FOR BHF USE

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

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: 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) AVRUM WEINFELD
(Title) CEO

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 WESTMONT # 0050120 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	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			8,050	8,050	8
9	SNF/PED					9
10	ICF	49,736	3,866	2,301	55,903	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,736	3,866	10,351	63,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.49%

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 9/3/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/3/08 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 8,050

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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	396,681	62,694	90,981	550,356		550,356		550,356			1
2	Food Purchase		518,353		518,353	(11,563)	506,790	(756)	506,034			2
3	Housekeeping		11,235	363,240	374,475		374,475		374,475			3
4	Laundry		14,513	337,092	351,605		351,605		351,605			4
5	Heat and Other Utilities			323,044	323,044		323,044		323,044			5
6	Maintenance	134,373	135,239	69,331	338,943		338,943	1,136	340,079			6
7	Other (specify):*			17,312	17,312		17,312	179	17,491			7
8	TOTAL General Services	531,054	742,034	1,201,000	2,474,088	(11,563)	2,462,525	559	2,463,084			8
	B. Health Care and Programs											
9	Medical Director			32,500	32,500		32,500		32,500			9
10	Nursing and Medical Records	4,668,767	365,422	18,606	5,052,795		5,052,795	27,788	5,080,583			10
10a	Therapy			66,046	66,046		66,046		66,046			10a
11	Activities	168,610	7,873	3,904	180,387		180,387		180,387			11
12	Social Services	113,224	5,245	256	118,725		118,725		118,725			12
13	CNA Training											13
14	Program Transportation			510	510		510		510			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,950,601	378,540	121,822	5,450,963		5,450,963	27,788	5,478,751			16
	C. General Administration											
17	Administrative	172,134		893,000	1,065,134		1,065,134	(1,046,918)	18,216			17
18	Directors Fees											18
19	Professional Services			371,286	371,286		371,286	15,675	386,961			19
20	Dues, Fees, Subscriptions & Promotions			153,272	153,272		153,272	(70,018)	83,254			20
21	Clerical & General Office Expenses	390,141	50,723	215,880	656,744		656,744	(36,004)	620,740			21
22	Employee Benefits & Payroll Taxes			906,051	906,051	11,563	917,614		917,614			22
23	Inservice Training & Education			12,983	12,983		12,983	925	13,908			23
24	Travel and Seminar			12,919	12,919		12,919	4,357	17,276			24
25	Other Admin. Staff Transportation							(5,730)	(5,730)			25
26	Insurance-Prop.Liab.Malpractice			204,758	204,758		204,758	30,032	234,790			26
27	Other (specify):*			240,564	240,564		240,564	(211,621)	28,943			27
28	TOTAL General Administration	562,275	50,723	3,010,713	3,623,711	11,563	3,635,274	(1,319,302)	2,315,972			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,043,930	1,171,297	4,333,535	11,548,762		11,548,762	(1,290,955)	10,257,807			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: 01/01/2018** **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	89,925	
	REPAIRS & MAINTENANCE		1,056	
				90,981
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICES		363,240	
				363,240
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE			
	CONTRACTED LAUNDRY SERVICES		337,092	337,092
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		22,358	
	ELECTRICITY		121,070	
	WATER		170,801	
	CABLE TV - LOBBY		8,815	
				323,044
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		32,987	
	PAINTING & DECORATING			
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		1,360	
	ELEVATOR MAINTENANCE & REPAIR			
	OUTSIDE LABOR			
	EXTERMINATING SERVICE			
	FIRE SERVICE		34,984	
				69,331
7	**OTHER**			
	SCAVENGER AND EXTERMINATING SERVICES		17,312	
	SECURITY SERVICE			
				17,312
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	32,500	32,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	4,623	
	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	13,983	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2		
				18,606
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	20,912	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	12,413	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	26,892	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	5,829	
				66,046
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,904	
				3,904
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	256	
	SOCIAL WORKER	XVIII B 45-2		
				256
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number BRIA OF WESTMONT **#0050120** **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		510	
				510
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	893,000	893,000
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,191	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	133,295	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		223,800	371,286
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	56,914	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	23,640	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	33,345	
	LICENSES & PERMITS	XIX F	13,179	
	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	21,350	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	320	
	PATIENT BACKGROUND CHECKS	XIX F	4,524	
				153,272
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,775	
	EQUIPMENT REPAIR & MAINTENANCE		118,932	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18	37,027	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		50,645	
	MESSENGER SERVICE		501	
				215,880

