

		FOR BHF USE					

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

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: 0034678 Facility Name: BRIA OF BELLEVILLE Address: 150 NORTH 27TH ST BELLEVILLE 62226 County: ST CLAIR Telephone Number: (618) 235-6600 Fax # (618) 235-7555 HFS ID Number: Date of Initial License for Current Owners: 09/88 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: SANFORD BOKOR Telephone Number: (847) 675-3585 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) MARTIN WEISS (Title) PRESIDENT Paid Preparer (Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Print Name) SANFORD BOKOR and Title) PRESIDENT (Firm Name) KBKB, LTD & Address) 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
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Facility Name & ID Number

BRIA OF BELLEVILLE

#

0034678

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

III. STATISTICAL DATA

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

1	2	3	4		
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period		
1	94	Skilled (SNF)	94	34,404	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,240	7

B. Census-For the entire report period.

1	2	3	4	5		
Level of Care	Patient Days by Level of Care and Primary Source of Payment					
	Medicaid Recipient	Private Pay	Other	Total		
8	SNF		5,995	5,995	8	
9	SNF/PED				9	
10	ICF	32,027	1,203	2,354	35,584	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,027	1,203	8,349	41,579	14

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

81.15%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

09/88

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

09/88

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

62

and days of care provided

5,995

Medicare Intermediary

ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2016

Fiscal Year:

12/31/2016

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

Facility Name & ID Number **BRIA OF BELLEVILLE** # **0034678** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		2,624	568,925	571,549		571,549		571,549			1
2	Food Purchase		3,498		3,498		3,498		3,498			2
3	Housekeeping		9,583	240,921	250,504		250,504		250,504			3
4	Laundry		17,607	161,187	178,794		178,794		178,794			4
5	Heat and Other Utilities			174,905	174,905		174,905	134	175,039			5
6	Maintenance	105,356	58,798	14,435	178,589		178,589	602	179,191			6
7	Other (specify):*			45,974	45,974		45,974		45,974			7
8	TOTAL General Services	105,356	92,110	1,206,347	1,403,813		1,403,813	736	1,404,549			8
	B. Health Care and Programs											
9	Medical Director			43,800	43,800		43,800		43,800			9
10	Nursing and Medical Records	2,778,261	247,544	81,423	3,107,228		3,107,228	43,204	3,150,432			10
10a	Therapy			64,182	64,182		64,182		64,182			10a
11	Activities	123,611	7,756	1,700	133,067		133,067		133,067			11
12	Social Services	54,755	1,538	1,834	58,127		58,127		58,127			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,956,627	256,838	192,939	3,406,404		3,406,404	43,204	3,449,608			16
	C. General Administration											
17	Administrative	113,104		360,000	473,104		473,104	(87,971)	385,133			17
18	Directors Fees											18
19	Professional Services			525,116	525,116		525,116	(374,885)	150,231			19
20	Dues, Fees, Subscriptions & Promotions			101,865	101,865		101,865	(54,068)	47,797			20
21	Clerical & General Office Expenses	196,113	22,267	121,879	340,259		340,259	100,469	440,728			21
22	Employee Benefits & Payroll Taxes			577,896	577,896		577,896		577,896			22
23	Inservice Training & Education			19,284	19,284		19,284	1,057	20,341			23
24	Travel and Seminar			24,593	24,593		24,593	4,640	29,233			24
25	Other Admin. Staff Transportation							(6,153)	(6,153)			25
26	Insurance-Prop.Liab.Malpractice			199,654	199,654		199,654	21,693	221,347			26
27	Other (specify):*			29,059	29,059		29,059	(975)	28,084			27
28	TOTAL General Administration	309,217	22,267	1,959,346	2,290,830		2,290,830	(396,193)	1,894,637			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,371,200	371,215	3,358,632	7,101,047		7,101,047	(352,253)	6,748,794			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.

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	0
	REPAIRS & MAINTENANCE		1,533
	CONTRACTED DIETARY SERVICES		567,392
3	HOUSEKEEPING		
	CONTRACTED HAUSEKKEEPING SERVICES		240,921
			240,921
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		573
	CONTRACTED LAUNDRY SERVICES		160,614
			161,187
5	HEAT & OTHER UTILITIES		
	GAS HEAT		15,354
	ELECTRICITY		85,409
	WATER		71,566
	CABLE TV - LOBBY		2,576
			174,905
6	MAINTENANCE		
	GROUNDS MAINTENANCE		2,692
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		1,758
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		9,985
			14,435
7	OTHER		
	SCAVENGER AND EXTERMINATING SERVICES		45,974
	SECURITY SERVICE		0
			45,974
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	43,800

