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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0048645

Facility Name: BRIA OF CAHOKIA, LLC

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

County: ST. CLAIR

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

HFS ID Number:

Date of Initial License for Current Owners: 5/1/00

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA 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 01/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARTIN WEISS
(Title) MEMBER

Paid Preparer

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

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	133	TOTALS	133	48,545	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,740	2,740	8
9	SNF/PED					9
10	ICF	39,273		294	39,567	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,273		3,034	42,307	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.15%

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 5/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 2,740

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	171,508	21,817	14,773	208,098		208,098		208,098			1
2	Food Purchase		235,877		235,877		235,877	(41)	235,836			2
3	Housekeeping	262,418	46,668		309,086		309,086		309,086			3
4	Laundry	65,266	20,167	2,470	87,903		87,903		87,903			4
5	Heat and Other Utilities			113,489	113,489		113,489		113,489			5
6	Maintenance	94,360	47,967	15,859	158,186		158,186	751	158,937			6
7	Other (specify):*			19,975	19,975		19,975	119	20,094			7
8	TOTAL General Services	593,552	372,496	166,566	1,132,614		1,132,614	829	1,133,443			8
	B. Health Care and Programs											
9	Medical Director			12,334	12,334		12,334		12,334			9
10	Nursing and Medical Records	2,164,391	134,752	10,354	2,309,497		2,309,497	18,383	2,327,880			10
10a	Therapy			51,415	51,415		51,415		51,415			10a
11	Activities	97,981	2,441	1,521	101,943		101,943		101,943			11
12	Social Services	129,475	1,418	3,471	134,364		134,364		134,364			12
13	CNA Training											13
14	Program Transportation			455	455		455		455			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,391,847	138,611	79,550	2,610,008		2,610,008	18,383	2,628,391			16
	C. General Administration											
17	Administrative	82,776		480,000	562,776		562,776	(405,500)	157,276			17
18	Directors Fees											18
19	Professional Services			378,832	378,832		378,832	(193,535)	185,297			19
20	Dues, Fees, Subscriptions & Promotions			52,287	52,287		52,287	(20,221)	32,066			20
21	Clerical & General Office Expenses	132,285	19,903	161,826	314,014		314,014	52,817	366,831			21
22	Employee Benefits & Payroll Taxes			443,640	443,640		443,640		443,640			22
23	Inservice Training & Education			10,425	10,425		10,425	612	11,037			23
24	Travel and Seminar			22,510	22,510		22,510	2,882	25,392			24
25	Other Admin. Staff Transportation							(5,358)	(5,358)			25
26	Insurance-Prop.Liab.Malpractice			145,896	145,896		145,896	25,378	171,274			26
27	Other (specify):*			153,462	153,462		153,462	(121,282)	32,180			27
28	TOTAL General Administration	215,061	19,903	1,848,878	2,083,842		2,083,842	(664,207)	1,419,635			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,200,460	531,010	2,094,994	5,826,464		5,826,464	(644,995)	5,181,469			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BRIA OF CAHOKIA, LLC **#0048645** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	13,242	
	REPAIRS & MAINTENANCE		1,531	
				14,773
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,470	
				2,470
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		8,069	
	ELECTRICITY		74,770	
	WATER		23,353	
	CABLE TV - LOBBY		7,297	
				113,489
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,313	
	PAINTING & DECORATING			
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR			
	ELEVATOR MAINTENANCE & REPAIR			
	OUTSIDE LABOR			
	EXTERMINATING SERVICE			
	FIRE SERVICE		13,546	
				15,859
7	**OTHER**			
	SCAVENGER 7 EXTERMINATING SERVICES		19,975	
	SECURITY SERVICE			
				19,975
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,334	12,334