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	454,105	
	UNEMPLOYMENT COMPENSATION	XIX D	70,121	
	WORKERS COMPENSATION INSURANC	XIX D	184,987	
	HOSPITALIZATION INSURANCE	XIX D	125,634	
	EMPLOYEE BENEFITS - OTHER	XIX D	71,204	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				906,051
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		12,983	
				12,983
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	12,919	
				12,919
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF			
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		204,758	
				204,758
27	**OTHER**			
	BAD DEBTS	VI 24	240,564	
				240,564

GRAND TOTAL COLUMN 3 OTHER **4,333,535**

BRIA OF WESTMONT
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	518,353
LESS SALES TAX	(756)
NET FOOD	517,597
TOTAL PATIENT CENSUS	63,953
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	191,859
ADD # EMPLOYEE MEALS/DAY	12
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	4,380
PATIENT MEALS	191,859
ADD EMPLOYEE MEALS	4,380
TOTAL MEALS/YEAR	196,239
NET FOOD	517,597
DIVIDE TOTAL MEALS/YEAR	196,239
COST PER MEAL	2.64
TIMES EMPLOYEE MEALS	4,380
EMPLOYEE MEAL RECLASSIFIC	**11,563**

Facility Name & ID Number BRIA OF WESTMONT #0050120 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			296,820	296,820		296,820	217,065	513,885			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			648,901	648,901		648,901	42,050	690,951			32
33	Real Estate Taxes							127,133	127,133			33
34	Rent-Facility & Grounds			832,512	832,512		832,512	(832,512)				34
35	Rent-Equipment & Vehicles			88,305	88,305		88,305	2,947	91,252			35
36	Other (specify):* RENT OFFICE			15,600	15,600		15,600	47,060	62,660			36
37	**TOTAL Ownership**			2,382,138	2,382,138		2,382,138	(896,257)	1,485,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		482,514	1,235,816	1,718,330		1,718,330		1,718,330			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			443,767	443,767		443,767		443,767			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		482,514	1,679,583	2,162,097		2,162,097		2,162,097			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,043,930	1,653,811	8,395,256	16,092,997		16,092,997	(2,187,212)	13,905,785			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: 01/01/2018 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	45,652	30		9
10	Interest and Other Investment Income	(52,352)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(756)	2		13
14	Non-Care Related Interest	(302,793)	32		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	(37,027)	21		18
19	Entertainment				19
20	Contributions	(21,350)	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	(240,564)	27		24
25	Fund Raising, Advertising and Promotional	(56,914)	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	(636,705)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,302,809)		$	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)	(884,403)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (884,403)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,187,212)		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 WESTMONT

ID# 0050120

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (130,975)	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	2
3	TRAVEL-MARKETING	(5,730)	25	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**	(636,705)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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	(756)	0	0	0	0	0	0	0	0	0	0	(756)	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	1,136	0	0	0	0	0	0	0	1,136	6
7	Other (specify):*	0	0	0	179	0	0	0	0	0	0	0	179	7
8	**TOTAL General Services**	(756)	0	0	1,315	0	0	0	0	0	0	0	559	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	27,788	0	0	0	0	0	0	0	27,788	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	27,788	0	0	0	0	0	0	0	27,788	16
	C. General Administration													
17	Administrative	0	0	(845,118)	(201,800)	0	0	0	0	0	0	0	(1,046,918)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,700	1,369	5,606	0	0	0	0	0	0	0	15,675	19
20	Fees, Subscriptions & Promotions	(78,264)	0	0	8,246	0	0	0	0	0	0	0	(70,018)	20
21	Clerical & General Office Expenses	(168,002)	0	67	131,931	0	0	0	0	0	0	0	(36,004)	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	925	0	0	0	0	0	0	0	925	23
24	Travel and Seminar	0	0	0	4,357	0	0	0	0	0	0	0	4,357	24
25	Other Admin. Staff Transportation	(5,730)	0	0	0	0	0	0	0	0	0	0	(5,730)	25
26	Insurance-Prop.Liab.Malpractice	0	26,655	0	3,377	0	0	0	0	0	0	0	30,032	26
27	Other (specify):*	(240,564)	0	3,750	25,193	0	0	0	0	0	0	0	(211,621)	27
28	**TOTAL General Administration**	(492,560)	35,355	(839,932)	(22,165)	0	0	0	0	0	0	0	(1,319,302)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(493,316)	35,355	(839,932)	6,938	0	0	0	0	0	0	0	(1,290,955)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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	45,652	166,281	0	5,132	0	0	0	0	0	0	0	217,065	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(355,145)	358,257	0	38,938	0	0	0	0	0	0	0	42,050	32
33	Real Estate Taxes	0	127,133	0	0	0	0	0	0	0	0	0	127,133	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	0	2,947	0	0	0	0	0	0	0	2,947	35
36	Other (specify):*	0	47,060	0	0	0	0	0	0	0	0	0	47,060	36
37	TOTAL Ownership	(809,493)	(133,781)	0	47,017	0	0	0	0	0	0	0	(896,257)	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)	(1,302,809)	(98,426)	(839,932)	53,955	0	0	0	0	0	0	0	(2,187,212)	45

