075			12
13	CNA Training											13
14	Program Transportation			95	95		95		95			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,474,287	315,913	155,076	4,945,276		4,945,276	44,221	4,989,497			16
	C. General Administration											
17	Administrative	202,773		516,000	718,773		718,773	(409,665)	309,108			17
18	Directors Fees											18
19	Professional Services			162,482	162,482		162,482	(62,767)	99,715			19
20	Dues, Fees, Subscriptions & Promotions			106,753	106,753		106,753	(33,347)	73,406			20
21	Clerical & General Office Expenses	355,719	42,752	189,971	588,442		588,442	43,689	632,131			21
22	Employee Benefits & Payroll Taxes			817,377	817,377		817,377		817,377			22
23	Inservice Training & Education			8,982	8,982		8,982	545	9,527			23
24	Travel and Seminar			10,656	10,656		10,656	4,819	15,475			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200,413	200,413		200,413	30,336	230,749			26
27	Other (specify):*			240,683	240,683		240,683	(206,483)	34,200			27
28	**TOTAL General Administration**	558,492	42,752	2,253,317	2,854,561		2,854,561	(632,873)	2,221,688			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,553,460	1,114,682	3,592,057	10,260,199		10,260,199	(583,187)	9,677,012			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 WESTMONT **#0050120** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	98,173	
	REPAIRS & MAINTENANCE		1,822	
				99,995
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		379,328	
				379,328
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		350,466	350,466
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		21,891	
	ELECTRICITY		106,693	
	WATER		161,093	
	CABLE TV - LOBBY		8,233	
				297,910
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		24,101	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		15,140	
				39,241
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICES		16,724	
	SECURITY SERVICE		0	
				16,724
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	57,000	57,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	5,524	
	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	423	
	PHARMACY CONSULTANT	XVIII B 39-2	16,647	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	40,805	
				63,399
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	13,859	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	7,915	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	5,286	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,978	
				30,038
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,908	
				2,908
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,636	
	SOCIAL WORKER	XVIII B 45-2	0	
				1,636
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number BRIA OF WESTMONT **#0050120** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		95	
				95
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	516,000	516,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,661	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	70,371	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		78,450	162,482
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	41,033	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	9,165	
	CONTRIBUTIONS	VI 20 XIX F	2,597	
	DUES & SUBSCRIPTIONS	XIX F	30,957	
	LICENSES & PERMITS	XIX F	10,975	
	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	6,600	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,751	
	PATIENT BACKGROUND CHECKS	XIX F	2,675	
				106,753
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		9,331	
	EQUIPMENT REPAIR & MAINTENANCE		127,333	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		52,041	
	MESSENGER SERVICE		1,266	
				189,971

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	416,576	
	UNEMPLOYMENT COMPENSATION	XIX D	85,058	
	WORKERS COMPENSATION INSURANC	XIX D	123,020	
	HOSPITALIZATION INSURANCE	XIX D	105,096	
	EMPLOYEE BENEFITS - OTHER	XIX D	87,627	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				817,377
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		8,982	
				8,982
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	10,656	
				10,656
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		200,413	
				200,413
27	**OTHER**			
	BAD DEBTS	VI 24	240,683	
				240,683

GRAND TOTAL COLUMN 3 OTHER **3,592,057**

BRIA OF WESTMONT
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	511,871
LESS SALES TAX	(962)
NET FOOD	510,909
TOTAL PATIENT CENSUS	62,594
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	187,782
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	39,420
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	187,782
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	187,782
NET FOOD	510,909
DIVIDE TOTAL MEALS/YEAR	187,782
COST PER MEAL	2.72
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number BRIA OF WESTMONT #0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			302,678	302,678		302,678	214,889	517,567			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			657,446	657,446		657,446	87,920	745,366			32
33	Real Estate Taxes							101,692	101,692			33
34	Rent-Facility & Grounds			832,512	832,512		832,512	(832,512)				34
35	Rent-Equipment & Vehicles			78,104	78,104		78,104	13,678	91,782			35
36	Other (specify):* OFFICE RENT			15,600	15,600		15,600	33,464	49,064			36
37	**TOTAL Ownership**			2,386,340	2,386,340		2,386,340	(880,869)	1,505,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		509,424	950,903	1,460,327		1,460,327		1,460,327			39
40	Barber and Beauty Shops			225	225		225		225			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			439,988	439,988		439,988		439,988			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		509,424	1,391,116	1,900,540		1,900,540		1,900,540			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,553,460	1,624,106	7,369,513	14,547,079		14,547,079	(1,464,056)	13,083,023			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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	37,818	30		9
10	Interest and Other Investment Income	(5,408)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(962)	2		13
14	Non-Care Related Interest	(314,544)	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		21		18
19	Entertainment		20		19
20	Contributions	(9,197)	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	(240,683)	27		24
25	Fund Raising, Advertising and Promotional	(41,033)	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	(577,648)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,151,657)		$	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)	(312,399)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (312,399)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,464,056)		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 WESTMONT

