

		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: 0050120

Facility Name: BRIA OF WESTMONT

Address: 6501 S CASS AVE WESTMONT 60559
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "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) _____ (Date) _____
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid
Preparer

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

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

Facility Name & ID Number BRIA OF WESTMONT

0050120 Report Period Beginning: 01/01/2016 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	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,528</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>107</u>	Intermediate (ICF)	<u>107</u>	<u>39,162</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	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			<u>5,914</u>	<u>5,914</u>	8
9	SNF/PED					9
10	ICF	<u>44,324</u>	<u>4,236</u>	<u>939</u>	<u>49,499</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,324	4,236	6,853	55,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.42%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 125 and days of care provided 5,914

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 WESTMONT** # **0050120** 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	60,709	20,711	740,255	821,675		821,675		821,675			1
2	Food Purchase		84,984		84,984		84,984		84,984			2
3	Housekeeping		49,980	349,410	399,390		399,390		399,390			3
4	Laundry		16,206	358,575	374,781		374,781		374,781			4
5	Heat and Other Utilities			284,363	284,363		284,363	726	285,089			5
6	Maintenance	104,751	121,178	43,118	269,047		269,047	2,533	271,580			6
7	Other (specify):*			16,719	16,719		16,719		16,719			7
8	TOTAL General Services	165,460	293,059	1,792,440	2,250,959		2,250,959	3,259	2,254,218			8
	B. Health Care and Programs											
9	Medical Director			63,000	63,000		63,000		63,000			9
10	Nursing and Medical Records	3,640,122	336,319	74,212	4,050,653		4,050,653	57,577	4,108,230			10
10a	Therapy			13,065	13,065		13,065		13,065			10a
11	Activities	112,516	3,088	1,805	117,409		117,409		117,409			11
12	Social Services	87,241	1,602	1,376	90,219		90,219		90,219			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,839,879	341,009	153,458	4,334,346		4,334,346	57,577	4,391,923			16
	C. General Administration											
17	Administrative	154,290		792,000	946,290		946,290	(548,203)	398,087			17
18	Directors Fees											18
19	Professional Services			106,459	106,459		106,459	(23,690)	82,769			19
20	Dues, Fees, Subscriptions & Promotions			159,671	159,671		159,671	(107,108)	52,563			20
21	Clerical & General Office Expenses	307,015	38,829	188,631	534,475		534,475	61,948	596,423			21
22	Employee Benefits & Payroll Taxes			683,468	683,468		683,468	(6,133)	677,335			22
23	Inservice Training & Education			2,048	2,048		2,048	1,408	3,456			23
24	Travel and Seminar			8,210	8,210		8,210	6,183	14,393			24
25	Other Admin. Staff Transportation							(2,769)	(2,769)			25
26	Insurance-Prop.Liab.Malpractice			248,748	248,748		248,748	2,426	251,174			26
27	Other (specify):*			248,180	248,180		248,180	(218,595)	29,585			27
28	TOTAL General Administration	461,305	38,829	2,437,415	2,937,549		2,937,549	(834,533)	2,103,016			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,466,644	672,897	4,383,313	9,522,854		9,522,854	(773,697)	8,749,157			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	13,370				
	REPAIRS & MAINTENANCE		0				
	CONTRACTED DIETARY SERVICES		726,885			740,255	
3	HOUSEKEEPING						
	CONTRACTED HOUSEKEEPING SERVICES		349,410				
						349,410	
4	LAUNDRY						
	EQUIPMENT REPAIRS & MAINTENANCE		0				
	CONTRACTED LAUNDRY SERVICES		358,575			358,575	
5	HEAT & OTHER UTILITIES						
	GAS HEAT		20,413				
	ELECTRICITY		97,119				
	WATER		160,173				
	CABLE TV - LOBBY		6,658				
						284,363	
6	MAINTENANCE						
	GROUNDS MAINTENANCE		16,008				
	PAINTING & DECORATING		0				
	BUILDING REPAIRS		0				
	MAINTENANCE TRAVEL		0				
	EQUIPMENT MAINTENANCE & REPAIR		0				
	ELEVATOR MAINTENANCE & REPAIR		0				
	OUTSIDE LABOR		0				
	EXTERMINATING SERVICE		0				
	FIRE SERVICE		27,110				
						43,118	
7	OTHER						
	SCAVENGER & EXTERMINATING SERVICES		16,719				
	SECURITY SERVICE		0				
						16,719	
9	MEDICAL DIRECTOR						
	MEDICAL DIRECTOR FEES	XVIII B 36-2	63,000			63,000	

