

		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: <u>0050120</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>BRIA OF WESTMONT</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.																							
Address: <u>6501 S CASS AVENUE</u> <u>WESTMONT</u> <u>60559</u>																									
Number City Zip Code																									
County: <u>DUPAGE</u>																									
Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>AVRUM WEINFELD</u></td></tr><tr><td>(Title) <u>CEO</u></td></tr><tr><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u></td></tr><tr><td>(Firm Name & Address) <u>KBKB, LTD</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-3585</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>AVRUM WEINFELD</u>	(Title) <u>CEO</u>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-3585</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-3585</u>																								
Date of Initial License for Current Owners: <u>09/03/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>KATHLEEN MCNAMARA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number BRIA OF WESTMONT

0050120 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	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,528</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3	<u>107</u>	Intermediate (ICF)	<u>107</u>	<u>39,162</u>	<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>215</u>	TOTALS	<u>215</u>	<u>78,690</u>	<u>7</u>

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>8,083</u>	<u>8,083</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF	<u>35,002</u>	<u>2,616</u>	<u>6,976</u>	<u>44,594</u>	<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>35,002</u>	<u>2,616</u>	<u>15,059</u>	<u>52,677</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.94%

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 9/3/08

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 9/3/08 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 108 and days of care provided 8,083

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number **BRIA OF WESTMONT** # **0050120** 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	511,382	47,047	96,647	655,076		655,076		655,076			1
2	Food Purchase		439,043		439,043		439,043	(196)	438,847			2
3	Housekeeping	149,614	22,600	212,971	385,185		385,185		385,185			3
4	Laundry	16,635	4,155	258,026	278,816		278,816		278,816			4
5	Heat and Other Utilities			316,900	316,900		316,900		316,900			5
6	Maintenance	167,199	96,891	54,026	318,116		318,116	1,001	319,117			6
7	Other (specify):*			21,906	21,906		21,906	204	22,110			7
8	TOTAL General Services	844,830	609,736	960,476	2,415,042		2,415,042	1,009	2,416,051			8
	B. Health Care and Programs											
9	Medical Director			89,313	89,313		89,313		89,313			9
10	Nursing and Medical Records	4,417,984	474,338	297,950	5,190,272		5,190,272	71,518	5,261,790			10
10a	Therapy	21,009		34,827	55,836		55,836		55,836			10a
11	Activities	174,062	5,713		179,775		179,775		179,775			11
12	Social Services	194,074	9,033		203,107		203,107		203,107			12
13	CNA Training			2,080	2,080		2,080		2,080			13
14	Program Transportation			2,877	2,877		2,877		2,877			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,807,129	489,084	427,047	5,723,260		5,723,260	71,518	5,794,778			16
	C. General Administration											
17	Administrative	113,125		600,000	713,125		713,125	(523,620)	189,505			17
18	Directors Fees											18
19	Professional Services			366,565	366,565		366,565	(209,788)	156,777			19
20	Dues, Fees, Subscriptions & Promotions			162,512	162,512		162,512	(21,190)	141,322			20
21	Clerical & General Office Expenses	434,714	40,797	192,349	667,860		667,860	57,216	725,076			21
22	Employee Benefits & Payroll Taxes			868,177	868,177		868,177	(8,241)	859,936			22
23	Inservice Training & Education			22,394	22,394		22,394	313	22,707			23
24	Travel and Seminar			11,357	11,357		11,357	2,011	13,368			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			317,747	317,747		317,747	40,929	358,676			26
27	Other (specify):*			1,569,279	1,569,279		1,569,279	(1,533,901)	35,378			27
28	TOTAL General Administration	547,839	40,797	4,110,380	4,699,016		4,699,016	(2,196,271)	2,502,745			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,199,798	1,139,617	5,497,903	12,837,318		12,837,318	(2,123,744)	10,713,574			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	96,647	
	REPAIRS & MAINTENANCE	0	
	CONTRACTED DIETARY SERVICES	0	
		96,647	
3	HOUSEKEEPING		
	CONTRACTED HOUSEKEEPING SERVICES	212,971	
		212,971	
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	0	
	CONTRACTED LAUNDRY SERVICES	258,026	
		258,026	
5	HEAT & OTHER UTILITIES		
	GAS HEAT	25,780	
	ELECTRICITY	112,191	
	WATER	168,371	
	CABLE TV - LOBBY	10,558	
		316,900	
6	MAINTENANCE		
	GROUNDS MAINTENANCE	42,718	
	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	11,308	
		54,026	
7	OTHER		
	SCAVENGER	21,906	
	SECURITY SERVICE	0	
		21,906	
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	89,313	89,313