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	15,679
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	949
	PHARMACY CONSULTANT	XVIII B 39-2	6,545
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	58,250
			81,423
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	22,724
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	20,713
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	6,037
	RESPIRATORY		14,708
			64,182
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,700
			1,700
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,834
	SOCIAL WORKER	XVIII B 45-2	0
			1,834
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL		
14				
	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION	0		
			0	
17				
	ADMINISTRATIVE			
	MANAGEMENT FEES XIX B	360,000	360,000	
	DIRECTORS FEES			
18				
	DIRECTORS FEES	0	0	
19				
	PROFESSIONAL SERVICES			
	DATA PROCESSING XIX C	11,494		
	ADMINISTRATIVE CONSULTANTS XIX C	0		
	PROFESSIONAL FEES XIX C	117,422		
	BOOKKEEPING/ADMINISTRATIVE SERVICES	396,200	525,116	
20				
	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING VI 19 XIX F	0		
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	52,410		
	EMPLOYEE WANT ADS XIX F	19,627		
	CONTRIBUTIONS VI 20 XIX F	0		
	DUES & SUBSCRIPTIONS XIX F	14,973		
	LICENSES & PERMITS XIX F	3,131		
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0		
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0		
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0		
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,016		
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,580		
	PATIENT BACKGROUND CHECKS XIX F	3,128		
			101,865	
21				
	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,496		
	EQUIPMENT REPAIR & MAINTENANCE	82,735		
	OUTSIDE CLERICAL SERVICES	0		
	PENALTIES / OVERDRAFT CHARGES VI 18	4,950		
	HOME OFFICE EXPENSE	0		
	THEFT & DAMAGE LOSS	0		
	TELEPHONE	23,508		
	MESSANGER SERVICE	5,190		
			121,879	

LINE	SCHED REF	TOTAL		
22				
	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES XIX D	252,727		
	UNEMPLOYMENT COMPENSATION XIX D	91,006		
	WORKERS COMPENSATION INSURANCE XIX D	121,147		
	HOSPITALIZATION INSURANCE XIX D	99,611		
	EMPLOYEE BENEFITS - OTHER XIX D	13,405		
	EMPLOYEE PHYSICAL EXAMS XIX D	0		
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0		
	PENSION/PROFIT SHARING PLANS XIX D	0		
			577,896	
23				
	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS	19,284		
			19,284	
24				
	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS XIX G	0		
	TRAVEL XIX G	24,593		
			24,593	
25				
	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF	0		
			0	
26				
	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE	199,654		
			199,654	
27				
	OTHER			
	BAD DEBTS VI 24	29,059		
			29,059	

GRAND TOTAL COLUMN 3 OTHER

3,358,632

BRIA OF BELLEVILLE
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	3,498	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	3,498	
TOTAL PATIENT CENSUS	41,579	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	124,737	
ADD # EMPLOYEE MEALS/DAY		
TIMES # DAYS	<u>34,404</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	124,737	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	124,737	
NET FOOD	3,498	
DIVIDE TOTAL MEALS/YEAR	<u>124,737</u>	
COST PER MEAL	0.03	
TIMES EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>	

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			51,004	51,004		51,004	216,111	267,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,630	64,630		64,630	173,680	238,310			32
33	Real Estate Taxes			5,635	5,635		5,635	61,490	67,125			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			32,581	32,581		32,581	9,090	41,671			35
36	Other (specify):*							24,863	24,863			36
37	TOTAL Ownership			633,850	633,850		633,850	5,234	639,084			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		320,948	808,560	1,129,508		1,129,508		1,129,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			295,702	295,702		295,702		295,702			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		320,948	1,104,262	1,425,210		1,425,210		1,425,210			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,371,200	692,163	5,096,744	9,160,107		9,160,107	(347,019)	8,813,088			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,558	30		9
10	Interest and Other Investment Income	(2,669)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,950)	21		18
19	Entertainment		20		19
20	Contributions	(7,016)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,059)	27		24
25	Fund Raising, Advertising and Promotional	(52,410)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(58,035)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,581)		\$	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)	(215,438)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (215,438)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (347,019)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (51,882)	21	1
2	TRANSPORTATION STAFF-MARKETING	(6,153)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(58,035)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF BELLEVILLE# 0034678

Report Period Beginning:

01/01/2016

Ending:

12/31/2016**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	134	0	0	0	0	0	0	0	134	5
6	Maintenance	0	0	0	602	0	0	0	0	0	0	0	602	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	736	0	0	0	0	0	0	0	736	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	43,204	0	0	0	0	0	0	0	43,204	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	43,204	0	0	0	0	0	0	0	43,204	16
	C. General Administration													
17	Administrative	0	0	(97,255)	9,284	0	0	0	0	0	0	0	(87,971)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,800	(296,998)	(89,687)	0	0	0	0	0	0	0	(374,885)	19
20	Fees, Subscriptions & Promotions	(59,426)	0	445	4,913	0	0	0	0	0	0	0	(54,068)	20
21	Clerical & General Office Expenses	(56,832)	0	66,313	90,988	0	0	0	0	0	0	0	100,469	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	1,057	0	0	0	0	0	0	0	1,057	23
24	Travel and Seminar	0	0	0	4,640	0	0	0	0	0	0	0	4,640	24
25	Other Admin. Staff Transportation	(6,153)	0	0	0	0	0	0	0	0	0	0	(6,153)	25
26	Insurance-Prop.Liab.Malpractice	0	16,204	3,994	1,495	0	0	0	0	0	0	0	21,693	26
27	Other (specify):*	(29,059)	0	8,589	19,495	0	0	0	0	0	0	0	(975)	27
28	TOTAL General Administration	(151,470)	28,004	(314,912)	42,185	0	0	0	0	0	0	0	(396,193)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(151,470)	28,004	(314,912)	86,125	0	0	0	0	0	0	0	(352,253)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF BELLEVILLE # 0034678 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	22,558	191,932	1,064	557	0	0	0	0	0	0	0	216,111	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,669)	166,419	0	9,930	0	0	0	0	0	0	0	173,680	32
33	Real Estate Taxes	0	61,018	0	472	0	0	0	0	0	0	0	61,490	33
34	Rent-Facility & Grounds	0	(480,000)	0	0	0	0	0	0	0	0	0	(480,000)	34
35	Rent-Equipment & Vehicles	0	0	6,950	2,140	0	0	0	0	0	0	0	9,090	35
36	Other (specify):*	0	23,180	0	1,683	0	0	0	0	0	0	0	24,863	36
37	TOTAL Ownership	19,889	(37,451)	8,014	14,782	0	0	0	0	0	0	0	5,234	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)	(131,581)	(9,447)	(306,898)	100,907	0	0	0	0	0	0	0	(347,019)	45