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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	$ 832,512	WESTMONT REAL ESTATE, LLC		$	$ (832,512)	1
2	V	30	DEPRECIATION (SL)				166,281	166,281	2
3	V	32	INTEREST				354,526	354,526	3
4	V	32	AMORT LOAN COST				3,731	3,731	4
5	V	33	REAL ESTATE TAXES				127,133	127,133	5
6	V	36	MIP INSURANCE				47,060	47,060	6
7	V	19	PROFESSIONAL FEES				8,700	8,700	7
8	V	26	INSURANCE-HAZARD				26,655	26,655	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 832,512			$ 734,086	$ * (98,426)	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: 01/01/2018 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	$ 893,000	DA WESTMONT		$	$ (893,000)	15
16	V	17	OFFICER SALARIES-A. WEINFELD				23,941	23,941	16
17	V	17	OFICER SALARIES-D. WEISS				23,941	23,941	17
18	V	19	ACCOUNTING FEES				1,369	1,369	18
19	V	21	OFFICE EXPENSES				67	67	19
20	V	27	PAYROLL TAXES				3,750	3,750	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								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			$ 893,000			$ 53,068	$ * (839,932)	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: 01/01/2018 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	BOOKKEEPING/ADMINISTRATIVE	$ 223,800	BRIA HEALTH SERVICES, LLC		$	$ (223,800)	15
16	V	17	CFO SALARY-A.WEINFELD				22,000	22,000	16
17	V	10	SALARIES-MEDICARE/NURSING				26,898	26,898	17
18	V	21	SALARIES-PURCHASING D.SEGAL				7,790	7,790	18
19	V	21	SALARIES-CLERICAL RELATED PARTIES				20,990	20,990	19
20	V	21	SALARIES-CLERICAL				83,045	83,045	20
21	V	6	MAINTENANCE				1,136	1,136	21
22	V	7	SCAVENGER				179	179	22
23	V	10	NURSING CONSULTANT				890	890	23
24	V	19	PROFESSIONAL FEES				5,606	5,606	24
25	V	20	DUES,FEES,SUBSCRIPTIONS				8,246	8,246	25
26	V	21	OFFICE EXPENSE				20,106	20,106	26
27	V	23	SEMINARS				925	925	27
28	V	24	TRAVEL				4,357	4,357	28
29	V	26	INSURANCE				3,377	3,377	29
30	V	27	EMPLOYEE BENEFITS				25,193	25,193	30
31	V	30	DEPRECIATION				5,132	5,132	31
32	V	32	INTEREST				38,938	38,938	32
33	V	35	AUTO LEASE				1,602	1,602	33
34	V	35	EQUIPMENT RENTAL				1,345	1,345	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 223,800			$ 277,755	$ * 53,955	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: 01/01/2018 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	AVRUM & DEVORAH WEINFELD	40.00	BRIA OF CAHOKIA	CAHOKIA	WESTMONT REAL			1
2					ESTATE, LLC	SKOKIE	REAL ESTATE	2
3	DANIEL & REBECCA WEISS	40.00	BRIA OF FOREST EDGE	CHICAGO				3
4					IME REALTY CORP	SKOKIE	HOME OFFICE	4
5	MIRIAM ROBINSON	20.00	BRIA OF BELLEVILLE	BELLEVILLE				5
6					DA WESTMONT	SKOKIE	MGMT CONSULT	6
7			BRIA OF GENEVA	GENEVA				7
8					BRIA HEALTH			8
9			LAKE PARK	WAUKEGAN	SERVICES, LLC	SKOKIE	MGMT SERVICES	9
10								10
11			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				11
12				HEIGHTS				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 WESTMONT # 0050120 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	ALLOCATION FROM DA WESTMONT:								$		1
2										17-7	2
3											3
4	AVRUM WEINFELD	CFO	ADMINISTRAT.	40.00		8	20.00	SALARIES	30,000	17-7	4
5											5
6	DANIEL WEISS		ADMINISTRAT.	40.00		4	10.00	SALARIES	20,000	17-7	6
7											7
8											8
9	ALLOCATION FROM BRIA HEALTH SERVICES:										9
10	AVRUM WEINFELD		CFO			8	20.00	SALARIES	22,000	17-7	10
11											11
12											12
13								TOTAL	$ 72,000		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 WESTMONT # 0050120 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: 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	160,275	3	$ 60,000	$ 60,000	63,953	$ 23,941	1
2	17	OFICER SALARIES-D. WEISS	CENSUS DAYS	160,275	3	60,000	60,000	63,953	23,941	2