SCHED REF	TOTAL	LINE
NURSING		10
CONTRACT NURSING XVIII C 53-2	236,109	
LABORATORY & XRAY EXPENSE	11,081	
PURCHASED SERVICES	0	
PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
RESTORATIVE NURSING CONSULTANT XVIII B 38-2	39,515	
MEDICAL RECORDS CONSULTANT XVIII B 37-2	0	
PHARMACY CONSULTANT XVIII B 39-2	11,245	
UTILIZATION REVIEW FEES XVIII B __-2	0	
PHYSICIANS XVIII B __-2	0	
PSYCHIATRIC XVIII B __-2	0	
RN CONSULTANT XVIII B 38-2		
	297,950	
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	12,904	
OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	5,333	
RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	13,706	
SPEECH THERAPY CONSULTANT XVIII B 43-2	2,884	
	34,827	
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	2,080	2,080

LINE	V.COST CENTER EXPENSES	PAGE 3 COLUMN 3 OTHER	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		2,877	
				2,877
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	600,000	600,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	11,767	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	128,998	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		225,800	
				366,565
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	9,959	
	EMPLOYEE WANT ADS	XIX F	100,089	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	25,220	
	LICENSES & PERMITS	XIX F	9,125	
	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	16,943	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,176	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				162,512
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,306	
	EQUIPMENT REPAIR & MAINTENANCE		151,326	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		27,829	
	MESSENGER SERVICE		888	
				192,349

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	460,607
	UNEMPLOYMENT COMPENSATION XIX D	32,463
	WORKERS COMPENSATION INSURANCE XIX D	157,826
	HOSPITALIZATION INSURANCE XIX D	131,224
	EMPLOYEE BENEFITS - OTHER XIX D	77,816
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	8,241
	PENSION/PROFIT SHARING PLANS XIX D	0
		868,177
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	22,394
		22,394
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	11,357
		11,357
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	317,747
		317,747
27	OTHER	
	BAD DEBTS VI 24	1,569,279
		1,569,279

GRAND TOTAL COLUMN 3 OTHER **5,497,903**

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			237,285	237,285		237,285	281,097	518,382			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			543,947	543,947		543,947	356,652	900,599			32
33	Real Estate Taxes							130,488	130,488			33
34	Rent-Facility & Grounds			832,512	832,512		832,512	(832,512)				34
35	Rent-Equipment & Vehicles			94,231	94,231		94,231	3,015	97,246			35
36	Other (specify):* RENT OFFICE			15,600	15,600		15,600	44,430	60,030			36
37	TOTAL Ownership			2,223,575	2,223,575		2,223,575	(516,830)	1,706,745			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		442,541	945,291	1,387,832		1,387,832		1,387,832			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			375,879	375,879		375,879		375,879			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		442,541	1,321,170	1,763,711		1,763,711		1,763,711			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,199,798	1,582,158	9,042,648	16,824,604		16,824,604	(2,640,574)	14,184,030			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	105,668	30		9
10	Interest and Other Investment Income	(7,693)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(196)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(16,943)	20		20
21	Owner or Key-Man Insurance	(8,241)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,569,279)	27		24
25	Fund Raising, Advertising and Promotional	(9,959)	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 PAGE 5A	(606,928)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,113,571)		\$	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)	(527,003)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (527,003)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,640,574)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (105,775)	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	2
3	MARKETING TRAVEL	(1,153)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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44				44
45				45
46				46
47				47
48				48
49	Total	(606,928)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF WESTMONT# 0050120

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	(196)	0	0	0	0	0	0	0	0	0	0	(196)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	1,001	0	0	0	0	0	0	0	1,001	6
7	Other (specify):*	0	0	0	204	0	0	0	0	0	0	0	204	7
8	TOTAL General Services	(196)	0	0	1,205	0	0	0	0	0	0	0	1,009	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	71,518	0	0	0	0	0	0	0	71,518	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	71,518	0	0	0	0	0	0	0	71,518	16
	C. General Administration													
17	Administrative	0	0	(545,620)	22,000	0	0	0	0	0	0	0	(523,620)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,700	1,895	(220,383)	0	0	0	0	0	0	0	(209,788)	19
20	Fees, Subscriptions & Promotions	(26,902)	0	0	5,712	0	0	0	0	0	0	0	(21,190)	20
21	Clerical & General Office Expenses	(105,775)	0	0	162,991	0	0	0	0	0	0	0	57,216	21
22	Employee Benefits & Payroll Taxes	(8,241)	0	0	0	0	0	0	0	0	0	0	(8,241)	22
23	Inservice Training & Education	0	0	0	313	0	0	0	0	0	0	0	313	23
24	Travel and Seminar	(1,153)	0	0	3,164	0	0	0	0	0	0	0	2,011	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	36,202	0	4,727	0	0	0	0	0	0	0	40,929	26
27	Other (specify):*	(1,569,279)	0	4,272	31,106	0	0	0	0	0	0	0	(1,533,901)	27
28	TOTAL General Administration	(1,711,350)	44,902	(539,453)	9,630	0	0	0	0	0	0	0	(2,196,271)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,711,546)	44,902	(539,453)	82,353	0	0	0	0	0	0	0	(2,123,744)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF WESTMONT # 0050120 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