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 PG6-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.

☒ 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	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENT	\$ 480,000	LINCOLN ASSOCIATES, L.P.		\$	(480,000)	1
2	V	30	DEPRECIATION				191,932	191,932	2
3	V	32	INTEREST EXPENSE				163,118	163,118	3
4	V	32	AMORT LOAN COST				3,301	3,301	4
5	V	33	REAL ESTATE TAXES				61,018	61,018	5
6	V	36	MIP INSURANCE				23,180	23,180	6
7	V	26	INSURANCE				16,204	16,204	7
8	V	19	PROFESSIONAL FEES				11,800	11,800	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 480,000			\$ 470,553	\$ * (9,447)	14

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$ 360,000	WEISS MANAGEMENT GROUP, INC.		\$	\$ (360,000)	15
16	V	19	BOOKKEEPING/ADM SERVICES	300,000				(300,000)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATIVE SALARIES				262,745	262,745	19
20	V	19	PROFESSIONAL FEES				3,002	3,002	20
21	V	20	LICENSES & PERMITS				445	445	21
22	V	21	OFFICE EXPENSES				66,313	66,313	22
23	V	26	INSURANCE				3,994	3,994	23
24	V	27	EMPLOYEE BENEFITS				8,589	8,589	24
25	V	30	DEPRECIATION (SL)				1,064	1,064	25
26	V	35	AUTO LEASE				6,950	6,950	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			\$ 660,000			\$ 353,102	\$ * (306,898)	39

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

Facility Name & ID Number	BRIA OF BELLEVILLE	#	0034678	Report Period Beginning:	01/01/2016	Ending:	12/31/2016
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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. ☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	BOOKKEEPING/ADM SERVICES	\$ 96,200	BRIA HEALTH SERVICES, LLC		\$	\$ (96,200)	15
16	V	20	WANT ADS/BACKGR CKS	3,144				(3,144)	16
17	V								17
18	V	17	CFO SALARY-A.WEINFELD				9,284	9,284	18
19	V	10	SALARIES-MEDICARE/NURSING				43,204	43,204	19
20	V	21	SALARIES-PURCHASING D.SEGAL				15,457	15,457	20
21	V	21	SALARIES-CLERICAL				60,845	60,845	21
22	V	5	UTILITIES				134	134	22
23	V	6	MAINTENANCE				602	602	23
24	V	19	PROFESSIONAL FEES				6,513	6,513	24
25	V	20	WANT ADS/BACKGR CKS				8,057	8,057	25
26	V	21	OFFICE EXPENSE				14,686	14,686	26
27	V	23	SEMINARS				1,057	1,057	27
28	V	24	TRAVEL				4,640	4,640	28
29	V	26	INSURANCE				1,495	1,495	29
30	V	27	EMPLOYEE BENEFITS				19,495	19,495	30
31	V	30	DEPRECIATION				557	557	31
32	V	32	INTEREST				9,930	9,930	32
33	V	33	RE TAX				472	472	33
34	V	36	OFFICE RENT-HINSDALE MGMT				1,683	1,683	34
35	V	35	STORAGE FEES				983	983	35
36	V	35	AUTO LEASE				1,157	1,157	36
37	V	35							37
38	V								38
39	Total			\$ 99,344			\$ 200,251	\$ * 100,907	39

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

Facility Name & ID Number

BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	MARTIN J. WEISS	45.10	BRIA OF CAHOKIA	CAHOKIA	WEISS MGMT	LINCOLNWOOD	MANAGEMENT/	2
3	DANIEL WEISS	12.31			GROUP, INC		CLERICAL	3
4	GARY WEINTRAUB	14.45	BRIA OF FOREST EDGE	CHICAGO				4
5	ILANA FINN	4.69			BRIA HEALTH	LINCOLNWOOD	MANAGEMENT	5
6	CATHLENE WEISS	5.88	BRIA OF GENEVA	GENEVA	SERVICES, LLC		SERVICES	6
7	SUZANNE KOENIG	9.18						7
8	NATAN WEISS	8.39	LAKE PARK CENTER	WAUKEGAN	LINCOLN ASSO-	LINCOLNWOOD	REAL ESTATE	8
9					CIATES, L.P.			9
10			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				10
11				HEIGHTS				11
12								12
13			BRIA OF PALOS HILLS	PALOS HILLS				13
14								14
15			BRIA OF RIVER OAKS	BURNHAM				15
16								16
17								17
18			BRIA OF WESTMONT	WESTMONT				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 BELLEVILLE # 0034678 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								\$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIVE	45.10	SEE	10	22.22	SALARY	97,313	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	SCHEDULE	10	9.52	SALARY	67,303	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	8.39		10	11.24	SALARY	97,313	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 261,929		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 BELLEVILLE# 0034678

