

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0043406

Facility Name: BRIA OF CHICAGO HEIGHTS

Address: 120 WEST 26TH STREET SO CHICAGO HTS 60411
Number City Zip Code

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1997

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: KATHLEEN MCNAMARA Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) _____
(Print Name and Title) KATHLEEN MCNAMARA VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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 CHICAGO HEIGHTS

0043406 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	64	Skilled (SNF)	64	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	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			1,217	1,217	8
9	SNF/PED					9
10	ICF	28,390		623	29,013	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,390		1,840	30,230	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.75%

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

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

NONE

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

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

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 11/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/01/97 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 20 and days of care provided 1,217

Medicare Intermediary WPS WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS** # **0043406** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
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	115,834	15,369	284,593	415,796		415,796		415,796			1
2	Food Purchase		110,006		110,006		110,006		110,006			2
3	Housekeeping	86,647	17,298	132,458	236,403		236,403		236,403			3
4	Laundry	22,493	12,324	87,755	122,572		122,572		122,572			4
5	Heat and Other Utilities			142,809	142,809		142,809		142,809			5
6	Maintenance	95,785	72,054	25,845	193,684		193,684	574	194,258			6
7	Other (specify):* SECURITY/TRANSP	101,254		22,499	123,753		123,753	116	123,869			7
8	TOTAL General Services	422,013	227,051	695,959	1,345,023		1,345,023	690	1,345,713			8
	B. Health Care and Programs											
9	Medical Director			25,063	25,063		25,063		25,063			9
10	Nursing and Medical Records	2,331,349	185,078	50,870	2,567,297		2,567,297	52,212	2,619,509			10
10a	Therapy		752	35,882	36,634		36,634		36,634			10a
11	Activities	138,928			138,928		138,928		138,928			11
12	Social Services	137,449			137,449		137,449		137,449			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,607,726	185,830	111,815	2,905,371		2,905,371	52,212	2,957,583			16
	C. General Administration											
17	Administrative	117,054		234,600	351,654		351,654	(223,600)	128,054			17
18	Directors Fees											18
19	Professional Services			218,267	218,267		218,267	(65,041)	153,226			19
20	Dues, Fees, Subscriptions & Promotions			48,774	48,774		48,774	(8,314)	40,460			20
21	Clerical & General Office Expenses	180,694	18,185	113,374	312,253		312,253	109,604	421,857			21
22	Employee Benefits & Payroll Taxes			527,118	527,118		527,118		527,118			22
23	Inservice Training & Education			6,742	6,742		6,742	179	6,921			23
24	Travel and Seminar			8,149	8,149		8,149	1,815	9,964			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			232,482	232,482		232,482	25,062	257,544			26
27	Other (specify):*			2,323,271	2,323,271		2,323,271	(2,305,420)	17,851			27
28	TOTAL General Administration	297,748	18,185	3,712,777	4,028,710		4,028,710	(2,465,715)	1,562,995			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,327,487	431,066	4,520,551	8,279,104		8,279,104	(2,412,813)	5,866,291			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	LINE
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	0	
	REPAIRS & MAINTENANCE	0	
	CONTRACTED DIETARY SERVICES	284,593	
		284,593	
3	HOUSEKEEPING		
	CONTRACTED HOUSEKEEPING SERVICES	132,458	
		132,458	
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	0	
	CONTRACTED LAUNDRY SERVICES	87,755	
		87,755	
5	HEAT & OTHER UTILITIES		
	GAS HEAT	16,916	
	ELECTRICITY	51,463	
	WATER	69,782	
	CABLE TV - LOBBY	4,648	
		142,809	
6	MAINTENANCE		
	GROUNDS MAINTENANCE	8,480	
	PAINTING & DECORATING	0	
	BUILDING REPAIRS	0	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	4,388	
	ELEVATOR MAINTENANCE & REPAIR	0	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	0	
	FIRE SERVICE	12,977	
		25,845	
7	OTHER		
	SCAVENGER	22,499	
	SECURITY SERVICE	0	
		22,499	
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	25,063	25,063