	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	105,668	170,671	0	4,758	0	0	0	0	0	0	0	281,097	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(7,693)	338,660	0	25,685	0	0	0	0	0	0	0	356,652	32
33	Real Estate Taxes	0	130,488	0	0	0	0	0	0	0	0	0	130,488	33
34	Rent-Facility & Grounds	0	(832,512)	0	0	0	0	0	0	0	0	0	(832,512)	34
35	Rent-Equipment & Vehicles	0	0	0	3,015	0	0	0	0	0	0	0	3,015	35
36	Other (specify):*	0	44,430	0	0	0	0	0	0	0	0	0	44,430	36
37	TOTAL Ownership	(402,025)	(148,263)	0	33,458	0	0	0	0	0	0	0	(516,830)	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)	(2,113,571)	(103,361)	(539,453)	115,811	0	0	0	0	0	0	0	(2,640,574)	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				170,671	170,671	2
3	V	32	INTEREST				334,929	334,929	3
4	V	32	AMORT LOAN COST				3,731	3,731	4
5	V	33	REAL ESTATE TAXES				130,488	130,488	5
6	V	36	MIP INSURANCE				44,430	44,430	6
7	V	19	PROFESSIONAL FEES				8,700	8,700	7
8	V	26	INSURANCE-HAZARD				36,202	36,202	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 832,512			\$ 729,151	\$ * (103,361)	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	\$ 600,000	DA WESTMONT		\$	\$ (600,000)	15
16	V								16
17	V								17
18	V	17	OFFICER SALARIES-A. WEINFELD				27,190	27,190	18
19	V	17	OFICER SALARIES-D. WEISS				27,190	27,190	19
20	V	19	ACCOUNTING FEES				1,382	1,382	20
21	V	19	DATA PROCESSING				513	513	21
22	V	27	PAYROLL TAXES				4,272	4,272	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 600,000			\$ 60,547	\$ * (539,453)	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:	1/1/2020	Ending:	12/31/2020
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VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	BOOKKEEPING/ADMINISTRATIVE	\$ 225,800	BRIA HEALTH SERVICES, LLC		\$	\$ (225,800)	15
16	V								16
17	V	17	CFO SALARY-A.WEINFELD				22,000	22,000	17
18	V	10	SALARIES-MEDICARE/NURSING				39,352	39,352	18
19	V	10	SALARIES-REGIONAL DIR RELATED PARTIES				26,215	26,215	19
20	V	21	SALARIES-CLERICAL RELATED PARTIES				37,705	37,705	20
21	V	21	SALARIES-CLERICAL				102,888	102,888	21
22	V	6	MAINTENANCE				1,001	1,001	22
23	V	7	SCAVENGER				204	204	23
24	V	10	NURSING CONSULTANT & SUPPLIES				5,951	5,951	24
25	V	19	PROFESSIONAL FEES				5,417	5,417	25
26	V	20	DUES,FEES,SUBSCRIPTIONS				5,712	5,712	26
27	V	21	OFFICE EXPENSE				22,398	22,398	27
28	V	23	SEMINARS				313	313	28
29	V	24	TRAVEL				3,164	3,164	29
30	V	26	INSURANCE				4,727	4,727	30
31	V	27	EMPLOYEE BENEFITS				31,106	31,106	31
32	V	30	DEPRECIATION				4,758	4,758	32
33	V	32	INTEREST				25,685	25,685	33
34	V	35	AUTO LEASE				1,816	1,816	34
35	V	35	EQUIPMENT RENTAL				1,199	1,199	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 225,800			\$ 341,611	\$ * 115,811	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:

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 & DEVORAH WEINFELD	40.00	BRIA OF CAHOKIA	CAHOKIA	WESTMONT REAL			1
2					ESTATE, LLC	SKOKIE	REAL ESTATE	2
3	DANIEL & REBECCA WEISS	40.00	BRIA OF FOREST EDGE	CHICAGO				3
4					IME REALTY CORP	SKOKIE	HOME OFFICE	4
5	MIRIAM ROBINSON	20.00	BRIA OF BELLEVILLE	BELLEVILLE				5
6					DA WESTMONT	SKOKIE	MGMT CONSULT	6
7			BRIA OF GENEVA	GENEVA				7
8					BRIA HEALTH			8
9			LAKE PARK	WAUKEGAN	SERVICES, LLC	SKOKIE	MGMT SERVICES	9
10								10
11			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				11
12				HEIGHTS				12
13								13
14			BRIA OF PALOS HILLS	PALOS HILLS				14
15								15
16			BRIA OF RIVER OAKS	BURNHAM				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number **BRIA OF WESTMONT** # **0050120** Report Period Beginning: **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	ALLOCATION FROM DA WESTMONT:				SEE				\$		1
2					ATTACHED						2
3	AVRUM WEINFELD	SHAREHOLDER	ADMINISTRAT.	40.00	SCHEDULE	8	20.00	SALARIES	40,000	17-7	3
4	DANIEL WEISS	SHAREHOLDER	ADMINISTRAT.	40.00		4	10.00	SALARIES	30,000	17-7	4
5											5
6	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										6
7	DANIEL WEISS	SHAREHOLDER	ADMINISTRAT.	40.00		4	10.00	SALARIES	7,000	17-7	7
8											8
9	ALLOCATION FROM BRIA HEALTH SERVICES:										9
10	AVRUM WEINFELD	SHAREHOLDER	ADMINISTRAT.	40.00		8	20.00	SALARIES	22,000	17-7	10
11											11
12	DANIEL WEISS	SHAREHOLDER	REGIONAL DIR	40.00		4	10.00	SALARIES	6,640	17-7	12
13								TOTAL	\$ 105,640		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 WESTMONT # 0050120 Report Period Beginning: 1/1/2020 Ending: 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 DA WESTMONT
Street Address 5151 CHURCH STREET
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 674-5795
Fax Number (847) 674-5794