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	18	
	LABORATORY & XRAY EXPENSE			
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2		
	PHARMACY CONSULTANT	XVIII B 39-2	10,336	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2		
				10,354
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	28,043	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	17,237	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	195	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	5,940	
				51,415
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,521	
				1,521
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	3,471	
	SOCIAL WORKER	XVIII B 45-2		
				3,471
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number BRIA OF CAHOKIA, LLC **#0048645** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		455	
				455
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	480,000	480,000
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,385	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	153,547	
	BOOKKEEPING/ADMINISTATIVE SERVICE		211,900	378,832
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,157	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	9,134	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	9,087	
	LICENSES & PERMITS	XIX F	2,475	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	13,624	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,910	
	PATIENT BACKGROUND CHECKS	XIX F	3,900	
				52,287
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,840	
	EQUIPMENT REPAIR & MAINTENANCE		102,670	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18	24,757	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		28,459	
	MESSENGER SERVICE		3,100	
				161,826

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	242,028	
	UNEMPLOYMENT COMPENSATION	XIX D	48,142	
	WORKERS COMPENSATION INSURANC	XIX D	59,231	
	HOSPITALIZATION INSURANCE	XIX D	69,018	
	EMPLOYEE BENEFITS - OTHER	XIX D	25,221	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				443,640
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,425	
				10,425
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	22,510	
				22,510
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF			
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		145,896	
				145,896
27	**OTHER**			
	BAD DEBTS	VI 24	153,462	
				153,462

GRAND TOTAL COLUMN 3 OTHER **2,094,994**

BRIA OF CAHOKIA, LLC
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	235,877
LESS SALES TAX	(41)
NET FOOD	235,836
TOTAL PATIENT CENSUS	42,307
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	126,921
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	17,885
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	126,921
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	126,921
NET FOOD	235,836
DIVIDE TOTAL MEALS/YEAR	126,921
COST PER MEAL	1.86
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFIC	**0**

Facility Name & ID Number BRIA OF CAHOKIA, LLC #0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			106,044	106,044		106,044	82,820	188,864			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,894	39,894		39,894	245,895	285,789			32
33	Real Estate Taxes							45,749	45,749			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(540,000)				34
35	Rent-Equipment & Vehicles			18,112	18,112		18,112	7,066	25,178			35
36	Other (specify):* STORAGE			1,506	1,506		1,506	47,019	48,525			36
37	**TOTAL Ownership**			705,556	705,556		705,556	(111,451)	594,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,751	794,136	878,887		878,887		878,887			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			317,553	317,553		317,553		317,553			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		84,751	1,111,689	1,196,440		1,196,440		1,196,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,200,460	615,761	3,912,239	7,728,460		7,728,460	(756,446)	6,972,014			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Reference	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	(49,158)	30		9
10	Interest and Other Investment Income	(3,438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(41)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(13,624)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(153,462)	27		24
25	Fund Raising, Advertising and Promotional	(12,157)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(38,492)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (270,372)		$	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)	(486,074)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (486,074)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (756,446)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRIA OF CAHOKIA, LLC