LINE		SCHED REF	TOTAL				
10	NURSING						
	CONTRACT NURSING	XVIII C 53-2	2,166				
	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	845				
	PHARMACY CONSULTANT	XVIII B 39-2	16,848				
	UTILIZATION REVIEW FEES	XVIII B __-2	0				
	PHYSICIANS	XVIII B __-2	0				
	PSYCHIATRIC	XVIII B __-2	0				
	RN CONSULTANT	XVIII B 38-2	54,353				
						74,212	
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	7,221				
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	3,781				
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	652				
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,411				
						13,065	
11	ACTIVITIES						
	CABLE TV - PATIENT ROOMS		0				
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,805				
						1,805	
12	SOCIAL SERVICES						
	SOCIAL REHABILITATION SERVICES		0				
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,376				
	SOCIAL WORKER	XVIII B 45-2	0				
						1,376	
13	NURSE AIDE TRAINING						
	NURSE AIDE TRAINING COSTS	XIII	0			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 792,000	792,000
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 12,108	
	ADMINISTRATIVE CONSULTANTS	XIX C	
	PROFESSIONAL FEES	XIX C 51,851	
	BOOKKEEPING/ADMINISTRATIVE SERVICES	42,500	106,459
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 103,510	
	EMPLOYEE WANT ADS	XIX F 18,132	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 23,345	
	LICENSES & PERMITS	XIX F 3,659	
	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 8,775	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,650	
	PATIENT BACKGROUND CHECKS	XIX F 600	
			159,671
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,961	
	EQUIPMENT REPAIR & MAINTENANCE	139,167	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	46,163	
	MESSENGER SERVICE	1,340	
			188,631

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 334,062	
	UNEMPLOYMENT COMPENSATION	XIX D 61,332	
	WORKERS COMPENSATION INSURANCE	XIX D 102,311	
	HOSPITALIZATION INSURANCE	XIX D 80,936	
	EMPLOYEE BENEFITS - OTHER	XIX D 98,694	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 6,133	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
			683,468
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	2,048	
			2,048
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 8,210	
			8,210
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		
			0
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	248,748	
			248,748
27	OTHER		
	BAD DEBTS	VI 24 248,180	
			248,180

GRAND TOTAL COLUMN 3 OTHER

4,383,313

BRIA OF WESTMONT
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	84,984	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	84,984	
TOTAL PATIENT CENSUS	55,413	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	166,239	
ADD # EMPLOYEE MEALS/DAY		
TIMES # DAYS	<u>39,528</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	166,239	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	166,239	
NET FOOD	84,984	
DIVIDE TOTAL MEALS/YEAR	<u>166,239</u>	
COST PER MEAL	0.51	
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			252,636	252,636		252,636	148,896	401,532			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			526,023	526,023		526,023	62,876	588,899			32
33	Real Estate Taxes							103,275	103,275			33
34	Rent-Facility & Grounds			832,512	832,512		832,512	(832,512)				34
35	Rent-Equipment & Vehicles			79,984	79,984		79,984	7,125	87,109			35
36	Other (specify):* OFFICE RENT			15,600	15,600		15,600	36,141	51,741			36
37	TOTAL Ownership			2,206,755	2,206,755		2,206,755	(974,199)	1,232,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		419,129	952,392	1,371,521		1,371,521		1,371,521			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			419,376	419,376		419,376		419,376			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		419,129	1,371,768	1,790,897		1,790,897		1,790,897			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,466,644	1,092,026	7,961,836	13,520,506		13,520,506	(1,747,896)	11,772,610			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	(22,130)	30		9
10	Interest and Other Investment Income	(2,581)	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	(325,613)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(8,775)	20		20
21	Owner or Key-Man Insurance	(6,133)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(248,180)	27		24
25	Fund Raising, Advertising and Promotional	(103,510)	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	(562,079)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,279,001)		\$	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)	(468,895)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (468,895)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,747,896)		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	\$ (59,310)	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	2
3	TRANSPORTATION STAFF-MARKETING	(2,769)	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	(562,079)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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	547	179	0	0	0	0	0	0	0	726	5
6	Maintenance	0	0	1,731	802	0	0	0	0	0	0	0	2,533	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	2,278	981	0	0	0	0	0	0	0	3,259	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	57,577	0	0	0	0	0	0	0	57,577	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	57,577	0	0	0	0	0	0	0	57,577	16
	C. General Administration													
17	Administrative	0	0	(560,575)	12,372	0	0	0	0	0	0	0	(548,203)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,700	1,430	(33,820)	0	0	0	0	0	0	0	(23,690)	19
20	Fees, Subscriptions & Promotions	(112,285)	0	0	5,177	0	0	0	0	0	0	0	(107,108)	20
21	Clerical & General Office Expenses	(59,310)	0	0	121,258	0	0	0	0	0	0	0	61,948	21
22	Employee Benefits & Payroll Taxes	(6,133)	0	0	0	0	0	0	0	0	0	0	(6,133)	22
23	Inservice Training & Education	0	0	0	1,408	0	0	0	0	0	0	0	1,408	23
24	Travel and Seminar	0	0	0	6,183	0	0	0	0	0	0	0	6,183	24
25	Other Admin. Staff Transportation	(2,769)	0	0	0	0	0	0	0	0	0	0	(2,769)	25
26	Insurance-Prop.Liab.Malpractice	0	0	434	1,992	0	0	0	0	0	0	0	2,426	26
27	Other (specify):*	(248,180)	0	3,604	25,981	0	0	0	0	0	0	0	(218,595)	27
28	TOTAL General Administration	(428,677)	8,700	(555,107)	140,551	0	0	0	0	0	0	0	(834,533)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(428,677)	8,700	(552,829)	199,109	0	0	0	0	0	0	0	(773,697)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(22,130)	168,577	1,710	739	0	0	0	0	0	0	0	148,896	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(328,194)	376,440	1,395	13,235	0	0	0	0	0	0	0	62,876	32
33	Real Estate Taxes	0	99,849	2,797	629	0	0	0	0	0	0	0	103,275	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	4,271	2,854	0	0	0	0	0	0	0	7,125	35
36	Other (specify):*	0	49,499	(15,600)	2,242	0	0	0	0	0	0	0	36,141	36
37	TOTAL Ownership	(850,324)	(138,147)	(5,427)	19,699	0	0	0	0	0	0	0	(974,199)	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)	(1,279,001)	(129,447)	(558,256)	218,808	0	0	0	0	0	0	0	(1,747,896)	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 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.