	1	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	OFFICER SALARIES-A. WEINFEL	CENSUS DAYS	116,240	2	\$ 60,000	\$ 60,000	52,677	\$ 27,190	1
2	17	OFFICER SALARIES-D. WEISS	CENSUS DAYS	116,240	2	60,000	60,000	52,677	27,190	2
3	19	ACCOUNTING FEES	CENSUS DAYS	116,240	2	3,050		52,677	1,382	3
4	19	DATA PROCESSING	CENSUS DAYS	116,240	2	1,132		52,677	513	4
5	27	PAYROLL TAXES	CENSUS DAYS	116,240	2	9,426		52,677	4,272	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 133,608	\$ 120,000		\$ 60,547	25

Facility Name & ID Number BRIA OF WESTMONT# 0050120

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 STREET

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		\$ 22,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	9	355,924	355,924	52,677	39,352	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	52,677	102,888	5
6	6	MAINTENANCE	CENSUS DAYS	9	9,053		52,677	1,001	6
7	7	SCAVENGER	CENSUS DAYS	9	1,836		52,677	204	7
8	10	NURSING CONSULTANT & SUPPL	CENSUS DAYS	9	53,827		52,677	5,951	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	9	49,003		52,677	5,417	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	9	51,648		52,677	5,712	10
11	21	OFFICE EXPENSE	CENSUS DAYS	9	202,594		52,677	22,398	11
12	23	SEMINARS	CENSUS DAYS	9	2,822		52,677	313	12
13	24	TRAVEL	CENSUS DAYS	9	28,614		52,677	3,164	13
14	26	INSURANCE	CENSUS DAYS	9	42,750		52,677	4,727	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	9	281,347		52,677	31,106	15
16	30	DEPRECIATION	CENSUS DAYS	9	43,023		52,677	4,758	16
17	32	INTEREST	CENSUS DAYS	9	232,306		52,677	25,685	17
18	35	AUTO LEASE	CENSUS DAYS	9	16,432		52,677	1,816	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	9	10,854		52,677	1,199	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,754,866	\$ 1,728,757		\$ 341,611	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		01/31/12	10,881,400	8,806,483	12/01/41	3.7500	334,929		2
3	LOAN COSTS	X		AMORTIZE OVER LIFE OF LOAN			111,302	78,002			3,731		3
4	FIFTH THIRD BANK	X		WORKING CAPITAL		11/10/14	2,000,000	809,050		4.7500	48,664		4
5	BRICKYARD BANK	X		LOAN		10/29/14	3,900,000	2,715,681	08/17/25	6.0000	194,596		5
	Working Capital												
6	FIFTH THIRD BANK	X		WORKING CAPITAL	DEMAND	09/05/08	2,000,000			PRIME+	20,974		6
7	F & M WEISS	X		WORKING CAPITAL		12/01/15	600,000	52,557	05/01/21	2.2000	2,641		7
8	RELATED PARTY ALLOCATION										25,685		8
9	TOTAL Facility Related						\$ 19,492,702	\$ 12,461,773				\$ 631,220	9
	B. Non-Facility Related*												
10	GOODWILL		X	GOODWILL		09/08	7,500,000	4,251,179	09/33	6.0000	277,072		10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$ 7,500,000	\$ 4,251,179				\$ 277,072	14
15	TOTALS (line 9+line14)						\$ 26,992,702	\$ 16,712,952				\$ 908,292	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,430 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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	119,654	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	124,449	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,795	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	125,693	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	130,488	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	97,424	8		
	2016	98,291	9		
	2017	112,640	10		
	2018	118,469	11		
	2019	124,449	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF WESTMONT COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

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>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>106,673.28</u>	\$ <u>106,673.28</u>
2.	<u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>7,371.70</u>	\$ <u>7,371.70</u>
3.	<u>09-22-101-003</u>	<u>NURSING HOME</u>	\$ <u>10,403.66</u>	\$ <u>10,403.66</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>124,448.64</u></u>	\$ <u><u>124,448.64</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.