ID# 0050120

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (77,648)	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	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**	(577,648)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF WESTMONT # 0050120 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(962)	0	0	0	0	0	0	0	0	0	0	(962)	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	910	543	0	0	0	0	0	0	0	1,453	5
6	Maintenance	0	0	2,484	2,143	0	0	0	0	0	0	0	4,627	6
7	Other (specify):*	0	0	0	347	0	0	0	0	0	0	0	347	7
8	**TOTAL General Services**	(962)	0	3,394	3,033	0	0	0	0	0	0	0	5,465	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	44,221	0	0	0	0	0	0	0	44,221	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	44,221	0	0	0	0	0	0	0	44,221	16
	C. General Administration													
17	Administrative	0	0	(422,971)	13,306	0	0	0	0	0	0	0	(409,665)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,700	1,383	(72,850)	0	0	0	0	0	0	0	(62,767)	19
20	Fees, Subscriptions & Promotions	(50,230)	250	0	16,633	0	0	0	0	0	0	0	(33,347)	20
21	Clerical & General Office Expenses	(77,648)	0	23	121,314	0	0	0	0	0	0	0	43,689	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	545	0	0	0	0	0	0	0	545	23
24	Travel and Seminar	0	0	0	4,819	0	0	0	0	0	0	0	4,819	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	28,090	230	2,016	0	0	0	0	0	0	0	30,336	26
27	Other (specify):*	(240,683)	0	7,249	26,951	0	0	0	0	0	0	0	(206,483)	27
28	**TOTAL General Administration**	(368,561)	37,040	(414,086)	112,734	0	0	0	0	0	0	0	(632,873)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(369,523)	37,040	(410,692)	159,988	0	0	0	0	0	0	0	(583,187)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF WESTMONT # 0050120 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	37,818	166,281	1,746	9,044	0	0	0	0	0	0	0	214,889	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(319,952)	367,519	1,723	38,630	0	0	0	0	0	0	0	87,920	32
33	Real Estate Taxes	0	99,167	2,088	437	0	0	0	0	0	0	0	101,692	33
34	Rent-Facility & Grounds	0	(832,512)	0	0	0	0	0	0	0	0	0	(832,512)	34
35	Rent-Equipment & Vehicles	0	0	8,809	4,869	0	0	0	0	0	0	0	13,678	35
36	Other (specify):*	0	48,302	(15,600)	762	0	0	0	0	0	0	0	33,464	36
37	TOTAL Ownership	(782,134)	(151,243)	(1,234)	53,742	0	0	0	0	0	0	0	(880,869)	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)	(1,151,657)	(114,203)	(411,926)	213,730	0	0	0	0	0	0	0	(1,464,056)	45

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 832,512	WESTMONT REAL ESTATE, LLC		$	$ (832,512)	1
2	V	30	DEPRECIATION (SL)				166,281	166,281	2
3	V	32	INTEREST				363,788	363,788	3
4	V	32	AMORT LOAN COST				3,731	3,731	4
5	V	33	REAL ESTATE TAXES				99,167	99,167	5
6	V	36	MIP INSURANCE				48,302	48,302	6
7	V	19	PROFESSIONAL FEES				8,700	8,700	7
8	V	26	INSURANCE-HAZARD				28,090	28,090	8
9	V	20	LICENSES & PERMITS				250	250	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 832,512			$ 718,309	$ * (114,203)	14

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	36	OFFICE RENT	$ 15,600	IME REALTY		$	$ (15,600)	15
16	V								16
17	V	5	UTILITIES				910	910	17
18	V	6	MAINTENANCE & REPAIRS				1,864	1,864	18
19	V	6	ALARM SERVICE				620	620	19
20	V	19	ACCOUNTING FEES				76	76	20
21	V	21	OFFICE EXPENSE				23	23	21
22	V	26	INSURANCE				230	230	22
23	V	30	DEPRECIATION (SL)				1,746	1,746	23
24	V	32	INTEREST				1,723	1,723	24
25	V	33	RE TAX				2,088	2,088	25
26	V	35	RENT EXPENSE				8,809	8,809	26
27	V								27
28	V	17	MANAGEMENT FEES	516,000	DA WESTMONT			(516,000)	28
29	V	17	OFFICER SALARIES-A. WEINFELD				23,257	23,257	29
30	V	17	OFICER SALARIES-D. WEISS				23,257	23,257	30
31	V	17	OTHER SALARIES				46,515	46,515	31
32	V	19	ACCOUNTING FEES				1,307	1,307	32
33	V	27	PAYROLL TAXES				7,249	7,249	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 531,600			$ 119,674	$ * (411,926)	39