3	19	ACCOUNTING FEES	CENSUS DAYS	160,275	3	3,430		63,953	1,369	3
4	21	OFFICE EXPENSES	CENSUS DAYS	160,275	3	168		63,953	67	4
5	27	PAYROLL TAXES	CENSUS DAYS	160,275	3	9,400		63,953	3,750	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					$ 132,998	$ 120,000		$ 53,068	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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		$ 22,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	516,944	9	217,425	217,425	63,953	26,898	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours		9	148,012	148,012		7,790	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours		9	41,826	41,826		20,990	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	516,944	9	671,273	671,273	63,953	83,045	5
6	6	MAINTENANCE	CENSUS DAYS	516,944	9	9,177		63,953	1,136	6
7	7	SCAVENGER	CENSUS DAYS	516,944	9	1,451		63,953	179	7
8	10	NURSING CONSULTANT	CENSUS DAYS	516,944	9	7,200		63,953	890	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	516,944	9	45,319		63,953	5,606	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	516,944	9	66,654		63,953	8,246	10
11	21	OFFICE EXPENSE	CENSUS DAYS	516,944	9	162,507		63,953	20,106	11
12	23	SEMINARS	CENSUS DAYS	516,944	9	7,477		63,953	925	12
13	24	TRAVEL	CENSUS DAYS	516,944	9	35,214		63,953	4,357	13
14	26	INSURANCE	CENSUS DAYS	516,944	9	27,300		63,953	3,377	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	516,944	9	203,639		63,953	25,193	15
16	30	DEPRECIATION	CENSUS DAYS	516,944	9	41,469		63,953	5,132	16
17	32	INTEREST	CENSUS DAYS	516,944	9	314,739		63,953	38,938	17
18	35	AUTO LEASE	CENSUS DAYS	516,944	9	12,960		63,953	1,602	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	516,944	9	10,875		63,953	1,345	19
20										20
21										21
22	35									22
23										23
24										24
25	TOTALS					$ 2,123,517	$ 1,177,536		$ 277,755	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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: WESTMONT REAL ESTATE, LLC						$	$			$	1
2	CAMBRIDGE REALTY	X		MORTGAGE	$67,995.96	01/31/12	10,881,400	9,338,086	12/01/41	3.7500	354,526	2
3	LOAN COSTS	X		AMORTIZE OVER LIFE OF LOAN			111,302	85,464			3,731	3
4	BRICKYARD BANK	X		WORKING CAPITAL	$16,970.55	11/10/14	2,000,000	1,387,000		6.0000	159,958	4
5	MB FINANCIAL	X		LOAN	$16,250.00	10/29/14	3,900,000	3,390,257	08/05/20	4.7500	144,477	5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL INSUR	DEMAND	09/05/08	2,000,000	1,300,000		PRIME+	32,449	6
7	F & M WEISS	X		WORKING CAPITAL		12/01/15	600,000	298,236	05/01/21	2.2000	9,224	7
8	RELATED PARETY ALLOCATION										38,938	8
9	TOTAL Facility Related				$101,216.51		$ 19,492,702	$ 15,799,043			$ 743,303	9
	B. Non-Facility Related*											
10	GOODWILL		X	GOODWILL	$42,088.99	09/08	7,500,000	7,935,984	09/33	6.0000	302,793	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$42,088.99		$ 7,500,000	$ 7,935,984			$ 302,793	14
15	TOTALS (line 9+line14)						$ 26,992,702	$ 23,735,027			$ 1,046,096	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 47,060 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: 01/01/2018 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.**	$	99,274	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.)	$	112,640	2
3. Under or (over) accrual (line 2 minus line 1).	$	13,366	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	113,767	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.	$	127,133	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	98,535	8
	2014	95,023	9
	2015	97,424	10
	2016	98,291	11
	2017	112,640	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 WESTMONT COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