A. Square Feet: 55,928

B. General Construction Type: Exterior BRICK Frame STEEL 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	NURSING HOME		1995	\$ 349,103	1
2	PARKING LOT		2006	410,723	2
3	TOTALS			\$ 759,826	3

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

0050120

Report Period Beginning:

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	
	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	\$	\$ 3,295,035	4
5				2016	6,976,963	178,896	39	178,896		812,486	5
6											6
7	RELATED PARTY ALLOCATIONS				79,962	2,131		2,131		2,131	7
8											8
	Improvement Type**										
9	FLOORING			1986	41,641		19			41,641	9
10	ROOF & WATER LINE			1987	31,143		20			31,143	10
11	IMPROVEMENTS			1988	44,614		31.5	1,416	1,416	46,015	11
12	IMPROVEMENTS			1989	40,935		31.5	1,299	1,299	40,860	12
13	DRIVEWAY			1989	17,137		15			17,137	13
14	IMPROVEMENTS			1990	37,367		31.5	1,186	1,186	36,122	14
15	IMPROVEMENTS			1991	45,002		31.5	1,428	1,428	41,887	15
16	IMPROVEMENTS			1992	49,649		31.5	1,577	1,577	44,851	16
17	ROOF TOP A/C UNITS			1993	9,100		31.5	289	289	8,068	17
18	IMPROVEMENTS			1993	53,243		39	1,366	1,366	37,415	18
19	IMPROVEMENTS			1994	31,230		39	801	801	21,343	19
20	FLOOR COVERING			1995	795		15			795	20
21	HAND RAIL			1995	2,249		39	58	58	1,501	21
22	FLOOR TILES			1995	5,471		39	140	140	3,588	22
23	WINDOW A/C UNITS			1995	14,146		39	363	363	9,240	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056		39	309	309	7,893	24
25	ALARM			1995	1,337		39	34	34	866	25
26	LAUNDRY BUILDING			1995	35,000		39	897	897	22,687	26
27	ROOF			1995	5,520		39	142	142	3,591	27
28	WINDOWS			1995	9,478		39	243	243	6,126	28
29	DOOR EDGE & DOOR FRAME			1996	2,099		39	54	54	1,348	29
30	LAUNDRY BUILDING			1996	175,187		39	4,491	4,491	110,227	30
31	AIR COOLERS			1996	6,642		39	171	171	4,187	31
32	RACING CAGE			1996	3,987		39	102	102	2,503	32
33	HAND RAIL			1996	1,156		39	30	30	731	33
34	WINDOWS			1996	11,496		39	295	295	7,191	34
35	TACK ROOM			1996	2,139		39	55	55	1,336	35
36	NEW CONFERENCE ROOM TILE			1997	2,938		39	76		1,770	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **BRIA OF WESTMONT**# **0050120**

Report Period Beginning:

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	INSTALL DIETARY DOOR	1997	\$ 1,478	\$	39	\$ 38	\$ 38	\$ 885	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	3,192	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	809	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	671	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	2,862	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	3,663	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	7,213	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	5,907	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,932	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	825	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	1,600	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	4,955	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	1,309	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	1,506	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	1,584	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	1,669	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	655	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	3,908	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	1,473	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	5	5	3,265	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	2,638	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	20,168	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	3,092	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	2,124	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	3,427	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	3	3	80,523	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	22,009	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	75,621	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	6,303	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	8,626	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	270,860	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	27,664	69
70	TOTAL (lines 4 thru 69)		\$ 13,443,579	\$ 308,778		\$ 350,087	\$ 41,233	\$ 5,277,363	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:

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	
1	Totals from Page 12A, Carried Forward		\$ 13,443,579	\$ 308,778		\$ 350,087	\$ 41,309	\$ 5,277,363	1
2	<u>FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS</u>	2002	8,997		15			8,997	2
3	<u>SHOWER ROOM</u>	2002	30,924		27.5	1,125	1,125	20,484	3
4	<u>INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER</u>	2002	9,010		27.5	328	328	5,918	4
5	<u>NEW NURSES STATION WITH CORIAN TOP</u>	2002	14,891		27.5	541	541	9,761	5
6	<u>2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTURE</u>	2002	40,056		20	2,003	2,003	38,057	6
7	<u>PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM</u>	2002	11,499		20	575	575	10,925	7
8	<u>PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM</u>	2003	12,767		27.5	464	464	8,101	8
9	<u>2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM</u>	2003	31,152		27.5	1,133	1,133	19,780	9
10	<u>THERAPY ROOM -FLOORING</u>	2003	87,509		27.5	3,182	3,182	55,552	10
11	<u>CONFERENCE ROOM-FLOORING</u>	2003	2,073		27.5	76	76	1,327	11
12	<u>LARGE DINING ROOM-BUILT IN TV CABINET</u>	2004	7,421		27.5	270	270	4,444	12
13	<u>TONE/VISUAL/VOICE NURSE CALL SYSTEM</u>	2004	89,825		27.5	3,266	3,266	53,209	13
14	<u>REMODEL OF RESIDENT ROOMS AND BATHROOMS</u>	2004	50,925		27.5	1,852	1,852	30,018	14
15	<u>RESIDENT ROOMS-FLOORING</u>	2005	9,821		27.5	357	357	5,608	15
16	<u>INSTALL CABLING SYSTEM</u>	2005	46,771		27.5	1,701	1,701	26,578	16
17	<u>INSTALL TWO AUTOMATIC SLIDING DOOR</u>	2005	28,000		27.5	1,018	1,018	15,312	17
18	<u>1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE</u>	2005	58,286		20	2,914	2,914	46,624	18
19	<u>INSTALL DOORS - F WING, RESIDENT ROOMS</u>	2006	4,260		27.5	155	155	2,306	19
20	<u>WALLCOVERING, FLOORING - 1ST FLOOR CORRID</u>	2006	63,838		27.5	2,321	2,321	34,331	20
21	<u>AIR CONDITIONS</u>	2006	7,968		27.5	289	289	4,186	21
22	<u>REPLACEMENT WALK - IN FREEZER DOOR</u>	2006	4,652		27.5	169	169	2,458	22
23	<u>REPLACEMENT OF KITCHEN TILES</u>	2007	13,200		27.5	380	380	5,320	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		182,794	26
27	<u>RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F</u>	2007	235,801	8,575	27.5	8,575		115,405	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		1,521	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		3,135	31
32	<u>REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE</u>	2007	3,108	113	27.5	113		1,521	32
33	<u>AIR CONDITIONS</u>	2008	12,661		5			12,661	33
34	TOTAL (lines 1 thru 33)		\$ 14,648,339	\$ 331,604		\$ 397,032	\$ 65,428	\$ 6,106,650	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:

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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 14,648,339	\$ 331,604		\$ 397,032	\$ 65,428	\$ 6,106,650	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		1,644	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		1,308	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		1,334	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		6,019	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		1,014	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		1,639	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		2,300	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		4,182	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		2,378	15
16	1ST FLOOR DINING ROOM.MEDICAL RECORDS,2ND FLOOR								16
17	DINING ROOM,ACTIVITY ROOM,BEAUTY SHOP, UTILITY								17
18	ROOM-FLOORING. WINDOW TREATMENTS	2011	19,818		5			19,818	18
19	INSTALL WATER HEATER	2011	11,585	421	27.5	421		4,122	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOO	2011	6,150	224	27.5	224		2,175	20
21	INSTALL FIRE ALARM SMOKES, HEATS, AV DEVCIE	2011	85,377	3,105	27.5	3,105		29,886	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	535	27.5	535		5,060	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	91	27.5	91		853	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	336	27.5	336		3,038	24
25	INSTALL ACCUTECH SYSTEM FOR FRONT DOOR	2012	4,814	175	27.5	175		1,553	25
26	DELAYED EGRESS LOCKING SYSTEM FOR 1ST FLOOR	2012	12,600	458	27.5	458		4,027	26
27	ROOM F-16 -INSTALL NEW PVT & COVE BASE	2012	5,316	193	27.5	193		1,632	27
28	PLASTER, PRIME & PAINT ALL ROOMS & BATH	2012	10,631	387	27.5	387		3,209	28
29	WEST PARKING LOT-SEALCOAT, CRACK FILLING,								29
30	STRIPING, ASPHALTING	2013	4,460	297	15	297		2,252	30
31	EMPLOYEE ENTRANCE DOOR & FRAME REPLACEMENT	2013	3,254	118	27.5	118		851	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		3,997	33
34	TOTAL (lines 1 thru 33)		\$ 15,056,937	\$ 340,444		\$ 405,872	\$ 65,428	\$ 6,366,997	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:

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 15,056,937	\$ 340,444		\$ 405,872	\$ 65,428	\$ 6,366,997	1
2	1ST & 2ND FLOOR LOBBY, FRONT CORRIDOR,RESIDENT								2
3	CORRIDORS: FLOORING,WALLCOVERING,PAINTING	2013	124,977	4,545	27.5	4,545		34,277	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		4,085	5
6	RESIDENT ROOMS: CURTAIN, WINDOW TREATMENTS	2014	15,035		5			15,035	6
7	DIALYSIS CENTER:CARPENTRY, ELECTRIC,PAINTING,TI	2019	146,353	5,322	27.5	5,322		7,761	7
8	PLUMBING,FLOORING								8
9	INSTALL SOFT START AT THE ELEVATOR	2019	22,000	800	27.5	800		1,100	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18	BUILDING RENOVATION :	2016	605,378	22,014	27.5	22,014		99,980	18
19	PRIVATE ROOMS, SEMI PRIVATE ROOMS,SOUTH NURSES STATION AND MEDICINE ROOM, A B C -WINGS CORRIDOR, BATHROOM &								19
20	SHOWER ROOMS-CLOSET INSERTS,UNITS OF ROOM DIVIDERS,FLOORING, WALLS & CEILINGS, NEW TILE, PLUMBING,								20
21	ELECTRIC, PAINTING,WINDOW TREATMENTS,SIGNAGE, INSTALL KEY PAD AT SECOND FLOOR HALL STATION								21
22	2ND FLOOR CORRIDOR: INSTALLATION OF CUSTOM TILE,								22
23	MILLWORK BASE	2016	51,474	1,872	27.5	1,872		8,034	23
24	RESIDENT ROOMS-COVE BASE, VINYL INSTALLATION	2017	5,329	194	27.5	194		768	24
25	INSTALLATION OF NEW TRACK SYSTEM	2018	13,124	875	15	875		2,188	25
26	INSTALL PURIFIED WATER LOOP	2018	7,692	280	27.5	280		572	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,064,449	\$ 376,933		\$ 442,361	\$ 65,428	\$ 6,540,797	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	\$ 608,815	\$ 33,154	\$ 73,394	\$ 40,240	3-10	\$ 371,612	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,097,007					1,097,007	73
74	RELATED PARTY		2,627	2,627				74
75	TOTALS	\$ 1,705,822	\$ 35,781	\$ 76,021	\$ 40,240		\$ 1,468,619	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)	\$ 18,530,097	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 412,714	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 518,382	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 105,668	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,009,416	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: \$ 72,519 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 VAN	2019 FORD E350	\$ #####	\$ 15,048	17
18	ADMINISTRATIVE	2020 JEEP CHEROKEE	469.00	3,870	18
19	ADMINISTRATIVE	2018 JEEP COMPASS	455.05	2,794	19
20					20
21	TOTAL		\$ #####	\$ 21,712	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