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	BOOKKEEPING/ADMINISTRATIVE	$ 78,450	BRIA HEALTH SERVICES, LLC		$	$ (78,450)	15
16	V	17	CFO SALARY-A.WEINFELD				13,306	13,306	16
17	V	10	SALARIES-MEDICARE/NURSING				43,358	43,358	17
18	V	21	SALARIES-PURCHASING D.SEGAL				20,545	20,545	18
19	V	21	SALARIES-CLERICAL RELATED PARTIES				15,100	15,100	19
20	V	21	SALARIES-CLERICAL				62,455	62,455	20
21	V	5	UTILITIES				543	543	21
22	V	6	MAINTENANCE				2,143	2,143	22
23	V	7	SCAVENGER				347	347	23
24	V	10	NURSING CONSULTANT				863	863	24
25	V	19	PROFESSIONAL FEES				5,600	5,600	25
26	V	20	DUES,FEES,SUBSCRIPTIONS				16,633	16,633	26
27	V	21	OFFICE EXPENSE				23,214	23,214	27
28	V	23	SEMINARS				545	545	28
29	V	24	TRAVEL				4,819	4,819	29
30	V	26	INSURANCE				2,016	2,016	30
31	V	27	EMPLOYEE BENEFITS				26,951	26,951	31
32	V	30	DEPRECIATION				9,044	9,044	32
33	V	32	INTEREST				38,630	38,630	33
34	V	33	RE TAX				437	437	34
35	V	36	OFFICE RENT-HINSDALE MGMT				762	762	35
36	V	35	STORAGE FEES				2,131	2,131	36
37	V	35	AUTO LEASE				1,377	1,377	37
38	V	35	EQUIPMENT RENTAL				1,361	1,361	38
39	Total			$ 78,450			$ 292,180	$ * 213,730	39