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

WEISS MANAGEMENT GROUP, INC

Street Address

6865 N LINCOLN AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 674-5794

Fax Number

(847) 674-5794

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6				
1	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	85,454	2	\$ 540,000	\$ 540,000	41,579	\$ 262,745	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	85,454	2	6,170		41,579	3,002	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	85,454	2	914		41,579	445	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	85,454	2	136,289	134,693	41,579	66,313	4
5	26	INSURANCE	PATIENT CENSUS	85,454	2	8,209		41,579	3,994	5
6	27	EMPLOYEE BENEFITS	PATIENT CENSUS	85,454	2	17,653		41,579	8,589	6
7	30	DEPRECIATION (SL)	PATIENT CENSUS	85,454	2	2,187		41,579	1,064	7
8	35	AUTO LEASE	PATIENT CENSUS	85,454	2	14,283		41,579	6,950	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					\$ 725,705	\$ 674,693		\$ 353,102	25

Facility Name & ID Number BRIA OF BELLEVILLE# 0034678

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

BRIA HEALTH SERVICES, LLC

Street Address

6865 N LINCOLN AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 674-5795

Fax Number

(847) 674-5794

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	CFO SALARY-A.WEINFELD	CENSUS DAYS	470,242	8	\$ 105,000	\$ 105,000	41,579	\$ 9,284	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	470,242	8	488,618	488,618	41,579	43,204	2
3	21	SALARIES-PURCHASING D.SEGA	CENSUS DAYS	470,242	8	174,808	174,808	41,579	15,457	3
4	21	SALARIES-CLERICAL	CENSUS DAYS	470,242	8	688,130	688,130	41,579	60,845	4
5	5	UTILITIES	CENSUS DAYS	470,242	8	1,521		41,579	134	5
6	6	MAINTENANCE	CENSUS DAYS	470,242	8	6,806		41,579	602	6
7	19	PROFESSIONAL FEES	CENSUS DAYS	470,242	8	73,657		41,579	6,513	7
8	20	WANT ADS/BACKGR CKS	CENSUS DAYS	470,242	8	91,117		41,579	8,057	8
9	21	OFFICE EXPENSE	CENSUS DAYS	470,242	8	166,089		41,579	14,686	9
10	23	SEMINARS	CENSUS DAYS	470,242	8	11,949		41,579	1,057	10
11	24	TRAVEL	CENSUS DAYS	470,242	8	52,475		41,579	4,640	11
12	26	INSURANCE	CENSUS DAYS	470,242	8	16,909		41,579	1,495	12
13	27	EMPLOYEE BENEFITS	CENSUS DAYS	470,242	8	220,477		41,579	19,495	13
14	30	DEPRECIATION	CENSUS DAYS	470,242	8	6,293		41,579	557	14
15	32	INTEREST	CENSUS DAYS	470,242	8	112,306		41,579	9,930	15
16	33	RE TAX	CENSUS DAYS	470,242	8	5,338		41,579	472	16
17	36	OFFICE RENT-HINSDALE MGMT	CENSUS DAYS	470,242	8	19,029		41,579	1,683	17
18	35	STORAGE FEES	CENSUS DAYS	470,242	8	11,121		41,579	983	18
19	35	AUTO LEASE	CENSUS DAYS	470,242	8	13,087		41,579	1,157	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,264,730	\$ 1,456,556		\$ 200,251	25

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: THE LINCOLN ASSOCIATION, LLC						\$					\$	1		
2	BEECH STREET CAPITAL		X	MORTGAGE	\$33,742.90	09/01/13		4,528,900	4,161,811	04/01/39	3.8700	163,118	2		
3	AMORT LOAN COST		X	AMORT OVER LIFE				84,735	73,732			3,301	3		
4													4		
5													5		
	Working Capital														
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND				1,371,492		PRIME+	61,762	6		
7		X		INSURANCE FINANCING								2,868	7		
8	RELATED PARTY ALLOCATION											9,930	8		
9	TOTAL Facility Related				\$33,742.90		\$	4,613,635	\$	5,607,035			\$	240,979	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	4,613,635	\$	5,607,035			\$	240,979	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,180 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.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.							
1. Real Estate Tax accrual used on 2015 report.	\$	57,701					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.)	\$	64,699					2	
3. Under or (over) accrual (line 2 minus line 1).	\$	6,998					3	
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	59,655					4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$						5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 200 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$						6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	66,653					7	
Real Estate Tax History:								
Real Estate Tax Bill for Calendar Year:	2011	61,492	8					
	2012	61,563	9					
	2013	61,481	10					
	2014	62,581	11					
	2015	64,699	12					
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL								
THE PAYMENT ON LINE 2 APPLIES TO THE 2015 TAX BILL.								