☒ 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)	
1	V	34	RENT	\$ 832,512	WESTMONT REAL ESTATE, LLC		\$	(832,512)	1
2	V	30	DEPRECIATION (SL)				168,577	168,577	2
3	V	32	INTEREST				372,709	372,709	3
4	V	32	AMORT LOAN COST				3,731	3,731	4
5	V	33	REAL ESTATE TAXES				99,849	99,849	5
6	V	36	MIP INSURANCE				49,499	49,499	6
7	V	19	ACCOUNTING FEES				8,700	8,700	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 832,512			\$ 703,065	\$ * (129,447)	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. ☒ 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	36	OFFICE RENT	\$ 15,600	IME REALTY		\$	\$ (15,600)	15
16	V								16
17	V	5	UTILITIES				547	547	17
18	V	6	MAINTENANCE				1,669	1,669	18
19	V	6	ALARM SERVICE				62	62	19
20	V	19	ACCOUNTING FEES				155	155	20
21	V	26	INSURANCE				434	434	21
22	V	30	DEPRECIATION (SL)				1,710	1,710	22
23	V	32	INTEREST				1,395	1,395	23
24	V	33	RE TAX				2,797	2,797	24
25	V	35	STORAGE FEES				4,271	4,271	25
26	V								26
27	V								27
28	V	17	MANAGEMENT FEES	792,000	DA WESTMONT			(792,000)	28
29	V	17	OFFICER SALARIES-A. WEINFELD				21,234	21,234	29
30	V	17	OFICER SALARIES-D. WEISS				21,234	21,234	30
31	V	17	ADMIN CONSULTANT-SHIRLEY HOLT				122,163	122,163	31
32	V	17	ADMIN CONSULTANT-A.R.M.				66,794	66,794	32
33	V	19	ACCOUNTING FEES				1,275	1,275	33
34	V	27	PAYROLL TAXES				3,604	3,604	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 807,600			\$ 249,344	\$ * (558,256)	39

* 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. ☒ 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	\$ 42,500	BRIA HEALTH SERVICES, LLC		\$	\$ (42,500)	15
16	V	20	WANT ADS/BACKGR CKS	5,562				(5,562)	16
17	V								17
18	V	17	CFO SALARY-A.WEINFELD				12,372	12,372	18
19	V	10	SALARIES-MEDICARE/NURSING				57,577	57,577	19
20	V	21	SALARIES-PURCHASING D.SEGAL				20,599	20,599	20
21	V	21	SALARIES-CLERICAL				81,088	81,088	21
22	V	5	UTILITIES				179	179	22
23	V	6	MAINTENANCE				802	802	23
24	V	19	PROFESSIONAL FEES				8,680	8,680	24
25	V	20	WANT ADS/BACKGR CKS				10,739	10,739	25
26	V	21	OFFICE EXPENSE				19,571	19,571	26
27	V	23	SEMINARS				1,408	1,408	27
28	V	24	TRAVEL				6,183	6,183	28
29	V	26	INSURANCE				1,992	1,992	29
30	V	27	EMPLOYEE BENEFITS				25,981	25,981	30
31	V	30	DEPRECIATION				739	739	31
32	V	32	INTEREST				13,235	13,235	32
33	V	33	RE TAX				629	629	33
34	V	36	OFFICE RENT-HINSDALE MGMT				2,242	2,242	34
35	V	35	STORAGE FEES				1,311	1,311	35
36	V	35	AUTO LEASE				1,543	1,543	36
37	V								37
38	V								38
39	Total			\$ 48,062			\$ 266,870	\$ * 218,808	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:

01/01/2016

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	AVRUM & DEVORAH WEINFELD	40.00	BRIA OF CAHOKIA	CAHOKIA	WESTMONT REAL			2
3					ESTATE, LLC	LINCOLNWOOD	REAL ESTATE	3
4	DANIEL & REBECCA WEISS	40.00	BRIA OF FOREST EDGE	CHICAGO				4
5					IME REALTY CORP	LINCOLNWOOD	HOME OFFICE	5
6	MIRIAM ROBINSON	20.00	BRIA OF BELLEVILLE	BELLEVILLE				6
7					DA WESTMONT	LINCOLNWOOD	MGMT CONSULT	7
8			BRIA OF GENEVA	GENEVA				8
9					BRIA HEALTH			9
10			LAKE PARK	WAUKEGAN	SERVICES, LLC	LINCOLNWOOD	MGMT SERVICES	10
11								11
12			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				12
13				HEIGHTS				13
14								14
15			BRIA OF PALOS HILLS	PALOS HILLS				15
16								16
17			BRIA OF RIVER OAKS	BURNHAM				17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM DA WESTMONT:								\$		1
2	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT		0.00		15	60.00	CONSULT FEE	66,794	17-7	2
3											3
4	AVRUM WEINFELD	CFO	ADMINISTRAT.	40.00		15	12.60	SALARIES	21,234	17-7	4
5											5
6	DANIEL WEISS		ADMINISTRAT.	40.00		10	9.52	SALARIES	21,234	17-7	6
7											7
8											8
9	ALLOCATION FROM BRIA HEALTH SERVICES:										9
10	AVRUM WEINFELD		CFO					SALARIES	12,372	17-7	10
11											11
12											12
13								TOTAL	\$ 121,634		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: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization IME REALTY CORP.
Street Address 6765 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	INCOME	131,420	6	\$ 4,608	\$	15,600	\$ 547	1
2	6	MAINTENANCE	INCOME	131,420	6	14,061		15,600	1,669	2
3	6	ALARM SERVICE	INCOME	131,420	6	520		15,600	62	3
4	19	ACCOUNTING FEES	INCOME	131,420	6	1,305		15,600	155	4
5	26	INSURANCE	INCOME	131,420	6	3,656		15,600	434	5
6	30	DEPRECIATION (SL)	INCOME	131,420	6	14,406		15,600	1,710	6
7	32	INTEREST	INCOME	131,420	6	11,748		15,600	1,395	7
8	33	RE TAX	INCOME	131,420	6	23,559		15,600	2,797	8
9	35	STORAGE FEES	INCOME	131,420	6	35,982		15,600	4,271	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					\$ 109,845	\$		\$ 13,040	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DA WESTMONT
Street Address 6865 N LINCOLN
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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	OFFICER SALARIES-A. WEINFEL	CENSUS DAYS	3	\$ 60,000	\$ 60,000	55,413	\$ 21,234	1
2	17	OFFICER SALARIES-D. WEISS	CENSUS DAYS	3	60,000	60,000	55,413	21,234	2
3	17	ADMIN CONSUL.SHIRLEY HOLT	CENSUS DAYS	1	122,163		55,413	122,163	3
4	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	3	188,737		55,413	66,794	4
5	19	ACCOUNTING FEES	CENSUS DAYS	3	3,605		55,413	1,275	5
6	27	PAYROLL TAXES	CENSUS DAYS	3	10,184		55,413	3,604	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				\$ 444,689	\$ 120,000		\$ 236,304	25

Facility Name & ID Number BRIA OF WESTMONT # 0050120 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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	55,413	\$ 12,372	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	470,242	8	488,618	488,618	55,413	57,577	2
3	21	SALARIES-PURCHASING D.SEGA	CENSUS DAYS	470,242	8	174,808	174,808	55,413	20,599	3
4	21	SALARIES-CLERICAL	CENSUS DAYS	470,242	8	688,130	688,130	55,413	81,088	4
5	5	UTILITIES	CENSUS DAYS	470,242	8	1,521		55,413	179	5
6	6	MAINTENANCE	CENSUS DAYS	470,242	8	6,806		55,413	802	6
7	19	PROFESSIONAL FEES	CENSUS DAYS	470,242	8	73,657		55,413	8,680	7
8	20	WANT ADS/BACKGR CKS	CENSUS DAYS	470,242	8	91,117		55,413	10,739	8
9	21	OFFICE EXPENSE	CENSUS DAYS	470,242	8	166,089		55,413	19,571	9
10	23	SEMINARS	CENSUS DAYS	470,242	8	11,949		55,413	1,408	10
11	24	TRAVEL	CENSUS DAYS	470,242	8	52,475		55,413	6,183	11
12	26	INSURANCE	CENSUS DAYS	470,242	8	16,909		55,413	1,992	12
13	27	EMPLOYEE BENEFITS	CENSUS DAYS	470,242	8	220,477		55,413	25,981	13
14	30	DEPRECIATION	CENSUS DAYS	470,242	8	6,293		55,413	739	14
15	32	INTEREST	CENSUS DAYS	470,242	8	112,306		55,413	13,235	15
16	33	RE TAX	CENSUS DAYS	470,242	8	5,338		55,413	629	16
17	36	OFFICE RENT-HINSDALE MGMT	CENSUS DAYS	470,242	8	19,029		55,413	2,242	17
18	35	STORAGE FEES	CENSUS DAYS	470,242	8	11,121		55,413	1,311	18
19	35	AUTO LEASE	CENSUS DAYS	470,242	8	13,087		55,413	1,543	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,264,730	\$ 1,456,556		\$ 266,870	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: WESTMONT REAL ESTATE, LLC						\$		\$			\$	1
2	CAMBRIDGE REALTY	X		MORTGAGE	\$67,995.96	01/31/12	10,881,400	9,831,334	12/01/41	3.7500	372,709		2
3	LOAN COSTS	X		AMORTIZE OVER LIFE OF LOAN			111,302	92,926			3,731		3
4	BRICKYARD BANK	X		WORKING CAPITAL	\$16,970.55	11/10/14	2,000,000	1,809,291	11/10/17	6.0000	113,326		4
5	MB FINANCIAL	X		LOAN	\$16,250.00	10/29/14	3,900,000	3,835,000	08/05/20	4.7500	46,977		5
	Working Capital												
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	09/05/08	2,000,000	1,670,000		PRIME+	27,273		6
7	F & M WEISS	X		WORKING CAPITAL		12/01/15	600,000	533,350	05/01/21	2.2000	12,834		7
8	RELATED PARTY ALLOCATION										14,630		8
9	TOTAL Facility Related				\$101,216.51		\$ 19,492,702	\$ 17,771,901			\$ 591,480		9
	B. Non-Facility Related*												
10	GOODWILL		X	GOODWILL	\$42,088.99	09/08	7,500,000	5,328,782	09/33	6.0000	325,613		10
11													11
12													12
13													13
14	TOTAL Non-Facility Related				\$42,088.99		\$ 7,500,000	\$ 5,328,782			\$ 325,613		14
15	TOTALS (line 9+line14)						\$ 26,992,702	\$ 23,100,683			\$ 917,093		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 49,499 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