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 2,080	\$	\$ 2,080
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	\$	\$ 2,080	\$	\$ 2,080
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,080			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(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	\$		\$ 388,740	\$		\$ 388,740	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			95,468			95,468	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			461,083			461,083	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				237,961		237,961	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY	39-2					110,043		110,043	
	Other (specify): IV THERAPY, RENTAL	39-2					94,537		94,537	13
14	TOTAL			\$		\$ 945,291	\$ 442,541		\$ 1,387,832	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,196,328	\$ 2,285,184	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 457,000)	3,041,664	3,041,664	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	555,555	575,134	6
7	Other Prepaid Expenses	138,994	138,994	7
8	Accounts Receivable (owners or related parties)	445,453	5,243,479	8
9	Other(specify): <u>ESCROWS</u>		319,859	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,377,994	\$ 11,604,314	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		966,702	13
14	Buildings, at Historical Cost	6,976,963	11,959,264	14
15	Leasehold Improvements, at Historical Cost	682,997	1,780,149	15
16	Equipment, at Historical Cost	608,816	1,017,612	16
17	Accumulated Depreciation (book methods)	(1,526,321)	(5,972,748)	17
18	Deferred Charges	38,555	38,555	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>Goodwill-Net of Amortization</u>)	1,333,333	1,333,333	22
23	Other(specify): <u>LOAN COSTS</u>		78,002	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,114,343	\$ 11,200,869	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,492,337	\$ 22,805,183	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,181,546	\$ 1,181,546	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,765	1,765	28
29	Short-Term Notes Payable		281,107	29
30	Accrued Salaries Payable	211,074	211,074	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,045	22,045	31
32	Accrued Real Estate Taxes(Sch.IX-B)		125,694	32
33	Accrued Interest Payable		27,520	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>PA LOAN</u>	842,300	842,300	36
37	<u>NOTE PAYABLE - PPP</u>	1,335,413	1,335,413	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,594,143	\$ 4,028,464	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,070,525	8,070,525	39
40	Mortgage Payable		8,525,376	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)	\$ 8,070,525	\$ 16,595,901	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,664,668	\$ 20,624,365	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,827,669	\$ 2,180,818	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,492,337	\$ 22,805,183	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,118,522	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,118,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	709,147	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 709,147	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)	\$ 2,827,669	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF WESTMONT

0050120

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	\$ 15,860,637	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,860,637	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***	7,693	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,693	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>COMPUTER INCOME</u>	7,325	28
28a	<u>STIMULUS PAYMENT</u>	1,658,096	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,665,421	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,533,751	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,415,042	31
32	Health Care	5,723,260	32
33	General Administration	4,699,016	33
	B. Capital Expense		
34	Ownership	2,223,575	34
	C. Ancillary Expense		
35	Special Cost Centers	1,387,832	35
36	Provider Participation Fee	375,879	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,824,604	40
41	Income before Income Taxes (line 30 minus line 40)**	709,147	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 709,147	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,311,138	44
45	Private Pay - Net Inpatient Revenue	705,833	45
46	Medicare - Net Inpatient Revenue	5,599,188	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	960,714	47
48	Other-(specify) <u>MANAGED CARE</u>	1,283,764	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,860,637	49