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.	09-22-101-001	NURSING HOME	$ 96,551.42	$ 96,551.42
2.	09-22-101-002	NURSING HOME	$ 6,672.64	$ 6,672.64
3.	09-22-101-003	NURSING HOME	$ 9,416.22	$ 9,416.22
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 112,640.28	$ 112,640.28

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 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 WESTMONT # 0050120 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 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	215			1995	$ 4,982,301	$ 127,751	39	$ 127,751	$	$ 3,039,533	4
5				2016	6,976,963	178,896	39	178,896		454,694	5
6											6
7	RELATED PARTY ALLOCATIONS				89,475	2,525		2,525			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	43,183	11
12	IMPROVEMENTS			1989	40,935		31.5	1,299	1,299	38,262	12
13	DRIVEWAY			1989	17,137		15			17,137	13
14	IMPROVEMENTS			1990	37,367		31.5	1,186	1,186	33,750	14
15	IMPROVEMENTS			1991	45,002		31.5	1,428	1,428	39,031	15
16	IMPROVEMENTS			1992	49,649		31.5	1,577	1,577	41,697	16
17	ROOF TOP A/C UNITS			1993	9,100		31.5	289	289	7,490	17
18	IMPROVEMENTS			1993	53,243		39	1,366	1,366	34,683	18
19	IMPROVEMENTS			1994	31,230		39	801	801	19,741	19
20	FLOOR COVERING			1995	795		15			795	20
21	HAND RAIL			1995	2,249		39	58	58	1,385	21
22	FLOOR TILES			1995	5,471		39	140	140	3,308	22
23	WINDOW A/C UNITS			1995	14,146		39	363	363	8,514	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056		39	309	309	7,275	24
25	ALARM			1995	1,337		39	34	34	798	25
26	LAUNDRY BUILDING			1995	35,000		39	897	897	20,893	26
27	ROOF			1995	5,520		39	142	142	3,307	27
28	WINDOWS			1995	9,478		39	243	243	5,640	28
29	DOOR EDGE & DOOR FRAME			1996	2,099		39	54	54	1,240	29
30	LAUNDRY BUILDING			1996	175,187		39	4,491	4,491	101,245	30
31	AIR COOLERS			1996	6,642		39	171	171	3,845	31
32	RACING CAGE			1996	3,987		39	102	102	2,299	32
33	HAND RAIL			1996	1,156		39	30	30	671	33
34	WINDOWS			1996	11,496		39	295	295	6,601	34
35	TACK ROOM			1996	2,139		39	55	55	1,226	35
36	NEW CONFERENCE ROOM TILE			1997	2,938		39	76		1,618	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: 01/01/2018 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 DIETARY DOOR	1997	$ 1,478	$	39	$ 38	$ 38	$ 809	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	2,916	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	739	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	615	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	2,610	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	3,343	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	6,561	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	5,369	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,754	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	749	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	1,452	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	4,495	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	1,187	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	1,364	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	1,434	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	1,511	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	593	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	3,538	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	1,333	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	3,097	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	2,378	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	18,172	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	2,786	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,912	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	3,085	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	76,494	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	19,785	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	67,815	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	5,641	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	7,720	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	243,774	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	24,752	69
70	TOTAL (lines 4 thru 69)		$ 13,453,092	$ 309,172		$ 354,662	$ 45,414	$ 4,575,139	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: 01/01/2018 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		$ 13,453,092	$ 309,172		$ 354,662	$ 45,490	$ 4,575,139	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997		15			8,997	2
3	SHOWER ROOM	2002	30,924		27.5	1,125	1,125	18,234	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010		27.5	328	328	5,262	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891		27.5	541	541	8,679	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	34,051	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	9,775	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767		27.5	464	464	7,173	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152		27.5	1,133	1,133	17,514	9
10	THERAPY ROOM -FLOORING	2003	87,509		27.5	3,182	3,182	49,188	10
11	CONFERENCE ROOM-FLOORING	2003	2,073		27.5	76	76	1,175	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421		27.5	270	270	3,904	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825		27.5	3,266	3,266	46,677	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925		27.5	1,852	1,852	26,314	14
15	RESIDENT ROOMS-FLOORING	2005	9,821		27.5	357	357	4,894	15
16	INSTALL CABLING SYSTEM	2005	46,771		27.5	1,701	1,701	23,176	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000		27.5	1,018	1,018	13,276	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286		20	2,914	2,914	40,796	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260		27.5	155	155	1,996	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838		27.5	2,321	2,321	29,689	20
21	AIR CONDITIONS	2006	7,968		27.5	289	289	3,608	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652		27.5	169	169	2,120	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200		27.5	380	380	4,560	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		155,210	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,575	27.5	8,575		98,255	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		1,295	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		2,669	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		1,295	32
33	AIR CONDITIONS	2008	12,661		5			12,661	33
34	TOTAL (lines 1 thru 33)		$ 14,657,852	$ 331,998		$ 401,607	$ 69,609	$ 5,310,536	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: 01/01/2018 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 12B, Carried Forward		$ 14,657,852	$ 331,998		$ 401,607	$ 69,609	$ 5,310,536	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		1,380	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		1,098	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		1,120	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		4,949	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		842	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		1,361	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		1,910	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		3,366	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		1,914	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		3,280	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOO	2011	6,150	224	27.5	224		1,727	20
21	INSTALL FIRE ALARM SMOKES, HEATS, AV DEVCIE	2011	85,377	3,105	27.5	3,105		23,676	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	535	27.5	535		3,990	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	91	27.5	91		671	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	336	27.5	336		2,366	24
25	INSTALL ACCUTECH SYSTEM FOR FRONT DOOR	2012	4,814	175	27.5	175		1,203	25
26	DELAYED EGRESS LOCKING SYSTEM FOR 1ST FLOOR	2012	12,600	458	27.5	458		3,111	26
27	ROOM F-16 -INSTALL NEW PVT & COVE BASE	2012	5,316	193	27.5	193		1,246	27
28	PLASTER, PRIME & PAINT ALL ROOMS & BATH	2012	10,631	387	27.5	387		2,435	28
29	WEST PARKING LOT-SEALCOAT, CRACK FILLING,								29
30	STRIPING, ASPHALTING	2013	4,460	297	15	297		1,658	30
31	EMPLOYEE ENTRANCE DOOR & FRAME REPLACEMENT	2013	3,254	118	27.5	118		615	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		2,875	33
34	TOTAL (lines 1 thru 33)		$ 15,066,450	$ 340,838		$ 410,447	$ 69,609	$ 5,553,203	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: 01/01/2018 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 12C, Carried Forward		$ 15,066,450	$ 340,838		$ 410,447	$ 69,609	$ 5,553,203	1
2	1ST & 2ND FLOOR LOBBY, FRONT CORRIDOR,RESIDENT								2
3	CORRIDORS: FLOORING,WALLCOVERING,PAINTING	2013	124,977	4,545	27.5	4,545		25,187	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		2,911	5
6	RESIDENT ROOMS: CURTAIN, WINDOW TREATMENTS	2014	15,035	1,732	5	1,732		14,169	6
7									7
8	BUILDING RENOVATION :	2016	605,378	22,014	27.5	22,014		55,952	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		4,290	13
14	RESIDENT ROOMS-COVE BASE, VINYL INSTALLATION	2017	5,329	194	27.5	194		380	14
15	INSTALLATION OF NEW TRACK SYSTEM	2018	13,124	438	15	438		438	15
16	INSTALL PURIFIED WATER LOOP	2018	7,692	12	27.5	12		12	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)		$ 15,905,609	$ 372,232		$ 441,841	$ 69,609	$ 5,656,542	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: 01/01/2018 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	$ 562,459	$ 61,073	$ 67,821	$ 6,748	3-10	$ 224,145	71
72	Current Year Purchases	32,321	32,321	1,616	(30,705)	10	1,616	72
73	Fully Depreciated Assets	1,097,007					1,097,007	73
74	RELATED PARTY ALLOCATIONJS		2,607	2,607				74
75	TOTALS	$ 1,691,787	$ 96,001	$ 72,044	$ (23,957)		$ 1,322,768	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)	$ 18,357,222	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 468,233	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 513,885	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 45,652	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,979,310	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: 01/01/2018 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 ☒ X NO