[illegible]

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF WESTMONT COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>09-22-101-001</u>	<u>NURSING HOME</u>	\$ <u>81,727.32</u>	\$ <u>81,727.32</u>
2.	<u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>6,510.18</u>	\$ <u>6,510.18</u>
3.	<u>09-22-101-003</u>	<u>NURSING HOME</u>	\$ <u>9,186.70</u>	\$ <u>9,186.70</u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>97,424.20</u></u>	\$ <u><u>97,424.20</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928

B. General Construction Type: Exterior BRICKFrame STEELNumber 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		1995	\$ 349,103	1
2	PARKING LOT		2006	410,723	2
3	TOTALS			\$ 759,826	3

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	215			1995	\$ 4,982,301	\$ 127,751	39	\$ 127,751	\$	\$ 2,784,031
5				2016	6,976,963	96,902	39	96,902		96,902
6										
7										
8	RELATED PARTY ALLOCATIONS					2,310		2,310		
	Improvement Type**									
9	FLOORING			1986	41,641		19			41,641
10	ROOF & WATER LINE			1987	31,143		20			31,143
11	IMPROVEMENTS			1988	44,614		31.5	1,416	1,416	40,351
12	IMPROVEMENTS			1989	40,935		31.5	1,299	1,299	35,664
13	DRIVEWAY			1989	17,137		15			17,137
14	IMPROVEMENTS			1990	37,367		31.5	1,186	1,186	31,378
15	IMPROVEMENTS			1991	45,002		31.5	1,428	1,428	36,175
16	IMPROVEMENTS			1992	49,649		31.5	1,577	1,577	38,543
17	ROOF TOP A/C UNITS			1993	9,100		31.5	289	289	6,912
18	IMPROVEMENTS			1993	53,243		39	1,366	1,366	31,951
19	IMPROVEMENTS			1994	31,230		39	801	801	18,139
20	FLOOR COVERING			1995	795		15			795
21	HAND RAIL			1995	2,249		39	58	58	1,269
22	FLOOR TILES			1995	5,471		39	140	140	3,028
23	WINDOW A/C UNITS			1995	14,146		39	363	363	7,788
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056		39	309	309	6,657
25	ALARM			1995	1,337		39	34	34	730
26	LAUNDRY BUILDING			1995	35,000		39	897	897	19,099
27	ROOF			1995	5,520		39	142	142	3,023
28	WINDOWS			1995	9,478		39	243	243	5,154
29	DOOR EDGE & DOOR FRAME			1996	2,099		39	54	54	1,132
30	LAUNDRY BUILDING			1996	175,187		39	4,491	4,491	92,263
31	AIR COOLERS			1996	6,642		39	171	171	3,503
32	RACING CAGE			1996	3,987		39	102	102	2,095
33	HAND RAIL			1996	1,156		39	30	30	611
34	WINDOWS			1996	11,496		39	295	295	6,011
35	TACK ROOM			1996	2,139		39	55	55	1,116
36	NEW CONFERENCE ROOM TILE			1997	2,938		39	76	76	1,466

*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:

01/01/2016 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	INSTALL DIETARY DOOR	1997	\$ 1,478	\$	39	\$ 38	\$ 38	\$ 733	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	2,640	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	669	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	559	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	2,358	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	3,023	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	5,909	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	4,831	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,576	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	673	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	1,304	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	4,035	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	1,065	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	1,222	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	1,284	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	1,353	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	531	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	3,168	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	1,193	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	2,771	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	2,118	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	16,176	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	2,480	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,700	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	2,743	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	68,442	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	17,561	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	60,009	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	4,979	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	6,814	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	216,688	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	21,840	69
70	TOTAL (lines 4 thru 69)		\$ 13,363,617	\$ 226,963		\$ 272,453	\$ 45,490	\$ 3,870,865	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:

01/01/2016 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		\$ 13,363,617	\$ 226,963		\$ 272,453	\$ 45,490	\$ 3,870,865	1
2	<u>FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS</u>	2002	8,997		15	600	600	8,580	2
3	<u>SHOWER ROOM</u>	2002	30,924		27.5	1,125	1,125	15,984	3
4	<u>INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER</u>	2002	9,010		27.5	328	328	4,606	4
5	<u>NEW NURSES STATION WITH CORIAN TOP</u>	2002	14,891		27.5	541	541	7,597	5
6	<u>2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR</u>	2002	40,056		20	2,003	2,003	30,045	6
7	<u>PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM</u>	2002	11,499		20	575	575	8,625	7
8	<u>PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM</u>	2003	12,767		27.5	464	464	6,245	8
9	<u>2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM</u>	2003	31,152		27.5	1,133	1,133	15,248	9
10	<u>THERAPY ROOM -FLOORING</u>	2003	87,509		27.5	3,182	3,182	42,824	10
11	<u>CONFERENCE ROOM-FLOORING</u>	2003	2,073		27.5	76	76	1,023	11
12	<u>LARGE DINING ROOM-BUILT IN TV CABINET</u>	2004	7,421		27.5	270	270	3,364	12
13	<u>TONE/VISUAL/VOICE NURSE CALL SYSTEM</u>	2004	89,825		27.5	3,266	3,266	40,145	13
14	<u>REMODEL OF RESIDENT ROOMS AND BATHROOMS</u>	2004	50,925		27.5	1,852	1,852	22,610	14
15	<u>RESIDENT ROOMS-FLOORING</u>	2005	9,821		27.5	357	357	4,180	15
16	<u>INSTALL CABLING SYSTEM</u>	2005	46,771		27.5	1,701	1,701	19,774	16
17	<u>INSTALL TWO AUTOMATIC SLIDING DOOR</u>	2005	28,000		27.5	1,018	1,018	11,240	17
18	<u>1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE</u>	2005	58,286		20	2,914	2,914	34,968	18
19	<u>INSTALL DOORS - F WING, RESIDENT ROOMS</u>	2006	4,260		27.5	155	155	1,686	19
20	<u>WALLCOVERING, FLOORING - 1ST FLOOR CORRID</u>	2006	63,838		27.5	2,321	2,321	25,047	20
21	<u>AIR CONDITIONS</u>	2006	7,968		27.5	289	289	3,030	21
22	<u>REPLACEMENT WALK - IN FREEZER DOOR</u>	2006	4,652		27.5	169	169	1,782	22
23	<u>REPLACEMENT OF KITCHEN TILES</u>	2007	13,200		27.5	380	380	3,800	23
24									24
25	<u>WESTMONT REAL ESTATE, LLC</u>								25
26	<u>NEW PARKING LOT</u>	2007	206,876	13,792	15	13,792		127,626	26
27	<u>RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F</u>	2007	235,801	8,575	27.5	8,575		81,105	27
28	<u>RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F</u>	2007	84,360		5			84,360	28
29	<u>INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING</u>	2007	3,108	113	27.5	113		1,069	29
30	<u>TUCKPOINTING, AIR CONDITIONS, WATER HEATER</u>	2007	18,594		5			18,594	30
31	<u>INSTALLATION OF RAILLING ON EXTERIOR STAIRS</u>	2007	6,407	233	27.5	233		2,203	31
32	<u>REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE</u>	2007	3,108	113	27.5	113		1,069	32
33	<u>AIR CONDITIONS</u>	2008	12,661		5			12,661	33
34	TOTAL (lines 1 thru 33)		\$ 14,568,377	\$ 249,789		\$ 319,998	\$ 70,209	\$ 4,511,955	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:

01/01/2016 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 12B, Carried Forward		\$ 14,568,377	\$ 249,789		\$ 319,998	\$ 70,209	\$ 4,511,955	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		1,116	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		888	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		906	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		3,879	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		670	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		1,083	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		1,520	11
12	WALL AIR CONDITIONS	2010	7,612		5			7,612	12
13	1ST FLOOR DINING ROOM-WALLCOVERING, BLINDS	2010	19,660		5			19,660	13
14	A-WING RESIDENT ROOM-BUIT-IN WARDROBES	2010	11,222	408	27.5	408		2,550	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		1,450	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	1,141	5	1,141		19,818	18
19	INSTALL WATER HEATER	2011	11,585	421	27.5	421		2,438	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOO	2011	6,150	224	27.5	224		1,279	20
21	INSTALL FIRE ALARM SMOKES, HEATS, AV DEVCIE	2011	85,377	3,105	27.5	3,105		17,466	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	535	27.5	535		2,920	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	91	27.5	91		489	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	336	27.5	336		1,694	24
25	INSTALL ACCUTECH SYSTEM FOR FRONT DOOR	2012	4,814	175	27.5	175		853	25
26	DELAYED EGRESS LOCKING SYSTEM FOR 1ST FLOOR	2012	12,600	458	27.5	458		2,195	26
27	ROOM F-16 -INSTALL NEW PVT & COVE BASE	2012	5,316	193	27.5	193		860	27
28	PLASTER, PRIME & PAINT ALL ROOMS & BATH	2012	10,631	387	27.5	387		1,661	28
29	WEST PARKING LOT-SEALCOAT, CRACK FILLING,								29
30	STRIPING, ASPHALTING	2013	4,460	297	15	297		1,064	30
31	EMPLOYEE ENTRANCE DOOR & FRAME REPLACEMENT	2013	3,254	118	27.5	118		379	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		1,753	33
34	TOTAL (lines 1 thru 33)		\$ 14,976,975	\$ 259,770		\$ 329,979	\$ 70,209	\$ 4,736,942	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:

01/01/2016 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 12C, Carried Forward		\$ 14,976,975	\$ 259,770		\$ 329,979	\$ 70,209	\$ 4,736,942	1
2	1ST & 2ND FLOOR LOBBY, FRONT CORRIDOR, RESIDENT								2
3	CORRIDORS: FLOORING, WALLCOVERING, PAINTING	2013	124,977	4,545	27.5	4,545		16,097	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		1,737	5
6	RESIDENT ROOMS: CURTAIN, WINDOW TREATMENTS	2014	15,035	2,887	5	2,887		10,705	6
7									7
8	BUILDING RENOVATION :	2016	605,378	11,924	27.5	11,924		11,924	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	546	27.5	546		546	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,789,989	\$ 280,259		\$ 350,468	\$ 70,209	\$ 4,777,951	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	\$ 318,742	\$ 34,580	\$ 32,050	\$ (2,530)	3-10	\$ 127,317	71
72	Current Year Purchases	291,945	108,684	18,875	(89,809)	5-8	18,875	72
73	Fully Depreciated Assets	1,039,637					1,039,637	73
74	RELATED PARTY SL DEPRECIATION		139	139				74
75	TOTALS	\$ 1,650,324	\$ 143,403	\$ 51,064	\$ (92,339)		\$ 1,185,829	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)	\$ 18,200,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 423,662	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 401,532	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,130)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,963,780	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: \$ 64,905 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					18
19					19
20					20
21	TOTAL		\$ #####	\$ 15,079	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	\$		\$ 385,149	\$		\$ 385,149	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			146,527			146,527	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			420,716			420,716	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				319,682		319,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					42,541		42,541	12
13	MEDICAL SUPPLIES, RENTALS, Other (specify): RESPIRATORY	39-2					56,906		56,906	13
14	TOTAL			\$		\$ 952,392	\$ 419,129		\$ 1,371,521	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (418,380)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	3,494,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,342		6
7	Other Prepaid Expenses	168,834		7
8	Accounts Receivable (owners or related parties)	336,473		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,703,672	\$	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	656,852		15
16	Equipment, at Historical Cost	553,317		16
17	Accumulated Depreciation (book methods)	(429,538)		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) GOODWILL	7,500,000		22
23	Other(specify): AMORT OF GOODWILL	(4,166,667)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,090,927	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,794,599	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 979,526	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,031		28
29	Short-Term Notes Payable	1,670,000		29
30	Accrued Salaries Payable	103,774		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,345		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)	\$ 2,774,676	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,506,423		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)	\$ 11,506,423	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,281,099	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 513,500	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,794,599	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,813,523	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,813,527	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(980,027)	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	(320,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,300,027)	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)	\$ 513,500	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF WESTMONT

0050120

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	\$ 12,512,794	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,512,794	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***	2,581	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,581	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>COMPUTER INCOME</u>	29,147	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,147	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,544,522	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,250,959	31
32	Health Care	4,334,346	32
33	General Administration	2,937,549	33
	B. Capital Expense		
34	Ownership	2,206,755	34
	C. Ancillary Expense		
35	Special Cost Centers	1,371,521	35
36	Provider Participation Fee	419,376	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,520,506	40
41	Income before Income Taxes (line 30 minus line 40)**	(975,984)	41
42	Income Taxes	(4,043)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (980,027)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,785,998	44
45	Private Pay - Net Inpatient Revenue	967,010	45
46	Medicare - Net Inpatient Revenue	3,580,695	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	743,799	47
48	Other-(specify) <u>MANAGED CARE</u>	435,292	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,512,794	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.

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	2,024	2,072	\$ 117,290	\$ 56.61	1
2	Assistant Director of Nursing	2,624	2,744	79,386	28.93	2
3	Registered Nurses	28,997	30,010	1,021,555	34.04	3
4	Licensed Practical Nurses	22,449	23,927	702,912	29.38	4
5	CNAs & Orderlies	103,357	107,939	1,431,706	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,483	8,982	112,516	12.53	10
11	Social Service Workers	3,984	4,160	87,241	20.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,635	4,682	60,709	12.97	15
16	Dishwashers					16
17	Maintenance Workers	5,487	5,863	104,751	17.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,216	1,536	102,790	66.92	20
21	Assistant Administrator	1,592	1,616	51,500	31.87	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,993	16,789	307,015	18.29	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	1,824	2,120	37,516	17.70	31
32	Other Health Care Care Plan Coord	6,664	7,200	249,757	34.69	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,329	219,640	\$ 4,466,644 *	\$ 20.34	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	\$ 13,370	1-3	35
36	Medical Director	O	63,000	9-3	36
37	Medical Records Consultant	N	845	10-3	37
38	Nurse Consultant	T	54,353	10-3	38
39	Pharmacist Consultant	H	16,848	10-3	39
40	Physical Therapy Consultant	L	7,221	10a-3	40
41	Occupational Therapy Consultant	Y	3,781	10a-3	41
42	Respiratory Therapy Consultant		652	10a-3	42
43	Speech Therapy Consultant	F	1,411	10a-3	43
44	Activity Consultant	E	1,805	11-3	44
45	Social Service Consultant	E	1,376	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 164,662		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	48	2,166	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	48	\$ 2,166		53