SCHED REF	TOTAL	LINE
NURSING		10
CONTRACT NURSING XVIII C 53-2	31,300	
LABORATORY & XRAY EXPENSE	0	
PURCHASED SERVICES	0	
PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
RESTORATIVE NURSING CONSULTANT XVIII B 38-2	13,050	
MEDICAL RECORDS CONSULTANT XVIII B 37-2	0	
PHARMACY CONSULTANT XVIII B 39-2	6,520	
UTILIZATION REVIEW FEES XVIII B __-2	0	
PHYSICIANS XVIII B __-2	0	
PSYCHIATRIC XVIII B __-2	0	
RN CONSULTANT XVIII B 38-2		
	50,870	
THERAPY		10a
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	17,920	
OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	14,851	
RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	1,812	
SPEECH THERAPY CONSULTANT XVIII B 43-2	1,299	
	35,882	
ACTIVITIES		11
CABLE TV - PATIENT ROOMS	0	
ACTIVITY REHAB CONSULTANT XVIII B 44-2	0	
	0	
SOCIAL SERVICES		12
SOCIAL REHABILITATION SERVICES	0	
SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0	
SOCIAL WORKER XVIII B 45-2	0	
	0	
NURSE AIDE TRAINING		13
NURSE AIDE TRAINING COSTS XIII	0	0

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION			22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	PATIENT TRANSPORTATION		0		FICA TAXES	XIX D	252,368
			0		UNEMPLOYMENT COMPENSATION	XIX D	36,336
17	ADMINISTRATIVE				WORKERS COMPENSATION INSURANCE	XIX D	75,910
	MANAGEMENT FEES	XIX B	234,600		HOSPITALIZATION INSURANCE	XIX D	139,828
	DIRECTORS FEES				EMPLOYEE BENEFITS - OTHER	XIX D	22,676
18	DIRECTORS FEES		0		EMPLOYEE PHYSICAL EXAMS	XIX D	0
19	PROFESSIONAL SERVICES				INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	DATA PROCESSING	XIX C	7,777		PENSION/PROFIT SHARING PLANS	XIX D	0
	ADMINISTRATIVE CONSULTANTS	XIX C	0				
	PROFESSIONAL FEES	XIX C	123,640				
	BOOKKEEPING/ADMINISTRATIVE SERVICES		86,850				527,118
			218,267	23	INSERVICE TRAINING & EDUCATION		
20	FEES,SUBSCRIPTIONS,PROMOTIONS				EDUCATION & SEMINARS		6,742
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0				6,742
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,858	24	TRAVEL & SEMINARS		
	EMPLOYEE WANT ADS	XIX F	19,751		EDUCATION & SEMINARS	XIX G	0
	CONTRIBUTIONS	VI 20 XIX F	0		TRAVEL	XIX G	8,149
	DUES & SUBSCRIPTIONS	XIX F	11,456				8,149
	LICENSES & PERMITS	XIX F	4,906	25	ADMIN. STAFF TRANSPORTATION		
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0		TRANSPORTATION - STAFF		0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0				0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	26	INSURANCE - PROP. LIAB & MALPRACTICE		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	9,733		GENERAL INSURANCE		232,482
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	188				232,482
	PATIENT BACKGROUND CHECKS	XIX F	882				
			48,774	27	OTHER		
21	CLERICAL & GENERAL OFFICE EXPENSES				BAD DEBTS	VI 24	2,323,271
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,969				2,323,271
	EQUIPMENT REPAIR & MAINTENANCE		81,281				
	OUTSIDE CLERICAL SERVICES						
	PENALTIES / OVERDRAFT CHARGES	VI 18	0				
	HOME OFFICE EXPENSE		0				
	THEFT & DAMAGE LOSS		0				
	TELEPHONE		28,276				
	MESSENGER SERVICE		848				
			113,374				

GRAND TOTAL COLUMN 3 OTHER

4,520,551

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			3,086	3,086		3,086	239,435	242,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,782	11,782		11,782	113,456	125,238			32
33	Real Estate Taxes			(34,639)	(34,639)		(34,639)	373,215	338,576			33
34	Rent-Facility & Grounds			704,000	704,000		704,000	(704,000)				34
35	Rent-Equipment & Vehicles			27,051	27,051		27,051	1,732	28,783			35
36	Other (specify):* Office Rent			9,600	9,600		9,600	18,662	28,262			36
37	TOTAL Ownership			720,880	720,880		720,880	42,500	763,380			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,617	208,246	247,863		247,863		247,863			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			236,978	236,978		236,978		236,978			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		39,617	445,224	484,841		484,841		484,841			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,327,487	470,683	5,686,655	9,484,825		9,484,825	(2,370,313)	7,114,512			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	9,381	30		9
10	Interest and Other Investment Income	(5,537)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(9,733)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,323,271)	27		24
25	Fund Raising, Advertising and Promotional	(1,858)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A		22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,331,018)		\$	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	2	
		Amount	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)	(39,295)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (39,295)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,370,313)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0043406