16. Rental Amount for movable equipment: $ 62,718 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	$ #######	$ 15,079	17
18	FACILITY	2017 FORD ESCAPE	458.79	5,047	18
19	ADMINISTRATIVE	2018 JEEP COMPASS	455.05	5,461	19
20					20
21	TOTAL		$ #######	$ 25,587	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: 01/01/2018 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	$		$ 480,650	$		$ 480,650	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			160,550			160,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			594,616			594,616	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				262,572		262,572	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,Respiratory	39-2					100,633 119,309		100,633 119,309	13
14	TOTAL			$		$ 1,235,816	$ 482,514		$ 1,718,330	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: 01/01/2018 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	$ (339,549)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 286,000)	3,890,617		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,022		6
7	Other Prepaid Expenses	84,054		7
8	Accounts Receivable (owners or related parties)	925,687		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,672,831	$	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	682,997		15
16	Equipment, at Historical Cost	594,780		16
17	Accumulated Depreciation (book methods)	(1,029,036)		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	(5,166,667)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,559,037	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,231,868	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,249,943	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,831		28
29	Short-Term Notes Payable	1,300,000		29
30	Accrued Salaries Payable	168,946		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,134		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)**	$ 2,749,854	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,011,477		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)**	$ 10,011,477	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,761,331	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,470,537	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,231,868	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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**	$ 1,207,950	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,207,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	262,587	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)**	$ 262,587	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)**	$ 1,470,537	24 *