ID# 0048645

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (33,134)	21	1
2	TRAVEL-MARKETING	(5,358)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
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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**	(38,492)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(41)	0	0	0	0	0	0	0	0	0	0	(41)	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	751	0	0	0	0	0	0	0	751	6
7	Other (specify):*	0	0	0	119	0	0	0	0	0	0	0	119	7
8	**TOTAL General Services**	(41)	0	0	870	0	0	0	0	0	0	0	829	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	18,383	0	0	0	0	0	0	0	18,383	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	18,383	0	0	0	0	0	0	0	18,383	16
	C. General Administration													
17	Administrative	0	0	(411,000)	5,500	0	0	0	0	0	0	0	(405,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,700	1,956	(208,191)	0	0	0	0	0	0	0	(193,535)	19
20	Fees, Subscriptions & Promotions	(25,781)	0	105	5,455	0	0	0	0	0	0	0	(20,221)	20
21	Clerical & General Office Expenses	(33,134)	0	508	85,443	0	0	0	0	0	0	0	52,817	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	612	0	0	0	0	0	0	0	612	23
24	Travel and Seminar	0	0	0	2,882	0	0	0	0	0	0	0	2,882	24
25	Other Admin. Staff Transportation	(5,358)	0	0	0	0	0	0	0	0	0	0	(5,358)	25
26	Insurance-Prop.Liab.Malpractice	0	17,795	5,349	2,234	0	0	0	0	0	0	0	25,378	26
27	Other (specify):*	(153,462)	0	15,514	16,666	0	0	0	0	0	0	0	(121,282)	27
28	**TOTAL General Administration**	(217,735)	30,495	(387,568)	(89,399)	0	0	0	0	0	0	0	(664,207)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(217,776)	30,495	(387,568)	(70,146)	0	0	0	0	0	0	0	(644,995)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(49,158)	127,456	1,128	3,394	0	0	0	0	0	0	0	82,820	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,438)	223,575	0	25,758	0	0	0	0	0	0	0	245,895	32
33	Real Estate Taxes	0	45,749	0	0	0	0	0	0	0	0	0	45,749	33
34	Rent-Facility & Grounds	0	(540,000)	0	0	0	0	0	0	0	0	0	(540,000)	34
35	Rent-Equipment & Vehicles	0	0	5,115	1,951	0	0	0	0	0	0	0	7,066	35
36	Other (specify):*	0	47,019	0	0	0	0	0	0	0	0	0	47,019	36
37	TOTAL Ownership	(52,596)	(96,201)	6,243	31,103	0	0	0	0	0	0	0	(111,451)	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)	(270,372)	(65,706)	(381,325)	(39,043)	0	0	0	0	0	0	0	(756,446)	45

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 540,000	JEROME LANE, LLC		$	$ (540,000)	1
2	V								2
3	V	30	DEPRECIATION				127,456	127,456	3
4	V	32	INTEREST EXPENSE				218,675	218,675	4
5	V	32	AMORT LOAN COST				4,900	4,900	5
6	V	33	REAL ESTATE TAXES				45,749	45,749	6
7	V	19	PROFESSIONAL FEES				12,700	12,700	7
8	V	36	INSURANCE-MIP				47,019	47,019	8
9	V	26	INSURANCE-HAZART				17,795	17,795	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 540,000			$ 474,294	$ * (65,706)	14

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 480,000	WEISS MANAGEMENT GROUP		$	$ (480,000)	15
16	V								16
17	V								17
18	V	17	ADMINISTRATIVE SALARIES				69,000	69,000	18
19	V	19	PROFESSIONAL FEES				1,956	1,956	19
20	V	20	LICENSES & PERMITS				105	105	20
21	V	21	OFFICE EXPENSES				508	508	21
22	V	26	INSURANCE				5,349	5,349	22
23	V	27	EMPLOYEE BENEFITS				15,514	15,514	23
24	V	30	DEPRECIATION (SL)				1,128	1,128	24
25	V	35	AUTO LEASE				5,115	5,115	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 480,000			$ 98,675	$ * (381,325)	39

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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/ADM SERVICES	$ 211,900	BRIA HEALTH SERVICES, LLC		$	$ (211,900)	15
16	V	17	CFO SALARY-A.WEINFELD				5,500	5,500	16
17	V	10	SALARIES-MEDICARE/NURSING				17,794	17,794	17
18	V	21	SALARIES-PURCHASING D.SEGAL				15,580	15,580	18
19	V	21	SALARIES-CLERICAL RELATED PARTIES				1,626	1,626	19
20	V	21	SALARIES-CLERICAL				54,937	54,937	20
21	V	6	MAINTENANCE				751	751	21
22	V	7	SCAVENGER				119	119	22
23	V	10	NURSING CONSULTANT				589	589	23
24	V	19	PROFESSIONAL FEES				3,709	3,709	24
25	V	20	DUES,FEES,SUBSCRIPTIONS				5,455	5,455	25
26	V	21	OFFICE EXPENSE				13,300	13,300	26
27	V	23	SEMINARS				612	612	27
28	V	24	TRAVEL				2,882	2,882	28
29	V	26	INSURANCE				2,234	2,234	29
30	V	27	EMPLOYEE BENEFITS				16,666	16,666	30
31	V	30	DEPRECIATION				3,394	3,394	31
32	V	32	INTEREST				25,758	25,758	32
33	V	35	AUTO LEASE				1,061	1,061	33
34	V	35	EQUIPMENT RENTAL				890	890	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 211,900			$ 172,857	$ * (39,043)	39