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION \$			16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 **B. General Construction Type:** Exterior BRICK Frame Number of Stories 2

C. Does the Operating Entity? ☒ (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? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (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 ☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	3+ACRES	1987	\$ 148,649	1
2	PARKING LOT	2+ACRES	2005	50,000	2
3	TOTALS	#VALUE!		\$ 198,649	3

Facility Name & ID Number **BRIA OF BELLEVILLE**

0034678

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	152			1988	\$ 2,011,351	\$ 63,852	31.5	\$ 63,852	\$	1,780,949	4
5				2003	1,249,221	45,426	27.5	45,426		611,358	5
6											6
7											7
8	RELATED PARTY ALLOCATION					452		452			8
	Improvement Type**										
9	VARIOUS			1990	11,158	354	31.5	354		9,298	9
10	VARIOUS			1993	6,676	171	39	171		4,805	10
11	VARIOUS			1994	7,797	200	39	200		5,458	11
12	VARIOUS			1995	13,072	335	39	335		8,267	12
13	CARPET			1996	907	23	39	23		512	13
14	BILLBOARD			1996	900	23	39	23		515	14
15	SMOKE DETECTORS			1996	602	15	39	15		340	15
16	PARKING LOT			1996	8,006	205	39	205		4,690	16
17	AWNING			1996	905	23	39	23		530	17
18	CARPETING			1996	1,512	39	39	39		911	18
19	DOOR LOCKS			1997	2,100	54	39	54		1,138	19
20	WALL PAPER			1997	2,012	52	39	52		1,106	20
21	HANDRAIL			1997	3,217	83	39	83		1,689	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		5,655	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	236	39	236		4,485	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		1,461	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		531	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD			1999	6,144	158	39	158		2,454	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	1,446	39	1,446		22,408	27
28	WALLPAPER			2000	14,896	382	39	382		6,857	28
29	SEWER LINE REPAIR			2000	11,743	301	39	301		4,960	29
30	AIR CONDITIONING UNITS			2000	8,848	227	39	227		3,740	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	69	39	69		1,140	31
32	NEW NURSES STATION			2000	20,379	522	39	522		8,623	32
33	FIRE ALARM SYSTEM			2000	1,826	47	39	47		776	33
34	HOT WATER SYSTEM			2000	3,849	99	20	99		2,648	34
35	TILED FLOORS			2000	54,185	1,389	39	1,389		22,928	35
36				2000	18,490	474	39	474		7,819	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 BELLEVILLE**# **0034678**

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	\$ 13,369	\$	20	\$ 668	\$ 668	\$ 13,346	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		20,244	38
39	ROOF	2001	47,500	1,727	27.5	1,727		26,769	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		5,176	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		6,882	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		6,401	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		30,736	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		21,174	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159		20	1,558	1,558	23,370	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		3,663	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		9,105	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTRANCE	2002	7,245	263	27.5	263		3,868	48
49	LANDSCAPING	2004	7,759		15	517	517	6,398	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	21,359	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	4,082	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC TILE	2004	105,250		20	5,263	5,263	68,419	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		1,329	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		1,054	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		12,674	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		3,941	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		3,506	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		16,454	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		7,780	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906		5			17,906	60
61	AIR CONDITIONERS	2007	7,968		5			7,968	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	2,084	27.5	2,084		19,711	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		3,163	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		1,343	64
65	PAINTING	2007	9,986		5			9,986	65
66	GARDEN	2007	60,172	2,188	15	4,012	1,824	36,016	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		1,674	67
68	PAINTING - 30 ROOMS	2008	2,550		5			2,550	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		923	69
70	TOTAL (lines 4 thru 69)		\$ 4,265,246	\$ 134,900		\$ 146,687	\$ 11,787	\$ 2,947,021	70