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

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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	$ 16,193,810	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,193,810	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***	52,352	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,352	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	COMPUTER INCOME	26,756	28
28a	INSURANCE	88,180	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 114,936	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,361,098	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,474,088	31
32	Health Care	5,450,963	32
33	General Administration	3,623,711	33
	B. Capital Expense		
34	Ownership	2,382,138	34
	C. Ancillary Expense		
35	Special Cost Centers	1,718,330	35
36	Provider Participation Fee	443,767	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,092,997	40
41	**Income before Income Taxes (line 30 minus line 40)****	268,101	41
42	**Income Taxes**	(5,514)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 262,587	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,191,877	44
45	Private Pay - Net Inpatient Revenue	933,548	45
46	Medicare - Net Inpatient Revenue	5,186,741	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	783,804	47
48	Other-(specify) MANAGED CARE	1,097,840	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,193,810	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: 01/01/2018 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	1,920	2,000	$ 101,250	$ 50.63	1
2	Assistant Director of Nursing	7,343	7,993	276,284	34.57	2
3	Registered Nurses	41,517	43,277	1,408,595	32.55	3
4	Licensed Practical Nurses	25,954	27,702	777,676	28.07	4
5	CNAs & Orderlies	115,821	120,985	1,825,918	15.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,780	12,213	168,610	13.81	10
11	Social Service Workers	5,160	5,262	113,224	21.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,885	33,965	396,681	11.68	15
16	Dishwashers					16
17	Maintenance Workers	7,239	7,655	134,373	17.55	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,744	2,800	151,085	53.96	20
21	Assistant Administrator	640	640	21,049	32.89	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,476	25,483	390,141	15.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,120	37,565	17.72	31
32	Other Health C: Care Plan Coord	5,977	6,305	241,479	38.30	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	285,408	298,400	$ 6,043,930 *	$ 20.25	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	$ 89,925	1-3	35
36	Medical Director	O	32,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	13,983	10-3	39
40	Physical Therapy Consultant	L	20,912	10a-3	40
41	Occupational Therapy Consultant	Y	12,413	10a-3	41
42	Respiratory Therapy Consultant		26,892	10a-3	42
43	Speech Therapy Consultant	F	5,829	10a-3	43
44	Activity Consultant	E	3,904	11-3	44
45	Social Service Consultant	E	256	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 206,614		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9	$ 540	10-3	50
51	Licensed Practical Nurses	63	2,890	10-3	51
52	Certified Nurse Assistants/Aides	46	1,193	10-3	52
53	TOTAL (lines 50 - 52)	118	$ 4,623		53