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	MARTIN J. WEISS	30.00	BRIA OF BELLEVILLE	BELLEVILLE	WEISS MGMT		MANAGEMENT/	1
2	NATAN WEISS	30.00			GROUP, INC	SKOKIE	CLERICAL	2
3	DANIEL WEISS	30.00	BRIA OF GENEVA	GENEVA				3
4	GARY A. WEINTRAUB	10.00			BRIA HEALTH		MANAGEMENT	4
5			BRIA OF FOREST EDGE	CHICAGO	SERVICES, LLC	SKOKIE	SERVICES	5
6								6
7			LAKE PARK CENTER	WAUKEGAN	JEROME LANE,		REAL ESTATE	7
8					LLC	SKOKIE		8
9			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				9
10				HEIGHTS				10
11								11
12			BRIA OF WESTMONT	WESTMONT				12
13								13
14			BRIA OF PALOS HILLS	PALOS HILLS				14
15								15
16			BRIA OF RIVER OAKS	BURNHAM				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIC	30.00	SEE	15	38.00	SALARY	45,000	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	30.00	SCHEDULE	4	10.00	SALARY	12,000	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	30.00		4	10.00	SALARY	12,000	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,000		13

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

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: WEISS MANAGEMENT GROUP
Street Address: 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	ADMINISTRATIVE SALARIES	wghtd avr hours		2	$ 138,000	$ 138,000		$ 69,000	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	82,059	2	3,794		42,307	1,956	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	82,059	2	203		42,307	105	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	82,059	2	985		42,307	508	4
5	26	INSURANCE	PATIENT CENSUS	82,059	2	10,374		42,307	5,349	5
6	27	EMPLOYEE BENEFITS	PATIENT CENSUS	82,059	2	30,092		42,307	15,514	6
7	30	DEPRECIATION (SL)	PATIENT CENSUS	82,059	2	2,187		42,307	1,128	7
8	35	AUTO LEASE	PATIENT CENSUS	82,059	2	9,922		42,307	5,115	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					$ 195,557	$ 138,000		$ 98,675	25

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	$ 99,000	$ 99,000		$ 5,500	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	516,944	9	217,425	217,425	42,307	17,794	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours		9	148,012	148,012		15,580	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours		9	41,826	41,826		1,626	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	516,944	9	671,273	671,273	42,307	54,937	5
6	6	MAINTENANCE	CENSUS DAYS	516,944	9	9,177		42,307	751	6
7	7	SCAVENGER	CENSUS DAYS	516,944	9	1,451		42,307	119	7
8	10	NURSING CONSULTANT	CENSUS DAYS	516,944	9	7,200		42,307	589	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	516,944	9	45,319		42,307	3,709	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	516,944	9	66,654		42,307	5,455	10
11	21	OFFICE EXPENSE	CENSUS DAYS	516,944	9	162,507		42,307	13,300	11
12	23	SEMINARS	CENSUS DAYS	516,944	9	7,477		42,307	612	12
13	24	TRAVEL	CENSUS DAYS	516,944	9	35,214		42,307	2,882	13
14	26	INSURANCE	CENSUS DAYS	516,944	9	27,300		42,307	2,234	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	516,944	9	203,639		42,307	16,666	15
16	30	DEPRECIATION	CENSUS DAYS	516,944	9	41,469		42,307	3,394	16
17	32	INTEREST	CENSUS DAYS	516,944	9	314,739		42,307	25,758	17
18	35	AUTO LEASE	CENSUS DAYS	516,944	9	12,960		42,307	1,061	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	516,944	9	10,875		42,307	890	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,123,517	$ 1,177,536		$ 172,857	25