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

** See instructions.

Facility Name & ID Number		BRIA OF WESTMONT		STATE OF ILLINOIS		# 0050120		Report Period Beginning:		01/01/2016		Page 21		Ending: 12/31/2016	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		Ownership		Description		Amount		Description		Amount			
KIMBERLY SAGGESE		ADMINISTRATOR		0		Workers' Compensation Insurance		\$ 102,311		IDPH License Fee		\$ 1,990			
OSWALDO MORALES		ASST ADMIN		0		Unemployment Compensation Insurance		61,332		Advertising: Employee Recruitment		18,132			
						FICA Taxes		334,062		Health Care Worker Background Check		1,650			
						Employee Health Insurance		80,936		(Indicate # of checks performed 165)					
						Employee Meals		0		Patient Background Checks		600			
						Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		8,775			
						EMPLOYEE BENEFITS - OTHER		98,694		MARKETING/ADV/PROMO		103,510			
						EMPLOYEE PHYSICAL EXAMS		0		LICENSES/DUES/SUBSCRIPTIONS		25,014			
						PENSION/PROFIT SHARING PLANS		0		MGMT CO ALLOC		5,177			
TOTAL (agree to Schedule V, line 17, col. 1)						INSURANCE - EXECUTIVE LIFE		6,133		TRUST/FRANCHISE/CONTRIB/ETC		(8,775)			
(List each licensed administrator separately.)				\$ 154,290						Less: Public Relations Expense		(0)			
B. Administrative - Other								INSURANCE - EXECUTIVE LIFE VI 21				(6,133)			
Description				Amount						Non-allowable advertising		(103,510)			
DA WESTMONT MANAGEMENT FEES				\$ 792,000						Yellow page advertising		(0)			
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 792,000		TOTAL (agree to Schedule V, line 22, col.8)		\$ 677,335		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 52,563			
(Attach a copy of any management service agreement)															
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount	
ALPHA DATA SERVICES		DATA PROCESSING		\$ 9,145						\$		Out-of-State Travel		\$	
NATIONAL DATACARE		DATA PROCESSING		2,963											
KBKB, LTD		ACCOUNTING FEE		18,000											
RICHARD PEELO & ASSOCIAT		MEDICARE CONSULTANT		4,500								In-State Travel			
PERSONNEL PLANNERS		U/C CONSULTANT		2,385										8,210	
BRIA HEALTH SERVICES		BOOKKEEPING/ADMIN		42,500											
IPMG RISK MANAGEMENT		LIABILITY/REGULATORY		3,333								MGMT CO ALLOC		6,183	
US HOUSING CONSULTANT		PRE-REAC INSPECTION		2,132								Seminar Expense			
NAINA INTERIORS		DESIGN CONSULTANT		2,500										0	
LEGAL FEES		SEE SCHEDULE		19,001											
TOTAL (agree to Schedule V, line 19, column 3)				\$ 106,459		TOTAL		\$				Entertainment Expense		()	
(For legal fee disclosure, see page 39 of instructions)												(agree to Sch. V, line 24, col. 8)		\$ 14,393	
* Attach copy of IMRF notifications															
**See instructions.															

**BRIA OF WESTMONT
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	EVALUATE GOVERNMENT "HEAT INITIATIVE" STATUS	448
3/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	458
4/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,648
5/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	448
6/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,000
7/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,977
8/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,021
9/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	808
10/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
11/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	822
12/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	623
11/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	590
12/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	295
5/20/2016	LANER MUCHIN	2015 UNION ELECTIONS	563
3/14/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	2,597
4/12/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	1,166
5/9/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	742
6/10/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	1,431
10/31/2016	BOTHLAW DENNIS E. BOTH	CHICAGO CUT CONCRETE V. WESTMONT NURSING	1,182
3/9/2016	LAW OFFICES FIELD AND GOLDBERG	LOAN MODIFICATION	128
11/23/2015	LAW OFFICES FIELD AND GOLDBERG	VOID CHECK	(1,170)
1/30/2016	MEYERS & FLOWERS	GUARDIANSHIP	65
12/20/2016	THOMPSON COBURN	WESTMONT NURSING LOAN	870
11/29/2016	CT LIEN SOLUTIONS	FEDERAL TAX LIEN SEARCH	130
TOTAL			<u>19,001</u>

XX. GENERAL INFORMATION:

(1)

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

YES

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

IL COUNCIL ON LONG TERM CARE \$ 17,309

(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?
What was the average life used for new equipment added during this period?

YES

10 YR

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 50,918

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?
If YES, give effective date of lease.

NO

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

X

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

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(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 419,376

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

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