Report Period Beginning:1/1/2020

Ending:12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF CHICAGO HEIGHTS# 0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	574	0	0	0	0	0	0	0	0	574	6
7	Other (specify):*	0	0	116	0	0	0	0	0	0	0	0	116	7
8	TOTAL General Services	0	0	690	0	0	0	0	0	0	0	0	690	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	52,212	0	0	0	0	0	0	0	0	52,212	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	52,212	0	0	0	0	0	0	0	0	52,212	16
	C. General Administration													
17	Administrative	0	0	(223,600)	0	0	0	0	0	0	0	0	(223,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,700	(77,741)	0	0	0	0	0	0	0	0	(65,041)	19
20	Fees, Subscriptions & Promotions	(11,591)	0	3,277	0	0	0	0	0	0	0	0	(8,314)	20
21	Clerical & General Office Expenses	0	0	109,604	0	0	0	0	0	0	0	0	109,604	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	179	0	0	0	0	0	0	0	0	179	23
24	Travel and Seminar	0	0	1,815	0	0	0	0	0	0	0	0	1,815	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	22,350	2,712	0	0	0	0	0	0	0	0	25,062	26
27	Other (specify):*	(2,323,271)	0	17,851	0	0	0	0	0	0	0	0	(2,305,420)	27
28	TOTAL General Administration	(2,334,862)	35,050	(165,903)	0	0	0	0	0	0	0	0	(2,465,715)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,334,862)	35,050	(113,001)	0	0	0	0	0	0	0	0	(2,412,813)	29

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	9,381	227,324	2,730	0	0	0	0	0	0	0	0	239,435	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,537)	104,254	14,739	0	0	0	0	0	0	0	0	113,456	32
33	Real Estate Taxes	0	373,215	0	0	0	0	0	0	0	0	0	373,215	33
34	Rent-Facility & Grounds	0	(704,000)	0	0	0	0	0	0	0	0	0	(704,000)	34
35	Rent-Equipment & Vehicles	0	0	1,732	0	0	0	0	0	0	0	0	1,732	35
36	Other (specify):*	0	18,662	0	0	0	0	0	0	0	0	0	18,662	36
37	TOTAL Ownership	3,844	19,455	19,201	0	0	0	0	0	0	0	0	42,500	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)	(2,331,018)	54,505	(93,800)	0	0	0	0	0	0	0	0	(2,370,313)	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	\$ 704,000	MST REAL ESTATE LLC		\$	(704,000)	1
2	V	19	PROFESSIONAL FEES				12,700	12,700	2
3	V	26	HAZARD INSURANCE				22,350	22,350	3
4	V	30	SL DEPRECIATION				227,324	227,324	4
5	V	32	INTEREST				98,417	98,417	5
6	V	32	AMORT LOAN COST				5,837	5,837	6
7	V	33	REAL ESTATE TAX				373,215	373,215	7
8	V	36	MIP INSURANCE				18,662	18,662	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 704,000			\$ 758,505	\$ * 54,505	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	\$ 234,600	BRIA HEALTH SERVICES		\$	\$ (234,600)	15
16	V	19	BKKPND/ADMIN SERVICES	80,850				(80,850)	16
17	V								17
18	V	17	CFO SALARY-A.WEINFELD				11,000	11,000	18
19	V	10	SALARIES-MEDICARE/NURSING				22,582	22,582	19
20	V	10	SALARIES-REGIONAL DIR RELATED PARTIES				26,215	26,215	20
21	V	21	SALARIES-CLERICAL RELATED PARTIES				37,705	37,705	21
22	V	21	SALARIES-CLERICAL				59,045	59,045	22
23	V	6	MAINTENANCE				574	574	23
24	V	7	SCAVENGER				116	116	24
25	V	10	NURSING CONSULTANT & SUPPLIES				3,415	3,415	25
26	V	19	PROFESSIONAL FEES				3,109	3,109	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				3,277	3,277	27
28	V	21	OFFICE EXPENSE				12,854	12,854	28
29	V	23	SEMINARS				179	179	29
30	V	24	TRAVEL				1,815	1,815	30
31	V	26	INSURANCE				2,712	2,712	31
32	V	27	EMPLOYEE BENEFITS				17,851	17,851	32
33	V	30	DEPRECIATION				2,730	2,730	33
34	V	32	INTEREST				14,739	14,739	34
35	V	35	AUTO LEASE				1,043	1,043	35
36	V	35	EQUIPMENT RENTAL				689	689	36
37	V								37
38	V								38
39	Total			\$ 315,450			\$ 221,650	\$ * (93,800)	39