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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: JEROM LANE, LLC						$	$			$	1
2	CAMBRIDGE REALTY	X		MORTGAGE	$27,131.58	11/01/16	6,705,000	6,478,443	10/01/51	3.3500	218,675	2
3	LOAN COSTS	X		AMORT OVER LIFE OF LOAN			171,492	160,875			4,900	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	05/08/11	2,000,000	440,768		PRIME+	38,261	6
7		X		INSURANCE FINANCING							1,633	7
8	RELATED PARTY ALLOCATION										25,758	8
9	TOTAL Facility Related				$27,131.58		$ 8,876,492	$ 7,080,086			$ 289,227	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,876,492	$ 7,080,086			$ 289,227	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 47,019 Line # 36

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

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	60,341	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.)	$	52,781	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,560)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	53,309	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,749	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	45,604	8
2014	49,245	9
2015	50,678	10
2016	59,743	11
2017	52,781	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF CAHOKIA, LLC COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0048645

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-12.0-206-016	NURSING HOME	$ 52,781.22	$ 52,781.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,781.22	$ 52,781.22

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 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2014	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	133		2014		$ 2,668,552	$ 97,038	27.5	$ 97,038	$	$ 456,576	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				59,191	1,670		1,670			8
	Improvement Type**										
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2006	30,000	1,091	27.5	1,091		13,292	9
10	AIR CONDITIONS			2006	947		5			947	10
11	INSTALLATION OF EXAUST SYSTEM			2007	3,340	121	27.5	121		1,447	11
12	AIR CONDITIONS			2007	11,065		5			11,065	12
13	INSTALLATION OF ROOFTOP UNIT			2007	4,140	151	27.5	151		1,755	13
14	CALLCARE STATION REPLACEMENT			2007	3,122	114	27.5	114		1,316	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIO			2007	6,870	458	15	458		5,076	15
16	INSTALLATION OF DOORS-FRONT ENTRANCE,VESTIBULE			2007	11,640	423	27.5	423		4,706	16
17	PAINTING			2007	7,587		5			7,587	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS			2007	14,027		5			14,027	18
19	BUILDING RENOVATION AND REMODELING:			2007	228,253	8,300	27.5	8,300		91,646	19
20	A,B,C,D-WINGS CORRIDOR,RISIDENT ROOMS, THERAPY										20
21	ROOM,LOBBY, RECEPTION,ACTIVITY ROOM, HALL-LIGHT										21
22	FIXTURES,FLOORING,CEILING GRID & TILE,HANDRAILS,										22
23	CORNER GUARDS,NURSES STATION B-WING CORRIDOR										23
24	D-WING RESIDENT ROOM-FLOORING			2008	34,382	1,250	27.5	1,250		13,490	24
25	SHOWER-VARIOUS DIFFERENT AREAS			2008	16,266	591	27.5	591		6,329	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2008	26,400	960	27.5	960		10,120	26
27	INSTALLED NEW OFFICE, SIDEWALK TO THE OFFICE			2008	29,175	1,061	27.5	1,061		11,185	27
28	INSTALLATION OF ALARM SYSTEM			2008	42,875	1,559	27.5	1,559		16,305	28