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

Facility Name & ID Number **BRIA OF BELLEVILLE**# **0034678**

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,265,246	\$ 134,900		\$ 146,687	\$ 11,787	\$ 2,947,021	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		858	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		1,466	3
4	WALL AIR CONDITIONS	2009	5,187		5			5,187	4
5	INSTALL NEW COMPRESSOR,CRANK CASE HEATER	2009	3,195	116	27.5	116		885	5
6	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		2,210	6
7	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		31,712	7
8	WALLCOVERING, CARPET, PAINTING, BLINDS, CURTAINS	2009	29,344		5			29,344	8
9	WALL AIR CONDITIONS	2010	4,581		5			4,581	9
10	INSTALL STEEL DOOR	2010	10,694	389	27.5	389		2,480	10
11	FIRE PROTECTION WORK-SPRINKLERS PHASE 1	2010	97,653	3,551	27.5	3,551		21,750	11
12	FIRE PROTECTION WORK-SPRINKLERS PHASE 2	2011	97,652	3,551	27.5	3,551		18,199	12
13	WING CORRIDORS-FLOORING,WALLCOVERING,	2011	67,587	2,458	27.5	2,458		14,646	13
14	HANDRAILS,BUNPER GUARDS,SIGNAGE,WALL PROTECTION								14
15	INSTALL NEW CARRIER RTU	2011	4,517	164	27.5	164		909	15
16	PAINTING-100 & 200 HALL, LODGING, NURSES STATION	2011	44,405	4,254	5	4,254		44,405	16
17	WALL AIR CONDITIONS	2011	7,698		5			7,698	17
18	WALL AIR CONDITIONS	2012	4,194	231	5	231		4,165	18
19	REPLACED ROOF TOP UNIT & 5 TON CONDENSING UNIT	2012	9,995	363	27.5	363		1,618	19
20	INSTALL NEW PLASTIC CEMENT, CAP,COTTON MEMBRA-								20
21	NE ON EPDM ROOF	2012	2,595	94	27.5	94		458	21
22	PARKING LOT IMPROVMENTS; CONCRETE PATIO AND								22
23	DRAINAGE	2012	72,786	4,852	15	4,852		19,812	23
24	INSTALLED A 240CFM EXHAUST FAN ON A CURB OVER								24
25	THE NURSES STATION	2013	3,044	111	27.5	111		439	25
26	LOBBY; OFFICES-CARPET INSTALLATION; WALL BASE								26
27	INSTALLATION	2013	7,824	285	27.5	285		1,057	27
28	SEAL COAT PARKING LOT AND STRIPE PARKING SPACES	2013	3,000	200	15	200		733	28
29	100, 200, 300, 400 WINGS- CORRIDOR, RESIDENT ROOMS,								29
30	RESIDENT BATHROOMS-FLOORING	2013	164,523	5,983	27.5	5,983		18,198	30
31	INSTALLATION OF NURSING STATION; AREA BETWEEN 100								31
32	& 200 WINGS;CORRIDOR, RESIDENT ROOM IN CENTER-								32
33	CUSTOM PVT INSTALLATION	2014	75,482	2,745	27.5	2,745		6,977	33
34	TOTAL (lines 1 thru 33)		\$ 5,109,771	\$ 168,967		\$ 180,754	\$ 11,787	\$ 3,186,808	34

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

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,109,771	\$ 168,967		\$ 180,754	\$ 11,787	\$ 3,186,808	1
2	100 & 200 WINGS RESIDENT BATHS-INSTALLATION OF								2
3	CERAMIC TILE; ACTIVITY ROOM-COVE BASE & PVT INS-								3
4	TALLATION; BUILD 2 NEW WALLS WITH METAL	2014	51,277	1,865	27.5	1,865		4,429	4
5	INSTALL A FIRESTONE TPO ROOFING SYSTEM, GRAVE								5
6	GUARD,ROOF FLASHING OVER THE TOP FLANGE	2014	23,186	843	27.5	843		1,932	6
7	INSTALL NEW SIGN & CABINET TO EXISTING STRUCTUR	2014	5,737	382	15	382		860	7
8	LOBBY, 100 WING: CORRIDOR, NURSE STATION, RESIDENT ROOMS & BATHS, DINING & LIVING .ADMINISTRATOR, ADMISSIONS OFFICI								8
9	INSTALLATION OF CARPET TILE, WALLCOVERING, SIGNAGE, HANDRAIL AND BUMPER GUARD, INSTALL METAL FRAMES & WOOD								9
10	DOORS, INSTALL NEW PVT AND COVE BASE,CUSTOM DRESSERS & WARDROBES, HEADWALL & DIVIDER UNITS,OVERBED LIGHTS,								10
11	WALL SCONCE, CURTAINS & BLINDS,PAINT WALLS, DOORFRAMES AND CEILINGS, INSTALL NEW CERAMIC AND WALL TILE, DEMO								11
12	WALL BETWEEN ROOM 101 & 103, CAP ALL PLUMBING IN BATHROOM, CHANGE CONCRETE, INSTALL NEW LIGHT FIXTURES, DRY-								12
13	WALL, CUSTOM KITCHENETTE, RECEPTION DESK	2015	328,421	11,943	27.5	11,943		18,412	13
14	VESTIBULE, THERAPY CORRIDOR, 100 WING SPA, 100 WING GUEST BATHROOM:								14
15	WALLCOVERING, MILLWORK BASE, TILE, HANDRAIL	2015	9,839	358	27.5	358		701	15
16	INSTALL INTERIOR SIGNAGE-150 NORTH 27TH STREET	2015	4,264	284	15	284		521	16
17	ADDITION: THERAPY ROOM, FRONT ENTRIES, NEW								17
18	BATHROOMS/SHOWER ROOM	2015	424,500	15,436	27.5	15,436		23,797	18
19	GUEST BATHROOM, ACTIVITY ROOM CORRIDOR,VESTIBULE:								19
20	INSTALL NEW CERAMIC FLOOR, PVT & MILWORK BASE	2015	25,003	909	27.5	909		1,629	20
21	100/200 NURSE CALL SYSTEM RE-WIRE	2016	12,948	216	27.5	216		216	21
22	FURNISH AND INSTALLATION OF 400A FEEDER OVER								22
23	HEAD ON ROOF FROM MDP TO SUB PANEL	2016	9,500	43	27.5	43		43	23
24	200,500 WING CORRIDOR, ADMISSIONS OFFICE-SIGNAGE,								24
25	INSTALL NEW CERAMIC TILE, WALLCOVERING	2016	6,584	110	27.5	110		110	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,011,030	\$ 201,356		\$ 213,143	\$ 11,787	\$ 3,239,458	34