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

Facility Name & ID Number

BRIA OF CHICAGO HEIGHTS

0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Avrum Weinfeld	42.5%	Bria of Cahokia (formerly Atrium)	Cahokia	IME Realty Corp	Skokie	Home Office Building	1
2	Daniel Weiss	42.5%	Bria of Forest Edge	Chicago	MST Real Estate LLC	South Chicago Heights	Rental Real Estate	2
3	Michael Rosen	5%	Bria of Geneva	Geneva	DA Westmont, Inc	Skokie	Mgt Consulting	3
4	Dov Segal	5%	Lake Park	Waukegan	Bria Health Services LLC	Skokie	Consulting	4
5	Sandra Segal	5%	Bria of Palos Hills	Palos Hills	Weiss Mgt	Skokie	Mgt Consulting	5
6			Bria of River Oaks	Burnham				6
7			Bria of Westmont	Westmont				7
8			Bria of Belleville	Belleville				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

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS** # **0043406** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**

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 BRIA HEALTH SERVICES LLC:								\$		1
2					SEE						2
3	AVRUM WEINFELD	CFO	ADMIN	42.50	ATTACHED	4	10.00	SALARY	11,000	17-7	3
4					SCHEDULE						4
5											5
6	DANIEL WEISS	REGIONAL DIR	ADMIN	42.50		4	10.00	SALARY	6,640	17-7	6
7											7
8											8
9	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										9
10											10
11	DANIEL WEISS	SHAREHOLDER	ADMIN	42.50		4	10.00	SALARY	7,000	17.-7	11
12											12
13								TOTAL	\$ 24,640		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 CHICAGO HEIGHTS**# **0043406**

Report Period Beginning:

1/1/2020Ending: **2/31/2020**

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

5151 CHURCH ST

City / State / Zip Code

SKOKIE, IL 60077

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	wghtd avr hours	9	\$ 99,000	\$ 99,000		\$ 11,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	9	355,924	355,924	30,230	22,582	2
3	10	SALARIES-REGIONAL DIR RELA	wghtd avr hours	9	235,935	235,935		26,215	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours	9	107,288	107,288		37,705	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	9	930,610	930,610	30,230	59,045	5
6	6	MAINTENANCE	CENSUS DAYS	9	9,053		30,230	574	6
7	7	SCAVENGER	CENSUS DAYS	9	1,836		30,230	116	7
8	10	NURSING CONSULTANT & SUPPL	CENSUS DAYS	9	53,827		30,230	3,415	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	9	49,003		30,230	3,109	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	9	51,648		30,230	3,277	10
11	21	OFFICE EXPENSE	CENSUS DAYS	9	202,594		30,230	12,854	11
12	23	SEMINARS	CENSUS DAYS	9	2,822		30,230	179	12
13	24	TRAVEL	CENSUS DAYS	9	28,614		30,230	1,815	13
14	26	INSURANCE	CENSUS DAYS	9	42,750		30,230	2,712	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	9	281,347		30,230	17,851	15
16	30	DEPRECIATION	CENSUS DAYS	9	43,023		30,230	2,730	16
17	32	INTEREST	CENSUS DAYS	9	232,306		30,230	14,739	17
18	35	AUTO LEASE	CENSUS DAYS	9	16,432		30,230	1,043	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	9	10,854		30,230	689	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,754,866	\$ 1,728,757		\$ 221,650	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: MST REAL ESTATE LLC						\$							
2	CAPITAL ONE		X	ACQUISITION COST		4/1/13	93,490	40,948	10/1/35		3,436		2	
3	CAPITAL ONE		X	MORTGAGE		4/1/13	4,529,600	3,312,511	10/1/35	2.9000	98,417		3	
4	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			53,822	35,814			2,401		4	
5													5	
	Working Capital													
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND	04/12	1,101,000			PRIME+	11,782		6	
7													7	
8	RELATED PARTY ALLOCATION										14,739		8	
9	TOTAL Facility Related						\$ 5,777,912	\$ 3,389,273				\$ 130,775	9	
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$				\$	14	
15	TOTALS (line 9+line14)						\$ 5,777,912	\$ 3,389,273				\$ 130,775	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,662 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.)