29	INSTALLATION OF DOORS-OXYGEN ROOM, COURTYARD			2008	6,147	224	27.5	224		2,361	29
30	AIR CONDITIONS, WATER HEATER			2008	5,513		5			5,513	30
31	REPLACE EXISTING SPRINKLER PIPING			2008	9,498	345	27.5	345		3,493	31
32	SEALING PARKING LOT			2008	2,500	167	15	167		1,726	32
33	WALL AIR CONDITIONS			2009	6,308		5			6,308	33
34	WANDERGUARD E. STANDARD, BUMPER GUARD			2009	10,612	386	27.5	386		3,554	34
35	LOUNGE,RESIDENT & ACTIVITY ROOMS-FLOORING			2010	16,410	597	27.5	597		5,348	35
36	WALL AIR CONDITIONS			2010	6,712		5			6,712	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL DOORS AND HARDWARE	2010	$ 2,966	$ 108	27.5	$ 108	$	$ 914	37
38	INSTALL ACCELERATOR, REPLACE DRY PENDENT	2010	3,218	117	27.5	117		990	38
39	RANCH STYLE GARAGE	2010	15,515	564	27.5	564		4,724	39
40	NEW LAUNDRY ROOM-INSTALL DOORS,CONCRETE SLAB	2010	28,249	1,027	27.5	1,027		8,259	40
41	FOOTING FOR PERMIT,ELECTRICAL,WIRING,WINDOW,TILE								41
42	WALL AIR CONDITIONS	2011	6,639		5			6,639	42
43	SEAL COATING PARKING LOT	2011	20,931	1,395	15	1,395		10,928	43
44	INSTALLED QUARTER BARREL STYLE AWNINGS	2011	2,955	107	27.5	107		825	44
45	RESIDENT ROOMS-CUSTOM BUILT-IN WARDROBES	2011	18,278	665	27.5	665		5,126	45
46	INSTALL RTU & DUST RUN FROM ATTIC INTO ADM OFFIC	2011	12,989	472	27.5	472		3,481	46
47	SHOWER ROOM: FOUR PIESE FIBERGLASS SHOWER;	2011	12,163	442	27.5	442		3,186	47
48	FULL PLYWOOD BACKING ON ALL WALLS; POLYESTER								48
49	GELCOAT FINISH								49
50	WALL AIR CONDITIONS	2012	12,123		5	2,425	2,425	9,699	50
51	INSTALLED 35 GALLON GREASE TRAP IN THE FLOOR	2012	13,900	505	27.5	505		3,304	51
52	REPLACED PIPE IN ATTIC , INSTALLED COMPRESSOR	2012	12,100	440	27.5	440		2,805	52
53	WALL AIR CONDITIONS	2013	6,903	198	5	198		6,903	53
54	SPRINKLERS	2013	91,610	3,331	27.5	3,331		18,737	54
55	CARPET FOR COFFICES AND LOBBY INSET; WALK-OFF								55
56	CARPET; WALL BASE	2013	5,794	578	5	578		5,794	56
57	PLASTER CEILING-INSTALL 2 EXPANSION JOINTS; ATTIC								57
58	SPACE-RE-INSULATE WITH 6" BLOWN	2013	10,338	376	27.5	376		1,896	58
59	WALL AIR CONDITIONS	2014	10,764	620	5	620		6,148	59
60	INSTALL REDUCED PRESSURE BACKFLOW PREVENTER								60
61	ON FIRE SPRINKLER SERVICE	2014	8,815	321	27.5	321		1,458	61
62	POUR AND FINISH PAD AND WALKWAY	2015	18,283	665	27.5	665		2,466	62
63	INSTALLED A NEW DURO-LAST ROOFING SYSTEM	2015	18,397	669	27.5	669		2,035	63
64	INSTALLSUBPANELS AND FEED PTAC UNITS	2015	21,640	787	27.5	787		2,394	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,616,102	$ 129,893		$ 132,318	$ 2,425	$ 810,595	70

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 3,616,102	$ 129,893		$ 132,318	$ 2,425	$ 810,595	1
2	RELATED RARTY: JEROM LANE, LLC								2
3	INSTALLED A NEW DURO-LAST ROOFING SYSTEM	2016	66,725	2,426	27.5	2,426			3
4	A AND C WING CORRIDOR-INSTALLATION OF TILE	2018	17,043	543	27.5	543			4
5	INSTALL DIRECT ACCESS/AIPHONE AND DOOR LOCKS	2018	16,704	430	27.5	430			5
6	COMPLETE & FURNISH MUD WORK & REPAINT	2018	18,255	1,826	5	1,826			6
7	23 RESIDENT ROOMS-INSTALLATION OF VINAL TILE AND								7
8	ACRYLIC CEMENT FLOOR	2018	27,152	370	27.5	370			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)		$ 3,761,981	$ 135,488		$ 137,913	$ 2,425	$ 810,595	34