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	AVRUM & DEVORAH WEINFELD	40.00	BRIA OF CAHOKIA	CAHOKIA	WESTMONT REAL			2
3					ESTATE, LLC	SKOKIE	REAL ESTATE	3
4	DANIEL & REBECCA WEISS	40.00	BRIA OF FOREST EDGE	CHICAGO				4
5					IME REALTY CORP	SKOKIE	HOME OFFICE	5
6	MIRIAM ROBINSON	20.00	BRIA OF BELLEVILLE	BELLEVILLE				6
7					DA WESTMONT	SKOKIE	MGMT CONSULT	7
8			BRIA OF GENEVA	GENEVA				8
9					BRIA HEALTH			9
10			LAKE PARK	WAUKEGAN	SERVICES, LLC	SKOKIE	MGMT SERVICES	10
11								11
12			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				12
13				HEIGHTS				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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	ALLOCATION FROM DA WESTMONT:								$		1
2										17-7	2
3											3
4	AVRUM WEINFELD	CFO	ADMINISTRAT.	40.00		15	12.09	SALARIES	23,257	17-7	4
5											5
6	DANIEL WEISS		ADMINISTRAT.	40.00				SALARIES	23,257	17-7	6
7						10	9.52				7
8											8
9	ALLOCATION FROM BRIA HEALTH SERVICES:										9
10	AVRUM WEINFELD		CFO			15	12.09	SALARIES	13,306	17-7	10
11											11
12											12
13								TOTAL	$ 59,820		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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: IME REALTY CORP.
Street Address: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	121,050	6	$ 7,060	$	15,600	$ 910	1
2	6	MAINTENANCE & REPAIRS	INCOME	121,050	6	14,466		15,600	1,864	2
3	6	ALARM SERVICE	INCOME	121,050	6	4,809		15,600	620	3
4	19	ACCOUNTING FEES	INCOME	121,050	6	593		15,600	76	4
5	21	OFFICE EXPENSE	INCOME	121,050	6	177		15,600	23	5
6	26	INSURANCE	INCOME	121,050	6	1,781		15,600	230	6
7	30	DEPRECIATION (SL)	INCOME	121,050	6	13,548		15,600	1,746	7
8	32	INTEREST	INCOME	121,050	6	13,370		15,600	1,723	8
9	33	RE TAX	INCOME	121,050	6	16,204		15,600	2,088	9
10	35	RENT EXPENSE	INCOME	121,050	6	68,357		15,600	8,809	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					$ 140,365	$		$ 18,089	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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: DA WESTMONT
Street Address: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
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	OFFICER SALARIES-A. WEINFEL	CENSUS DAYS	161,482	3	$ 60,000	$ 60,000	62,594	$ 23,257	1
2	17	OFICER SALARIES-D. WEISS	CENSUS DAYS	161,482	3	60,000	60,000	62,594	23,257	2
3	17	OTHER SALARIES	CENSUS DAYS	161,482	3	120,000	120,000	62,594	46,515	3
4	19	ACCOUNTING FEES	CENSUS DAYS	161,482	3	3,372		62,594	1,307	4
5	27	PAYROLL TAXES	CENSUS DAYS	161,482	3	18,700		62,594	7,249	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					$ 262,072	$ 240,000		$ 101,585	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
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	CFO SALARY-A.WEINFELD	wghtd avr hours		9	$ 96,690	$ 96,690		$ 13,306	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	521,994	9	312,297	312,297	62,594	37,449	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours		9	164,360	164,360		20,545	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours		9	135,820	135,820		15,100	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	521,994	9	520,839	520,839	62,594	62,455	5
6	5	UTILITIES	CENSUS DAYS	521,994	9	4,514		62,594	543	6
7	6	MAINTENANCE	CENSUS DAYS	521,994	9	17,882		62,594	2,143	7
8	7	SCAVENGER	CENSUS DAYS	521,994	9	2,899		62,594	347	8
9	10	NURSING CONSULTANT	CENSUS DAYS	521,994	9	7,200		62,594	863	9
10	19	PROFESSIONAL FEES	CENSUS DAYS	521,994	9	46,709		62,594	5,600	10
11	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	521,994	9	138,710		62,594	16,633	11
12	21	OFFICE EXPENSE	CENSUS DAYS	521,994	9	193,606		62,594	23,214	12
13	23	SEMINARS	CENSUS DAYS	521,994	9	4,537		62,594	545	13
14	24	TRAVEL	CENSUS DAYS	521,994	9	40,190		62,594	4,819	14
15	26	INSURANCE	CENSUS DAYS	521,994	9	16,818		62,594	2,016	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	521,994	9	224,745		62,594	26,951	16
17	30	DEPRECIATION	CENSUS DAYS	521,994	9	75,436		62,594	9,044	17
18	32	INTEREST	CENSUS DAYS	521,994	9	322,149		62,594	38,630	18
19	33	RE TAX	CENSUS DAYS	521,994	9	3,652		62,594	437	19
20	36	OFFICE RENT-HINSDALE MGMT	CENSUS DAYS	521,994	9	6,350		62,594	762	20
21	35	STORAGE FEES	CENSUS DAYS	521,994	9	17,757		62,594	2,131	21
22	35	AUTO LEASE	CENSUS DAYS	521,994	9	11,494		62,594	1,377	22
23	35		CENSUS DAYS	521,994	9	11,352		62,594	1,361	23
24								62,594		24
25	TOTALS					$ 2,376,006	$ 1,230,006		$ 286,271	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: WESTMONT REAL ESTATE, LLC						$	$			$	1
2	CAMBRIDGE REALTY	X		MORTGAGE	$67,995.96	01/31/12	10,881,400	9,589,327	12/01/41	3.7500	363,788	2
3	LOAN COSTS	X		AMORTIZE OVER LIFE OF LOAN			111,302	89,195			3,731	3
4	BRICKYARD BANK	X		WORKING CAPITAL	$16,970.55	11/10/14	2,000,000	1,708,360	11/10/17	6.0000	110,098	4
5	MB FINANCIAL	X		LOAN	$16,250.00	10/29/14	3,900,000	3,640,000	08/05/20	4.7500	180,394	5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL INSUR	DEMAND	09/05/08	2,000,000	400,000		PRIME+	41,844	6
7	F & M WEISS	X		WORKING CAPITAL		12/01/15	600,000	417,085	05/01/21	2.2000	10,566	7
8	RELATED PARETY ALLOCATION										40,353	8
9	TOTAL Facility Related				$101,216.51		$ 19,492,702	$ 15,843,967			$ 750,774	9
	B. Non-Facility Related*											
10	GOODWILL		X	GOODWILL	$42,088.99	09/08	7,500,000	5,138,259	09/33	6.0000	314,544	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$42,088.99		$ 7,500,000	$ 5,138,259			$ 314,544	14
15	TOTALS (line 9+line14)						$ 26,992,702	$ 20,982,226			$ 1,065,318	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 48,302 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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	98,398	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.)	$	98,291	2
3. Under or (over) accrual (line 2 minus line 1).	$	(107)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	99,274	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.	$	99,167	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	96,000	8
	2013	98,535	9
	2014	95,023	10
	2015	97,424	11
	2016	98,291	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 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF WESTMONT COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-22-101-001	NURSING HOME	$ 82,454.92	$ 82,454.92
2.	09-22-101-002	NURSING HOME	$ 6,567.90	$ 6,567.90
3.	09-22-101-003	NURSING HOME	$ 9,268.54	$ 9,268.54
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 98,291.36	$ 98,291.36