B. Real Estate Taxes

\$ 338,576

FOR BHF USE ONLY

16	AMOUNT TO USE FOR RATE CALCULATION \$
----	---------------------------------------

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF CHICAGO HEIGHTS COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

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 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>32-29-401-011-0000</u>	<u>NURSING HOME</u>	\$ <u>355,988.08</u>	\$ <u>355,988.08</u>
2. <u>32-29-401-021-0000</u>	<u>NURSING HOME-PARKING LOT</u>	\$ <u>3,810.78</u>	\$ <u>3,810.78</u>
3. <u>32-29-401-027-0000</u>	<u>NURSING HOME-PARKING LOT</u>	\$ <u>258.85</u>	\$ <u>258.85</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>360,057.71</u></u>	\$ <u><u>360,057.71</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900

B. General Construction Type: Exterior CONCRETE

Frame METAL/CONCRETE

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).

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	RELATED PARTY:NURSING HOME		2004	\$ 229,826	1
2	PARKING LOT		2013	16,749	2
3	TOTALS			\$ 246,575	3

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS**# **0043406**

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		RELATED PARTY-MST REAL ESTATE LLC:			\$	\$		\$	\$	\$	4
5	112		2004		4,142,702	150,644	27.5	150,644		2,516,810	5
6											6
7											7
8		RELATED PARTY ALLOCATIONS			45,888	1,223		1,223			8
		Improvement Type**									
9		CEILING LIGHTING	1997		3,746	96	39	96		2,220	9
10		WATER SOFTENING SYSTEM	1997		6,926	178	39	178		4,116	10
11		FLOORING	1997		3,910	100	39	100		2,304	11
12		FLOORING / DOORS / WINDOWS	1998		29,194	748	39	748		16,930	12
13		ROOF	1998		84,450	2,165	39	2,165		49,528	13
14		DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.	1998		30,915	793	39	793		18,150	14
15		PAINTING / DECORATING	1998		15,111	387	39	387		8,724	15
16		FLOORING / DOORS / BATHROOM FIXTURES	1999		11,198	288	39	288		6,316	16
17		CHAIN LINK FENCE	1999		5,100	131	39	131		2,811	17
18		FLOOR TILES/COVE BASE	2000		22,766	828	27.5	828		17,353	18
19		PAIR OF ALUMINUM DOORS	2000		2,193	80	27.5	80		1,663	19
20		PLUMBING	2000		9,913	360	27.5	360		7,245	20
21		PLUMBING / VANITY / SINK / FLOORING	2001		37,788	1,374	27.5	1,374		27,108	21
22		PAVING	2002		18,562	675	27.5	675		12,516	22
23		BATHROOM SINKS	2002		3,888	141	27.5	141		2,544	23
24		BATHROOM SINKS	2003		7,776	283	27.5	283		5,082	24
25		FLOORING / CARPETING & TILE	2003		13,887	504	27.5	504		8,685	25
26		ROOF	2003		7,800	284	27.5	284		5,005	26
27		FENCE	2003		9,500		15	(308)	(308)	9,500	27
28		WINDOWS	2004		46,880	1,705	27.5	1,705		28,346	28
29		SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING	2007		298,345	10,849	27.5	10,849		150,500	29
30		ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST	2008		73,619	2,677	27.5	2,677		34,690	30
31		ROLLING SHUTTER	2008		3,970	144	27.5	144		1,818	31
32		BUILT-IN CABINETRY	2008		6,200	413	15	413		5,163	32
33		CANOPY	2009		6,500	236	27.5	236		2,645	33
34		SLIDING PATIO DOORS	2010		6,951	253	27.5	253		2,709	34
35		FLAT ROOF	2011		110,200	4,007	27.5	4,007		38,567	35
36		ROOFTOP A/C	2011		3,906	142	27.5	142		1,355	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 CHICAGO HEIGHTS**# **0043406**