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 207,763	$ 7,829	$ 20,013	$ 12,184	5-10	$ 204,693	71
72	Current Year Purchases	65,255	65,255	3,263	(61,992)	8-10	3,263	72
73	Fully Depreciated Assets	73,325						73
74	RELATED PARTY		27,675	27,675				74
75	TOTALS	$ 346,343	$ 100,759	$ 50,951	$ (49,808)		$ 207,956	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2008 FORD WAGON	2008	$ 37,400	$ 1,775	$	$ (1,775)		$ 37,400	76
77										77
78	ADMINISTRATIVE	2007 LAND ROVER/RANGE	2010	33,484					33,484	78
79										79
80	TOTALS			$ 70,884	$ 1,775	$	$ (1,775)		$ 70,884	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,529,208	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 238,022	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 188,864	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (49,158)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,089,435	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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: $ 13,255 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2015 LAND ROVER	$ #######	$	17
18		RANGE ROVE		4,857	18
19					19
20					20
21	TOTAL		$ #######	$ 4,857	21

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

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$		$ 299,538	$		$ 299,538	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			146,194			146,194	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			348,404			348,404	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				65,057		65,057	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): RENTAL	39-2					10,998 8,696		10,998 8,696	13
14	TOTAL			$		$ 794,136	$ 84,751		$ 878,887	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 CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 38,131	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 247,000)	3,367,856		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,873		6
7	Other Prepaid Expenses	63,201		7
8	Accounts Receivable (owners or related parties)	150,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,675,061	$	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	888,358		15
16	Equipment, at Historical Cost	417,228		16
17	Accumulated Depreciation (book methods)	(760,289)		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)**	$ 545,297	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,220,358	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,131,343	$	26
27	Officer's Accounts Payable	573,993		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	505,678		29
30	Accrued Salaries Payable	150,000		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,873		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)**	$ 2,367,887	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,367,887	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,852,471	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,220,358	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,107,707	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,107,711	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(255,240)	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)**	$ (255,240)	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)**	$ 1,852,471	24 *

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

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,469,782	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,469,782	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***	3,438	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,438	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,473,220	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,132,614	31
32	Health Care	2,610,008	32
33	General Administration	2,083,842	33
	B. Capital Expense		
34	Ownership	705,556	34
	C. Ancillary Expense		
35	Special Cost Centers	878,887	35
36	Provider Participation Fee	317,553	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,728,460	40
41	**Income before Income Taxes (line 30 minus line 40)****	(255,240)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (255,240)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,218,169	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	1,970,715	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	132,326	47
48	Other-(specify) MANAGED CARE	148,572	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,469,782	49

**TAX RETURN PREPARED ON CASH BASIS

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,146	2,250	$ 98,494	$ 43.78	1
2	Assistant Director of Nursing	1,996	2,120	73,309	34.58	2
3	Registered Nurses	5,639	5,783	166,671	28.82	3
4	Licensed Practical Nurses	27,380	28,654	688,342	24.02	4
5	CNAs & Orderlies	85,975	89,547	986,416	11.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,808	9,368	97,981	10.46	10
11	Social Service Workers	9,464	9,984	129,475	12.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,484	17,085	171,508	10.04	15
16	Dishwashers					16
17	Maintenance Workers	5,175	5,451	94,360	17.31	17
18	Housekeepers	27,192	28,426	262,418	9.23	18
19	Laundry	6,661	7,290	65,266	8.95	19
20	Administrator	1,688	1,776	82,776	46.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,858	8,391	132,285	15.77	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	2,437	2,685	38,401	14.30	31
32	Other Health C: Care Plan Coord	4,023	4,255	112,758	26.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,926	223,065	$ 3,200,460 *	$ 14.35	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	$ 13,242	1-3	35
36	Medical Director	O	12,334	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,336	10-3	39
40	Physical Therapy Consultant	L	28,043	10a-3	40
41	Occupational Therapy Consultant	Y	17,237	10a-3	41
42	Respiratory Therapy Consultant		195	10a-3	42
43	Speech Therapy Consultant	F	5,940	10a-3	43
44	Activity Consultant	E	1,521	11-3	44
45	Social Service Consultant	E	3,471	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 92,319		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	1	18	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	1	$ 18		53