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1995	$ 349,103	1
2	PARKING LOT		2006	410,723	2
3	TOTALS			$ 759,826	3

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	215			1995	$ 4,982,301	$ 127,751	39	$ 127,751	$	$ 2,911,782	4
5				2016	6,976,963	178,896	39	178,896		275,798	5
6											6
7	RELATED PARTY ALLOCATIONS					2,702		2,702			7
8											8
	Improvement Type**										
9	FLOORING			1986	41,641		19			41,641	9
10	ROOF & WATER LINE			1987	31,143		20			31,143	10
11	IMPROVEMENTS			1988	44,614		31.5	1,416	1,416	41,767	11
12	IMPROVEMENTS			1989	40,935		31.5	1,299	1,299	36,963	12
13	DRIVEWAY			1989	17,137		15			17,137	13
14	IMPROVEMENTS			1990	37,367		31.5	1,186	1,186	32,564	14
15	IMPROVEMENTS			1991	45,002		31.5	1,428	1,428	37,603	15
16	IMPROVEMENTS			1992	49,649		31.5	1,577	1,577	40,120	16
17	ROOF TOP A/C UNITS			1993	9,100		31.5	289	289	7,201	17
18	IMPROVEMENTS			1993	53,243		39	1,366	1,366	33,317	18
19	IMPROVEMENTS			1994	31,230		39	801	801	18,940	19
20	FLOOR COVERING			1995	795		15			795	20
21	HAND RAIL			1995	2,249		39	58	58	1,327	21
22	FLOOR TILES			1995	5,471		39	140	140	3,168	22
23	WINDOW A/C UNITS			1995	14,146		39	363	363	8,151	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056		39	309	309	6,966	24
25	ALARM			1995	1,337		39	34	34	764	25
26	LAUNDRY BUILDING			1995	35,000		39	897	897	19,996	26
27	ROOF			1995	5,520		39	142	142	3,165	27
28	WINDOWS			1995	9,478		39	243	243	5,397	28
29	DOOR EDGE & DOOR FRAME			1996	2,099		39	54	54	1,186	29
30	LAUNDRY BUILDING			1996	175,187		39	4,491	4,491	96,754	30
31	AIR COOLERS			1996	6,642		39	171	171	3,674	31
32	RACING CAGE			1996	3,987		39	102	102	2,197	32
33	HAND RAIL			1996	1,156		39	30	30	641	33
34	WINDOWS			1996	11,496		39	295	295	6,306	34
35	TACK ROOM			1996	2,139		39	55	55	1,171	35
36	NEW CONFERENCE ROOM TILE			1997	2,938		39	76		1,542	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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 DIETARY DOOR	1997	$ 1,478	$	39	$ 38	$ 38	$ 771	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	2,778	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	704	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	587	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	2,484	41
42	THE PARKING LOT	1998	42,711		15			42,711	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223		39	160	160	3,183	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	6,235	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	5,100	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,665	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	711	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	1,378	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	4,265	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	1,126	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	1,293	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	1,359	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	1,432	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	562	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	3,353	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	1,263	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	2,934	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	2,248	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	17,174	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	2,633	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,806	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	2,914	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	72,468	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	18,673	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	63,912	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	5,310	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	7,267	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	230,231	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	23,296	69
70	TOTAL (lines 4 thru 69)		$ 13,363,617	$ 309,349		$ 354,839	$ 45,414	$ 4,223,002	70