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	BRIA OF CHICAGO HEIGHTS (formerly WOODSIDE):		\$	\$		\$	\$	\$	37
38	DRAPERIES	2001	7,578		10			7,578	38
39	CUBICLE CURTAINS/FLOORING	2004	33,108		10			33,108	39
40	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC	2005	30,694	1,116	27.5	1,116		17,096	40
41	WALL TILE / EXIT SIGNS / PLUMBING / DOORS	2006	49,079	1,785	27.5	1,785		26,167	41
42									42
43									43
44	RELATED PARTY-MST REAL ESTATE LLC-SL DEPN CONTINUED FROM PAGE 12:								
45	ANNUNCIATOR PANEL	2011	4,350	158	27.5	158		1,481	45
46	DRIVEWAY/FRONT STEPS/FENCE	2012	10,158	369	15	677	308	5,755	46
47	CANOPY W/LOGO	2012	2,818	102	27.5	102		854	47
48	56 WINDOWS	2013	13,973	358	39	358		2,670	48
49	WIRING	2013	12,057	309	39	309		2,176	49
50	BLDG DEMOLITION & LANDFILL FOR NEW PARKING LOT	2013	32,544	2,170	15	2,170		15,461	50
51	PARKING LOT -SURVEY/RESURFACE/SEAL/STRIPE	2014	8,530	569	15	569		3,699	51
52	CORRIDORS-INSTALL NEW COLD WATER LINE & DRINKING FOUNTAINS/VCT FLOORING/CEILING TILES/CEILING LIGHT FIXTURES/DRYWALL OVEI								52
53	HANDRAILS/CORNER & DOOR FRAME GUARDS	2014	145,749	5,299	27.5	5,299		34,665	53
54	INSTALL WALLCOVERING IN FRONT CORRIDOR,VESTIBULE,LOBBY/PAINT WALLS IN 9 RESIDENT RMS,BACK CORRIDOR/PUBLIC BATHROOMS, PHYI								54
55	ROOM, SHOWER ROOMS	2014	90,071	3,275	27.5	3,275		21,424	55
56	RESIDENT & PUBLIC BATHROOMS - REPLACE ROTTED PIPES, WALLS, FRAMING - DRYWALL,PRIME,PAINT,TILE, INSTALL NEW TOILETS, SINKS, FAU								56
57	SWITCHES,LIGHTS	2014	40,384	1,468	27.5	1,468		9,603	57
58	RESIDENT RMS, VESTIBULE, LOBBY-LIGHT FIXTURES/REPLACE PLUMBING IN WALLS, NEW BASEBOARD HEATER COVERS/FLOORING/WALLCOVER								58
59	TREATMENTS/WALL PATCH/THRU-BRICK LINTEL FOR PTAC	2014	30,849	1,122	27.5	1,122		7,340	59
60	CONFERENCE RM-PAINT WALLS, CARPET TILE, COVE BASE, BLINDS, DOOR GUARDS / CORRIDOR-EXIT LIGHTS, SIGNAGE / 2 CUSTOM-BUILT NURSIN								60
61	WITH GRANITE TOPS	2014	36,219	1,317	27.5	1,317		8,615	61
62	RESIDENT RMS-SUSPENDED CEILINGS,CEILNG LIGHTS,LIGHT FIXTURES, TILE, FLOORING, COVE BASE, CUSTOM BUILT CLOSETS, WINDOW TREATM								62
63	BASEBOARD HEATER COVERS, LAMINATE BOTH SIDES OF DOORS, NEW DOOR LOCKSETS,CUBICLE TRACK & CURTAINS, DOOR FRAMING & CORR								63
64		2014	134,380	4,886	27.5	4,886		31,963	64
65	Create 6 thru-wall openings, electrical, & install A/C units	2014	16,969	617	27.5	617		3,831	65
66	Replace 3 Exterior side doors & concrete slab over basement door	2016	33,865	1,231	27.5	1,231		5,591	66
67	Exterior tuckpointing of 4 inner courtyards	2016	18,500	1,233	15	1,233		5,549	67
68	Replace rehab room door & basement support frame & door	2016	9,290	338	27.5	338		1,479	68
69	Chimney repair	2016	6,500	236	27.5	236		974	69
70	TOTAL (lines 4 thru 69)		\$ 5,837,449	\$ 209,666		\$ 209,666	\$	\$ 3,237,482	70