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

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	\$ 429,908	\$ 30,008	\$ 50,689	\$ 20,681	3-10	\$ 202,228	71
72	Current Year Purchases	22,900	12,024	2,114	(9,910)	8-10	2,114	72
73	Fully Depreciated Assets	165,854					165,854	73
74	RELATED PARTY SL DEPRECIATION		1,169	1,169				74
75	TOTALS	\$ 618,662	\$ 43,201	\$ 53,972	\$ 10,771		\$ 370,196	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	2005 FORD ECONOCARE	2005	\$ 41,500	\$	\$	\$		\$ 41,500	76
77										77
78										78
79										79
80	TOTALS			\$ 41,500	\$	\$	\$		\$ 41,500	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)	\$ 6,869,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 244,557	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 267,115	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,558	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,651,154	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.

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: *

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: \$ 20,901 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	FACILITY	2015 FORD T350HD	\$ 982.50	\$ 11,680	17
18					18
19					19
20					20
21	TOTAL		\$ 982.50	\$ 11,680	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.

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

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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	\$		\$ 354,115	\$		\$ 354,115	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			103,545			103,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			350,900			350,900	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				168,052		168,052	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					28,484		28,484	12
13	MEDICAL SUPPLIES, RENTALS, Other (specify): I.V. THERAPY3	39-2					124,412		124,412	13
14	TOTAL			\$		\$ 808,560	\$ 320,948		\$ 1,129,508	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (227,956)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	4,161,333		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	148,985		6
7	Other Prepaid Expenses	52,903		7
8	Accounts Receivable (owners or related parties)	245,695		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,380,960	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	172,026		13
14	Buildings, at Historical Cost	158,256		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	660,163		16
17	Accumulated Depreciation (book methods)	(714,153)		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)	\$ 276,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,657,252	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 916,002	\$	26
27	Officer's Accounts Payable	430,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,521,492		29
30	Accrued Salaries Payable	103,819		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,805		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)	\$ 2,992,118	\$	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)	\$ 2,992,118	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,665,134	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,657,252	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,701,699	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(755)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,700,944	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,810)	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)	\$ (35,810)	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)	\$ 1,665,134	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,121,628	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,121,628	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***	2,669	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,669	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)	\$ 9,124,297	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,403,813	31
32	Health Care	3,406,404	32
33	General Administration	2,290,830	33
	B. Capital Expense		
34	Ownership	633,850	34
	C. Ancillary Expense		
35	Special Cost Centers	1,129,508	35
36	Provider Participation Fee	295,702	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,160,107	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,810)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,810)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,595,368	44
45	Private Pay - Net Inpatient Revenue	217,537	45
46	Medicare - Net Inpatient Revenue	3,130,584	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	244,595	47
48	Other-(specify) <u>MANAGED CARE</u>	933,544	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,121,628	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,808	1,983	\$ 118,674	\$ 59.85	1
2	Assistant Director of Nursing	2,565	2,717	86,209	31.73	2
3	Registered Nurses	7,651	8,636	247,453	28.65	3
4	Licensed Practical Nurses	33,368	37,289	795,836	21.34	4
5	CNAs & Orderlies	102,735	107,066	1,258,913	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,208	11,756	123,611	10.51	10
11	Social Service Workers	3,209	3,273	54,755	16.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,412	6,696	105,356	15.73	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,896	2,080	113,104	54.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,993	12,679	196,113	15.47	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	1,896	2,080	35,526	17.08	31
32	Other Health Care Care Plan Coord	8,467	9,073	235,650	25.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	193,208	205,328	\$ 3,371,200 *	\$ 16.42	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	43,800	9-3	36
37	Medical Records Consultant	N	949	10-3	37
38	Nurse Consultant	T	58,250	10-3	38
39	Pharmacist Consultant	H	6,545	10-3	39
40	Physical Therapy Consultant	L	22,724	10a-3	40
41	Occupational Therapy Consultant	Y	20,713	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	6,037	10a-3	43
44	Activity Consultant	E	1,700	11-3	44
45	Social Service Consultant	E	1,834	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 162,552		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 278	10-3	50
51	Licensed Practical Nurses	421	15,401	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	429	\$ 15,679		53