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 13,363,617	$ 309,349		$ 354,839	$ 45,490	$ 4,223,002	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997		15	417	417	8,997	2
3	SHOWER ROOM	2002	30,924		27.5	1,125	1,125	17,109	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010		27.5	328	328	4,934	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891		27.5	541	541	8,138	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	32,048	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	9,200	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767		27.5	464	464	6,709	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152		27.5	1,133	1,133	16,381	9
10	THERAPY ROOM -FLOORING	2003	87,509		27.5	3,182	3,182	46,006	10
11	CONFERENCE ROOM-FLOORING	2003	2,073		27.5	76	76	1,099	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421		27.5	270	270	3,634	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825		27.5	3,266	3,266	43,411	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925		27.5	1,852	1,852	24,462	14
15	RESIDENT ROOMS-FLOORING	2005	9,821		27.5	357	357	4,537	15
16	INSTALL CABLING SYSTEM	2005	46,771		27.5	1,701	1,701	21,475	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000		27.5	1,018	1,018	12,258	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286		20	2,914	2,914	37,882	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260		27.5	155	155	1,841	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838		27.5	2,321	2,321	27,368	20
21	AIR CONDITIONS	2006	7,968		27.5	289	289	3,319	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652		27.5	169	169	1,951	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200		27.5	380	380	4,180	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		141,418	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,575	27.5	8,575		89,680	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360		5			84,360	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	113	27.5	113		1,182	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594		5			18,594	30
31	INSTALLATION OF RAILLING ON EXTERIROR STAIRS	2007	6,407	233	27.5	233		2,436	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		1,182	32
33	AIR CONDITIONS	2008	12,661		5			12,661	33
34	TOTAL (lines 1 thru 33)		$ 14,568,377	$ 332,175		$ 402,201	$ 70,026	$ 4,911,454	34

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 14,568,377	$ 332,175		$ 402,201	$ 70,026	$ 4,911,454	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		1,248	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		993	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		1,013	4
5	2ND FLOOR CORRIDOR-CARPET, WALLCOVERING	2009	103,122		5			103,122	5
6	WALL AIR CONDITIONS	2009	9,397		5			9,397	6
7	1ST FLOOR RESIDENT ROOMS-WINDOW TREATMENTS	2009	16,265		5			16,265	7
8	INSTALLATION OF SIGNAGE	2009	8,020	535	15	535		4,414	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		756	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		1,222	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		1,715	11
12	WALL AIR CONDITIONS	2010	7,612		5			7,612	12
13	1ST FLOOR DINING ROOM-WALLCOVERING, BLINDS	2010	19,660		5			19,660	13
14	A-WING RESIDENT ROOM-BUIT-IN WARDROBES	2010	11,222	408	27.5	408		2,958	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		1,682	15
16	1ST FLOOR DINING ROOM.MEDICAL RECORDS,2ND FLOOR								16
17	DINING ROOM,ACTIVITY ROOM,BEAUTY SHOP, UTILITY								17
18	ROOM-FLOORING. WINDOW TREATMENTS	2011	19,818		5			19,818	18
19	INSTALL WATER HEATER	2011	11,585	421	27.5	421		2,859	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOO	2011	6,150	224	27.5	224		1,503	20
21	INSTALL FIRE ALARM SMOKES, HEATS, AV DEVCIE	2011	85,377	3,105	27.5	3,105		20,571	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	535	27.5	535		3,455	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	91	27.5	91		580	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	336	27.5	336		2,030	24
25	INSTALL ACCUTECH SYSTEM FOR FRONT DOOR	2012	4,814	175	27.5	175		1,028	25
26	DELAYED EGRESS LOCKING SYSTEM FOR 1ST FLOOR	2012	12,600	458	27.5	458		2,653	26
27	ROOM F-16 -INSTALL NEW PVT & COVE BASE	2012	5,316	193	27.5	193		1,053	27
28	PLASTER, PRIME & PAINT ALL ROOMS & BATH	2012	10,631	387	27.5	387		2,048	28
29	WEST PARKING LOT-SEALCOAT, CRACK FILLING,								29
30	STRIPING, ASPHALTING	2013	4,460	297	15	297		1,361	30
31	EMPLOYEE ENTRANCE DOOR & FRAME REPLACEMENT	2013	3,254	118	27.5	118		497	31
32	2ND FLOOR CORRIDOR-CEILINGS ; REMODEL MEN BATH								32
33	ROOM ON THE 1ST FLOOR: TILE, VANITY, FAUSET	2013	15,433	561	27.5	561		2,314	33
34	TOTAL (lines 1 thru 33)		$ 14,976,975	$ 341,015		$ 411,041	$ 70,026	$ 5,145,281	34