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

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

1		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		\$ 5,837,449	\$ 209,666		\$ 209,666	\$	\$ 3,237,482	1
2	PARKING LOT-CONCRETE, ASPHALT WORK,DEMO,	2018	284,609	18,974	15	18,974		40,320	2
3	FENSING, LANDSCAPE, PLUMBING,EXTERIOR ELECTRICAL								3
4	CONOPY-NEW BUILDING & CANOPY SOFFIT, PARAPET,	2018	94,269	2,417	39	2,417		5,136	4
5	FRAMING/CAPENTRY,MASONRY/SHINGLES/CARP								5
6	REPLACE A SECTION OF SEWER PIPING	2020	72,415	77	39	77		77	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	TOTAL (lines 1 thru 33)		\$ 6,288,742	\$ 231,134		\$ 231,134	\$	\$ 3,283,015	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	\$ 131,116	\$ 185	\$ 9,566	\$ 9,381	8-15 YRS	\$ 114,630	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC		1,821	1,821				74
75	TOTALS	\$ 131,116	\$ 2,006	\$ 11,387	\$ 9,381		\$ 114,630	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)	\$ 6,666,433	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,140	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 242,521	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,381	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,397,645	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: \$ 11,884 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	2017 FORD TRANSIT VAN	\$ 898.82	\$ 6,381	17
18	FACILITY	2020 FORD TRANSIT	#####	8,786	18
19					19
20					20
21	TOTAL		\$ #####	\$ 15,167	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	\$		\$ 105,524	\$		\$ 105,524	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,804			10,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			91,918			91,918	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				24,129		24,129	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY	39-2					3,795		3,795	
	Other (specify): IV THERAPY,RENTA	39-2					11,693		11,693	13
14	TOTAL			\$		\$ 208,246	\$ 39,617		\$ 247,863	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	\$ 60,402	\$ 83,446	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 183,000)	1,785,652	1,785,652	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	341,999	363,881	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>ESCROWS</u>		475,926	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,188,053	\$ 2,708,905	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		246,575	13
14	Buildings, at Historical Cost		4,142,702	14
15	Leasehold Improvements, at Historical Cost	171,774	2,145,267	15
16	Equipment, at Historical Cost	131,116	205,005	16
17	Accumulated Depreciation (book methods)	(207,490)	(3,469,784)	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) <u>DUE FROM LLC</u>	1,016,982		22
23	Other(specify): <u>LOAN/CLOSING COSTS</u>		76,162	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,112,382	\$ 3,345,927	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,300,435	\$ 6,054,832	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,049,854	\$ 1,057,854	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		181,381	29
30	Accrued Salaries Payable	47,640	47,640	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,361	10,361	31
32	Accrued Real Estate Taxes(Sch.IX-B)		359,549	32
33	Accrued Interest Payable		8,005	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>PA LOAN</u>	1,315,900	1,315,900	36
37	<u>NOTE PAYABLE - PPP</u>	600,400	600,400	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,024,155	\$ 3,581,090	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,131,130	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)	\$	\$ 3,131,130	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,024,155	\$ 6,712,220	46
47	TOTAL EQUITY (page 18, line 24)	\$ 276,280	\$ (657,388)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,300,435	\$ 6,054,832	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,253,380	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,253,380	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,977,100)	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) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,977,100)	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)	\$ 276,280	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF CHICAGO HEIGHTS

0043406

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 6,684,605	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,684,605	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,537	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,537	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>STIMULUS PAYMENT</u>	817,583	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 817,583	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,507,725	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,345,023	31
32	Health Care	2,905,371	32
33	General Administration	4,028,710	33
	B. Capital Expense		
34	Ownership	720,880	34
	C. Ancillary Expense		
35	Special Cost Centers	247,863	35
36	Provider Participation Fee	236,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,484,825	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,977,100)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,977,100)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,603,271	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	832,982	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	81,097	47
48	Other-(specify) <u>MANAGED CARE</u>	167,255	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,684,605	49