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EFRAIM WEINFELD	ADMINISTRATOR	0	$ 86,155
LAUREN WETZEL	ADMINISTRATOR	0	64,930
OSWALDO MORALES	ASST ADMIN	0	8,077
LAUREN WETZEL	ASST ADMIN	0	12,972
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 172,134

B. Administrative - Other

Description		Amount
DA WESTMONT	MANAGEMENT FEES	$ 893,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 893,000

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 11,429
NATIONAL DATACARE	DATA PROCESSING	2,762
KBKB, LTD	ACCOUNTING FEE	23,500
RICHARD PEELO & ASSOCIAT	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	U/C CONSULTANT	6,215
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN	223,800
MCCABE KIRSHNER P.C.	ENGAGEMENT OF WTW	2,300
US HOUSING CONSULTANT	REAC INSPECTION	2,010
CHRIS GEORGE	ARCHITECTURAL FEE	5,000
ACHIVE ACCREDITATION	ACCREDITATION CONSULT	11,768
SEE LEGAL SCHEDULE ATTACHED		78,002
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 371,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 184,987
Unemployment Compensation Insurance	70,121
FICA Taxes	454,105
Employee Health Insurance	125,634
Employee Meals	11,563
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	71,204
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)	$ 917,614

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	23,640
Health Care Worker Background Check	320
(Indicate # of checks performed 9)	
Patient Background Checks 338	4,524
TRUST/FRANCHISE/CONTRIB/ETC	21,350
MARKETING/ADV/PROMO	56,914
LICENSES/DUES/SUBSCRIPTIONS	44,534
MGMT CO ALLOC	8,246
TRUST/FRANCHISE/CONTRIB/ETC	(21,350)
Less: Public Relations Expense	(0)
Non-allowable advertising	(56,914)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 83,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,919
MGMT CO ALLOC	4,357
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,276

**See instructions.

BRIA OF WESTMONT
LEGAL SCHEDULE
12/31/2018

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
2/23/2018	PETER FERRACUTI	DUPLICATE PAYMENT	(500)
2/15/2018	CHUBB GROUP OF INSURANCE C	DEFENSE COSTS	3,454
11/1/2018	GARY A WEINTRAUB PC	CONF HEARING PREP	1,713
9/30/2018	MCCABE KIRSHNER, P.C.	PL/GL LITIGATION	1,108
10/11/2018	MCCABE KIRSHNER, P.C.	PL/GL LITIGATION	2,300
11/30/2018	MCCABE KIRSHNER, P.C.	PL/GL LITIGATION	2,300
11/30/2018	MCCABE KIRSHNER, P.C.	PL/GL LITIGATION	2,300
12/31/2018	MCCABE KIRSHNER, P.C.	PL/GL LITIGATION	2,300
12/31/2018	MCCABE KIRSHNER, P.C.	PL/GL LITIGATION	2,300
3/15/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	4,538
5/7/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	4,458
6/7/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	5,498
7/7/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	3,079
9/9/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	5,588
10/10/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	1,770
11/11/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	5,616
12/12/2018	GREENBERG TRAURIG	STRATEGY & RESEARCH PLANNING	4,991
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	550
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	171
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	506
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
9/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
9/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	173
11/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
3/26/2018	SKIDELSKY & ASSOCIATES	REAL ESTATE ASSESSMENT	6,297
1/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	506
2/28/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
3/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	506
4/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	122
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
4/30/2018	VANEK LARSON & KOLB	GUARDIANSHIP	2,307
9/9/2018	VANEK LARSON & KOLB	GUARDIANSHIP	250
10/10/2018	VANEK LARSON & KOLB	GUARDIANSHIP	1,579
12/12/2018	LEGAL SERVICES RENDERED	RENEWAL LOC	425
TOTAL			**78,002**

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 $ 13,959**

(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. $ **53,155** Line **10-2**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **443,767**
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. $ **11,563** 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