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 12C, Carried Forward		$ 14,976,975	$ 341,015		$ 411,041	$ 70,026	$ 5,145,281	1
2	1ST & 2ND FLOOR LOBBY, FRONT CORRIDOR,RESIDENT								2
3	CORRIDORS: FLOORING,WALLCOVERING,PAINTING	2013	124,977	4,545	27.5	4,545		20,642	3
4	REMODEL 7 BATHROOMS IN PATIOS ROOMS ON THE 1ST								4
5	FLOOR: PLUMBING, ELECTRIC, OUTLETS FOR LIGHTS	2014	16,150	587	27.5	587		2,324	5
6	RESIDENT ROOMS: CURTAIN, WINDOW TREATMENTS	2014	15,035	1,732	5	1,732		12,437	6
7									7
8	BUILDING RENOVATION :	2016	605,378	22,014	27.5	22,014		33,938	8
9	PRIVATE ROOMS, SEMI PRIVATE ROOMS,SOUTH NURSES STATION AND MEDICINE ROOM, A B C -WINGS CORRIDOR, BATHROOM &								9
10	SHOWER ROOMS-CLOSET INSERTS,UNITS OF ROOM DIVIDERS,FLOORING, WALLS & CEILINGS, NEW TILE, PLUMBING,								10
11	ELECTRIC, PAINTING,WINDOW TREATMENTS,SIGNAGE, INSTALL KEY PAD AT SECOND FLOOR HALL STATION								11
12	2ND FLOOR CORRIDOR: INSTALLATION OF CUSTOM TILE,								12
13	MILLWORK BASE	2016	51,474	1,872	27.5	1,872		2,418	13
14	RESIDENT ROOMS-COVE BASE, VINYL INSTALLATION	2017	5,329	186	27.5	186		186	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)		$ 15,795,318	$ 371,951		$ 441,977	$ 70,026	$ 5,217,226	34

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 558,396	$ 97,882	$ 66,931	$ (30,951)	3-10	$ 160,832	71
72	Current Year Purchases	9,142	1,828	571	(1,257)		571	72
73	Fully Depreciated Assets	1,091,928					1,091,928	73
74	RELATED PARTY ALLOCATIONJS		8,088	8,088				74
75	TOTALS	$ 1,659,466	$ 107,798	$ 75,590	$ (32,208)		$ 1,253,331	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)	$ 18,214,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 479,749	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 517,567	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 37,818	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,470,557	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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: $ 53,332 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	2014 FORD E350	$ #######	$ 15,017	17
18	ADMINISTRATIVE	2014 HONDA CRV	424.39	3,395	18
19	FACILITY	2017 FORD ESCAPE	458.79	3,146	19
20	ADMINISTRATIVE	2018 JEEP COMPASS	455.05	3,214	20
21	TOTAL		$ #######	$ 24,772	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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 379,015	$		$ 379,015	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			118,922			118,922	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			452,966			452,966	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				322,340		322,340	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): RENTALS	39-2					187,084		187,084	13
14	TOTAL			$		$ 950,903	$ 509,424		$ 1,460,327	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 WESTMONT **#** 0050120 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 193,377	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 160,000)	3,380,885		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,799		6
7	Other Prepaid Expenses	3,232		7
8	Accounts Receivable (owners or related parties)	436,473		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,125,766	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,976,963		14
15	Leasehold Improvements, at Historical Cost	662,182		15
16	Equipment, at Historical Cost	562,459		16
17	Accumulated Depreciation (book methods)	(732,216)		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 (spe GOODWILL	7,500,000		22
23	Other(specify): AMORT OF GOODWILL	(4,666,667)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,302,721	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,428,487	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,739,953	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,606		28
29	Short-Term Notes Payable	400,000		29
30	Accrued Salaries Payable	141,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,222		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)**	$ 2,316,833	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,903,704		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)**	$ 10,903,704	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,220,537	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,207,950	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,428,487	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 513,500	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)**	$ 513,501	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	694,449	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)**	$ 694,449	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)**	$ 1,207,950	24 *

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 15,177,094	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,177,094	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***	5,408	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,408	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	59,026	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 59,026	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,241,528	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,460,362	31
32	Health Care	4,945,276	32
33	General Administration	2,854,561	33
	B. Capital Expense		
34	Ownership	2,386,340	34
	C. Ancillary Expense		
35	Special Cost Centers	1,460,552	35
36	Provider Participation Fee	439,988	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,547,079	40
41	**Income before Income Taxes (line 30 minus line 40)****	694,449	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 694,449	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,414,451	44
45	Private Pay - Net Inpatient Revenue	758,527	45
46	Medicare - Net Inpatient Revenue	3,987,968	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	809,994	47
48	Other-(specify) MANAGED CARE	1,206,154	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,177,094	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 WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	1,952	2,104	$ 107,805	$ 51.24	1
2	Assistant Director of Nursing	7,141	7,454	229,181	30.75	2
3	Registered Nurses	34,740	36,323	1,190,807	32.78	3
4	Licensed Practical Nurses	26,966	28,180	792,764	28.13	4
5	CNAs & Orderlies	111,411	116,438	1,594,742	13.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,039	13,575	184,656	13.60	10
11	Social Service Workers	3,929	4,126	85,836	20.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,291	33,794	388,258	11.49	15
16	Dishwashers					16
17	Maintenance Workers	6,967	7,492	132,423	17.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,008	2,040	130,375	63.91	20
21	Assistant Administrator	1,968	2,180	72,398	33.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,231	18,597	355,719	19.13	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	2,175	2,351	40,391	17.18	31
32	Other Health C: Care Plan Coord	6,395	6,750	248,105	36.76	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	270,213	281,404	$ 5,553,460 *	$ 19.73	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 98,173	1-3	35
36	Medical Director	O	57,000	9-3	36
37	Medical Records Consultant	N	423	10-3	37
38	Nurse Consultant	T	40,805	10-3	38
39	Pharmacist Consultant	H	16,647	10-3	39
40	Physical Therapy Consultant	L	13,859	10a-3	40
41	Occupational Therapy Consultant	Y	7,915	10a-3	41
42	Respiratory Therapy Consultant		5,286	10a-3	42
43	Speech Therapy Consultant	F	2,978	10a-3	43
44	Activity Consultant	E	2,908	11-3	44
45	Social Service Consultant	E	1,636	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 247,630		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	42	1,521	10-3	51
52	Certified Nurse Assistants/Aides	149	4,003	10-3	52
53	TOTAL (lines 50 - 52)	191	$ 5,524		53