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

**TAX RETURN

** Does this agree with taxable income (loss) per Federal Income

PREPARE ON

Tax Return? NO**

If not, please attach a reconciliation. CASH BASIS

*** 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	2,456	3,169	\$ 140,248	\$ 44.26	1
2	Assistant Director of Nursing	2,016	2,722	93,952	34.52	2
3	Registered Nurses	2,964	3,167	105,094	33.18	3
4	Licensed Practical Nurses	23,520	25,416	762,888	30.02	4
5	CNAs & Orderlies	56,730	61,787	1,005,291	16.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,522	8,927	138,928	15.56	10
11	Social Service Workers	5,037	6,853	137,449	20.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,563	6,857	115,834	16.89	15
16	Dishwashers					16
17	Maintenance Workers	4,217	4,999	95,785	19.16	17
18	Housekeepers	5,069	5,261	86,647	16.47	18
19	Laundry	1,191	1,328	22,493	16.94	19
20	Administrator	2,056	3,188	117,054	36.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,675	9,614	180,694	18.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,188	36,493	16.68	31
32	Other Health C: MDS Coordinator	6,262	6,724	187,383	27.87	32
33	Other(specify) Security	4,909	6,708	101,254	15.09	33
34	TOTAL (lines 1 - 33)	141,139	158,908	\$ 3,327,487 *	\$ 20.94	34

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

** See instructions.

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	25,063	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	13,050	10-3	38
39	Pharmacist Consultant	H	6,520	10-3	39
40	Physical Therapy Consultant	L	17,920	10a-3	40
41	Occupational Therapy Consultant	Y	14,851	10a-3	41
42	Respiratory Therapy Consultant		1,812	10a-3	42
43	Speech Therapy Consultant	F	1,299	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 80,515		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	73	\$ 8,134	10-3	50
51	Licensed Practical Nurses	156	19,908	10-3	51
52	Certified Nurse Assistants/Aides	50	3,258	10-3	52
53	TOTAL (lines 50 - 52)	279	\$ 31,300		53

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
ROSEMARY OLANREWAJU	ADMINISTRATOR	0	\$ 117,054	Workers' Compensation Insurance		\$ 75,910	IDPH License Fee	\$ 1,990
				Unemployment Compensation Insurance		36,336	Advertising: Employee Recruitment	19,751
				FICA Taxes		252,368	Health Care Worker Background Check	188
				Employee Health Insurance		139,828	(Indicate # of checks performed <u>2</u>)	
				Employee Meals		0	Patient Background Checks <u>51</u>	882
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	9,733
				EMPLOYEE BENEFITS - OTHER		22,676	MARKETING/ADV/PROMO	1,858
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	14,372
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC	3,277
				INSURANCE - EXECUTIVE LIFE		0	TRUST/FRANCHISE/CONTRIB/ETC	(9,733)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Public Relations Expense	(0)
							Non-allowable advertising	(1,858)
							Yellow page advertising	(0)
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
BRIA HEALTH SERVICES MANAGEMENT FEES			\$ 234,600	INSURANCE - EXECUTIVE LIFE VI 21			0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 234,600	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ALPHA DATA	DATA PROCESSING		\$ 123			\$	Out-of-State Travel	\$
PARAGON	DATA PROCESSING		5,370					
NATIONAL DATACARE CORP.	DATA PROCESSING		2,284					
RICHARD PEELO	MEDICARE CONSULTANT		4,500				In-State Travel	
KBKB LTD	ACCOUNTING FEES		18,000					8,149
PERSONNEL PLANNERS	UC CONSULTANT		2,435				BRIA HEALTH SVCS ALLOC	1,815
MTS CONSULTING	SALES TAX CONSULTANT		3,087					
RESOLUTE HEALTHCARE SOLUTIONS	LTC MEDICAID CONS.		2,151				Seminar Expense	
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN		86,850					0
SEE LEGAL SCHEDULE ATTACHED			93,467				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 218,267	TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 9,964	

*** Attach copy of IMRF notifications**

****See instructions.**

BRIA OF CHICAGO HEIGHTS
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
12/11/2020	JACKSON LEWIS P.C.	FLAT FEE - SENSITIVITY TRAINING	1,000.00
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
2/11/2020	MCCABE KIRSHNER P.C.	ILEFILE	476.90
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
3/27/2020	MCCABE KIRSHNER P.C.	ILEFILE	476.90
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,664.00
5/1/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
6/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
6/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
7/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
7/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
8/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
9/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
10/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
11/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
12/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
1/15/2020	SKIDELSKY & ASSOCIATES	2018 SPECIFIC OBJECTIONS	400.00
10/22/2020	SKIDELSKY & ASSOCIATES	2017 VALUATION OBJECTION	13,482.40
1/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
2/29/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
3/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
4/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
5/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
6/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
7/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
8/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
9/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
10/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
11/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
12/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
TOTAL			93,466.87

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC \$ 11,031
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,723 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. \$ 236,978
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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 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.