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

** See instructions.

Facility Name & ID Number		BRIA OF BELLEVILLE		STATE OF ILLINOIS		# 0034678		Report Period Beginning:		01/01/2016		Ending:		12/31/2016		Page 21	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount			
KENYA O'NEAL		ADMINISTRATOR		0		\$ 113,104		Workers' Compensation Insurance		\$ 121,147		IDPH License Fee		\$ 1,990			
								Unemployment Compensation Insurance		91,006		Advertising: Employee Recruitment		19,627			
								FICA Taxes		252,727		Health Care Worker Background Check		1,580			
								Employee Health Insurance		99,611		(Indicate # of checks performed 158)					
								Employee Meals		0		Patient Background Checks		308 3,128			
								Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		7,016			
								EMPLOYEE BENEFITS - OTHER		13,405		MARKETING/ADV/PROMO		52,410			
								EMPLOYEE PHYSICAL EXAMS		0		LICENSES/DUES/SUBSCRIPTIONS		16,114			
								PENSION/PROFIT SHARING PLANS		0		MGMT CO ALLOC		5,358			
								INSURANCE - EXECUTIVE LIFE		0		TRUST/FRANCHISE/CONTRIB/ETC		(7,016)			
												Less: Public Relations Expense		(0)			
												Non-allowable advertising		(52,410)			
												Yellow page advertising		(0)			
TOTAL (agree to Schedule V, line 17, col. 1)						\$ 113,104						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 47,797			
(List each licensed administrator separately.)																	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**									
Description		Amount		Description		Line # Amount		Description		Amount							
WEISS MANAGEMENT GROUP MANAGEMENT FEES		\$ 360,000		INSURANCE - EXECUTIVE LIFE VI 21		0		Out-of-State Travel		\$							
								In-State Travel		24,593							
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 360,000		TOTAL (agree to Schedule V, line 22, col.8)		\$ 577,896		MGMT CO ALLOC		4,640							
(Attach a copy of any management service agreement)								Seminar Expense		0							
C. Professional Services																	
Vendor/Payee		Type		Amount													
ALPHA DATA SERVICES		DATA PROCESSING		\$ 9,041													
NATIONAL DATACARE		DATA PROCESSING		2,454													
KBKB, LTD		ACCOUNTING FEES		12,200													
RICHARD PEELO & ASSOCIAT.		MEDICARE CONSULTANT		4,500													
PERSONNEL PLANNERS		UC CONSULTANT		13,986													
BRIA HEALTH SERVICES		BOOKKEEPING/ADM SVCS		96,200													
WEISS MANAGEMENT GROUP		BOOKKEEPING/ADM SVCS		300,000													
MICHIGAN PEER REVIEW		IDR REVIEW		3,220													
IPMG RISK MANAGEMENT		LIABILITY/REGULATORY		3,333													
LEGAL FEES		SEE SCHEDULE		80,182													
TOTAL (agree to Schedule V, line 19, column 3)				\$ 525,116													
(For legal fee disclosure, see page 39 of instructions)																	
				* Attach copy of IMRF notifications				**See instructions.									

**BRIA OF BELLEVILLE
SCHEDULE-LEGAL
12/31/2016**

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
1/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	340
2/29/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	614
3/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	854
4/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	458
5/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	793
6/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	3,481
7/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	646
8/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	855
9/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,204
10/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	988
11/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
12/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	3,438
1/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,828
2/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,242
3/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,478
4/4/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,242
5/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,360
6/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,567
7/5/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,655
8/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,773
9/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,832
10/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,537
11/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,891
12/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	2,596
11/30/2015	HEPLERBROOM LLC	RESIDENT ESTATE	270
11/30/2015	HEPLERBROOM LLC	RESIDENT ESTATE	4,641
12/21/2015	HEPLERBROOM LLC	RESIDENT ESTATE	116
12/21/2015	HEPLERBROOM LLC	RESIDENT ESTATE	2,253
1/27/2016	HEPLERBROOM LLC	RESIDENT ESTATE	1,735
1/27/2016	HEPLERBROOM LLC	RESIDENT ESTATE	436
2/23/2016	HEPLERBROOM LLC	RESIDENT ESTATE	2,409
2/24/2016	HEPLERBROOM LLC	GENERAL FILE	17
3/28/2016	HEPLERBROOM LLC	RESIDENT ESTATE	1,786
3/28/2016	HEPLERBROOM LLC	GENERAL FILE	33
4/27/2016	HEPLERBROOM LLC	RESIDENT ESTATE	628
7/20/2016	HEPLERBROOM LLC	RESIDENT ESTATE	198
8/23/2016	HEPLERBROOM LLC	RESIDENT ESTATE	314
10/25/2016	HEPLERBROOM LLC	RESIDENT ESTATE	270
11/23/2016	HEPLERBROOM LLC	RESIDENT ESTATE	4,634
12/20/2016	HEPLERBROOM LLC	RESIDENT ESTATE	2,697
1/19/2016	FEDERAL INSURANCE COMPANY	FEE FOR DEFENSE	22
4/25/2016	FEDERAL INSURANCE COMPANY	FEE FOR DEFENSE	12
9/11/2015	FEDERAL INSURANCE COMPANY	FEE FOR DEFENSE	419
11/21/2016	JACKSON LEWIS P.C.	CONSULTATION CAP FEE	314
10/27/2016	JACKSON LEWIS P.C.	CONSULTATION CAP FEE	5,158
12/12/2016	JACKSON LEWIS P.C.	CONSULTATION CAP FEE	143
2/8/2016	GREENSFELDER	COMPLIANCE LEGAL	6,190
TOTAL			<u>80,182</u>

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 \$ 13,738

(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?

If YES, what is the capacity?

NO

(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.

\$ 24,132

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

X

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.

\$ 295,702

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 benefit 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

HFS 3745 (N-4-99)

IL478-2471