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EFRIAM WEINFELD	ADMINISTRATOR	0	$ 130,375
OSWALDO MORALES	ASST ADMIN	0	72,398
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 202,773

B. Administrative - Other

Description		Amount
DA WESTMONT	MANAGEMENT FEES	$ 516,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 516,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 9,937
NATIONAL DATACARE	DATA PROCESSING	3,724
KBKB, LTD	ACCOUNTING FEE	18,000
RICHARD PEELO & ASSOCIAT	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	U/C CONSULTANT	1,228
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN	78,450
MCCABE KIRSHNER P.C.	ENGAGEMENT OF WTW	1,250
US HOUSING CONSULTANT	PRE-REAC INSPECTION	5,935
COMPLIANCE RESOURCES INC	THERAPY COMPLIANCE	1,330
ECONOCARE	DESIGN FEE	3,200
LEGAL FEES	SEE SCHEDULE	34,928
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 162,482

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,020
Unemployment Compensation Insurance	85,058
FICA Taxes	416,576
Employee Health Insurance	105,096
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	87,627
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 817,377

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	9,165
Health Care Worker Background Check	2,751
(Indicate # of checks performed 57)	
Patient Background Checks 221	2,675
TRUST/FRANCHISE/CONTRIB/ETC	9,197
MARKETING/ADV/PROMO	41,033
LICENSES/DUES/SUBSCRIPTIONS	39,942
MGMT CO ALLOC	16,883
TRUST/FRANCHISE/CONTRIB/ETC	(9,197)
Less: Public Relations Expense	(0)
Non-allowable advertising	(41,033)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,406

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,656
MGMT CO ALLOC	4,819
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,475

**See instructions.

BRIA OF WESTMONT
SCHEDULE-LEGAL
12/31/2017

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
1/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	2,491
2/28/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	3,741
3/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	2,386
4/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,330
5/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,013
6/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,282
7/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,282
8/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	122
9/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
10/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
11/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
12/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	578
1/2/2017	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	553
3/2/2017	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	358
1/30/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	936
5/3/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	65
5/24/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	129
7/8/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	968
7/8/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	1,740
9/11/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	86
9/11/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	108
8/4/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	22
8/4/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	1,463
9/30/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	22
11/11/2017	CHUBB GROUP OF INSURANCE CONMPAIES	SETTLEMENT	22
7/10/2017	LAW OFFICES OF PETER F. FERRACUTI	APPERANCES IN COURT	500
10/11/2017	LAW OFFICES OF PETER F. FERRACUTI	LETTER TO DEFENDANT, TELEPHONE CONFERENCE	500
11/17/2017	SB2 INC	BRIA-002 MONTHLY PROJECT	500
12/1/2017	SB2 INC	BRIA-002 MONTHLY PROJECT	500
13/31/17	SB2 INC	BRIA-002 MONTHLY PROJECT	500
12/31/2017	SB2 INC	MPIL-BRIA	172
12/6/2017	DRINKERBIDDLE & REATH	HIPAA COMPIANCE	550
	MB FINANCIAL	RENEWAL LOC	600
6/15/2017	BRICKYARD BANK	RENEWAL LOAN	1,315
		LEGAL SETTLEMENTS	7,000
TOTAL			**34,928**

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $ 22,834**

(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. $ **52,634** 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.
WESTMONT CONVALESCENT CENTER, # 0030015 09/03/08

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **439,988**
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