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL OLSON	ADMINISTRATOR	0	$ 47,865
MELISSA GRAY	ADMINISTRATOR	0	34,911
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,776

B. Administrative - Other

Description		Amount
WEISS MGMT GROUP, INC	MANAGEMENT FEES	$ 480,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 480,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 11,015
NATIONAL DATACARE	DATA PROCESSING	2,370
KBKB, LTD	ACCOUNTING FEES	12,200
RICHARD PEELO & ASSOCIAT	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	UC CONSULTANT	5,783
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN	211,900
MPRO	PROFESSIONAL REVIEWER	5,415
SEE LEGAL SCHEDULE ATTACHED		125,649
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 378,832

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 59,231
Unemployment Compensation Insurance		48,142
FICA Taxes		242,028
Employee Health Insurance		69,018
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		25,221
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)		$ 443,640

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	9,134
Health Care Worker Background Check	1,910
(Indicate # of checks performed 154)	
Patient Background Checks 336	3,900
TRUST/FRANCHISE/CONTRIB/ETC	13,624
MARKETING/ADV/PROMO	12,157
LICENSES/DUES/SUBSCRIPTIONS	9,572
MGMT CO ALLOC	5,560
TRUST/FRANCHISE/CONTRIB/ETC	(13,624)
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,157)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,066

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	22,510
MGMT CO ALLOC	2,882
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,392

**See instructions.

BRIA OF CAHOKIA, LLC
LEGAL SCHEDULE
12/31/2018

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
8/23/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	50,000
2/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,625
3/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,723
4/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,788
5/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,593
6/1/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,625
7/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,593
8/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,495
9/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,690
10/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,723
11/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,593
11/30/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,495
12/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ	1,430
1/1/2018	LANER MUCHIN	ULP CHARGES	2,969
1/1/2018	LANER MUCHIN	UNION NEGOTIATIONS	17,845
2/1/2018	LANER MUCHIN	UNION NEGOTIATIONS	378
3/1/2018	LANER MUCHIN	UNION NEGOTIATIONS	756
4/1/2018	LANER MUCHIN	UNION NEGOTIATIONS	138
6/30/2018	MICHAEL KLUPCHAK	SEIU UNION NEGOTIATIONS	11,813
12/15/2018	MICHAEL KLUPCHAK	UNION ISSUES; DECERTIFICATION ELECTION	4,988
7/1/2018	MUCH SHELIST	SURVEYS	1,364
2/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	550
2/1/2018	SB2 INC	MPIL-BRIA	171
3/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
3/1/2018	SB2 INC	MPIL-BRIA	167
4/2/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
4/2/2018	SB2 INC	MPIL-BRIA	167
5/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
5/1/2018	SB2 INC	MPIL-BRIA	167
6/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	506
6/1/2018	SB2 INC	MPIL-BRIA	167
7/2/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
7/2/2018	SB2 INC	MPIL-BRIA	167
8/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
8/1/2018	SB2 INC	MPIL-BRIA	167
9/4/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
9/4/2018	SB2 INC	MPIL-BRIA	167
10/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
10/1/2018	SB2 INC	MPIL-BRIA	173
11/1/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
11/1/2018	SB2 INC	MPIL-BRIA	167
12/3/2018	SB2 INC	BRIA-002 MONTHLY PROJECT	500
12/3/2018	SB2 INC	MPIL-BRIA	167
1/1/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
2/28/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
3/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
4/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	929
5/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
6/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
7/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
8/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
9/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
10/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
11/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
12/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
TOTAL			**125,649**

Facility Name & ID Number BRIA OF CAHOKIA, LLC # 0048645 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $ 13,566**

(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. $ **12,548** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
RIVER BLUFFS OF CAHOKIA NURSING & REHAB CENTER #0042713; 05/01/2000

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **317,553**
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