**TAX RETURN

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

PREPARED ON
CASH BASIS** 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	1,848	1,984	\$ 122,124	\$ 61.55	1
2	Assistant Director of Nursing	6,681	6,986	269,598	38.59	2
3	Registered Nurses	30,000	32,145	1,152,524	35.85	3
4	Licensed Practical Nurses	26,191	27,897	910,878	32.65	4
5	CNAs & Orderlies	87,396	93,674	1,603,748	17.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	537	577	21,009	36.41	8
9	Activity Director					9
10	Activity Assistants	10,461	11,241	174,062	15.48	10
11	Social Service Workers	7,281	7,762	194,074	25.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,890	35,603	511,382	14.36	15
16	Dishwashers					16
17	Maintenance Workers	6,464	6,958	167,199	24.03	17
18	Housekeepers	11,862	12,374	149,614	12.09	18
19	Laundry			16,635		19
20	Administrator	1,552	1,560	113,125	72.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,291	18,094	434,714	24.03	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	1,976	2,246	40,676	18.11	31
32	Other Health C: Care Plan Coord	8,066	8,435	318,436	37.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	251,496	267,536	\$ 6,199,798 *	\$ 23.17	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	\$ 96,647	1-3	35
36	Medical Director	O	89,313	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	39,515	10-3	38
39	Pharmacist Consultant	H	11,245	10-3	39
40	Physical Therapy Consultant	L	12,904	10a-3	40
41	Occupational Therapy Consultant	Y	5,333	10a-3	41
42	Respiratory Therapy Consultant		13,706	10a-3	42
43	Speech Therapy Consultant	F	2,884	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)		\$ 271,547		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	365	\$ 35,755	10-3	50
51	Licensed Practical Nurses	1,802	101,980	10-3	51
52	Certified Nurse Assistants/Aides	2,094	98,374	10-3	52
53	TOTAL (lines 50 - 52)	4,261	\$ 236,109		53

STATE OF ILLINOIS

Facility Name & ID Number

BRIA OF WESTMONT

0050120

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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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	
NORA O'GORMAN		ADMINISTRATOR	0	\$ 61,907	Workers' Compensation Insurance		\$ 157,826	IDPH License Fee		\$ 1,990	
JEFFREY RUSSELL		ADMINISTRATOR	0	51,218	Unemployment Compensation Insurance		32,463	Advertising: Employee Recruitment		100,089	
					FICA Taxes		460,607	Health Care Worker Background Check		1,176	
					Employee Health Insurance		131,224	(Indicate # of checks performed 20)			
					Employee Meals		0	Patient Background Checks		0	
					Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		16,943	
					EMPLOYEE BENEFITS - OTHER		77,816	MARKETING/ADV/PROMO		9,959	
					EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS		32,355	
					PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC		5,712	
					INSURANCE - EXECUTIVE LIFE		8,241	TRUST/FRANCHISE/CONTRIB/ETC		(16,943)	
								Less: Public Relations Expense		(0)	
								Non-allowable advertising		(9,959)	
								Yellow page advertising		(0)	
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 113,125				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 141,322	
(List each licensed administrator separately.)											
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
DA WESTMONT MANAGEMENT FEES			\$ 600,000					Out-of-State Travel		\$	
								In-State Travel			
										11,357	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 600,000					MGMT CO ALLOC		3,164	
(Attach a copy of any management service agreement)								Seminar Expense		0	
C. Professional Services											
Vendor/Payee		Type	Amount								
ALPHA DATA		DATA PROCESSING	\$ 120								
NATIONAL DATACARE CORP.		DATA PROCESSING	2,399								
PARAGON		DATA PROCESSING	9,248								
KBKB LTD		ACCOUNTING FEE	20,750								
BRIA HEALTH SERVICES		BOOKKEEPING/ADMIN	225,800								
RESOLUTE HEALTHCARE SOL.		LTC MEDICAID CONS.	5,998								
GCHMO, INC.		MANAGED CARE EXPERTS	3,800								
RICHARD PEELO		MEDICARE CONSULTANT	4,500								
PERSONNEL PLANNERS		UC CONSULTANT	5,808								
ACHIEVE ACCREDITATION		ACCREDITATION CONSULT	4,831								
CURASPAN HEALTH GROUP		PAC FOR HEALTH PLANS	10,659								
SEE LEGAL SCHEDULE ATTACHED			72,652								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 366,565	TOTAL			\$	Entertainment Expense		()	
(For legal fee disclosure, see page 39 of instructions)								(agree to Sch. V, line 24, col. 8)		\$ 14,521	

* Attach copy of IMRF notifications

**See instructions.

BRIA OF WESTMONT
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/8/2020	ADR SYSTEMS	MEDIATION	1,616
1/8/2020	ADR SYSTEMS	MEDIATION	1,616
12/11/2020	JACKSON LEWIS P.C.	FLAT FEE - SENSITIVITY TRAINING	1,000
6/10/2020	LAW OFFICE OF STEVEN J. MALMAN & ASSOC.	COURT CASE	12,036
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
6/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
7/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
8/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
9/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
9/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	4,000
10/15/2020	MCCABE KIRSHNER P.C.	ILEFILE	477
10/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	4,000
10/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
11/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
12/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500
4/6/2020	SKIDELSKY & ASSOCIATES	2019 REAL ESTATE ASSESSMENT AND TAXES	6,915
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
1/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
2/29/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
3/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
4/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
5/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
6/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
7/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
8/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
9/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	194
10/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
11/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
11/12/2020	U.S. LEGAL	COURT REPORTING FEES	60
11/12/2020	STEVEN J. MALMAN & ASSOCIATES	LEGAL SETTLEMENT	15,071.50
TOTAL			72,652

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$20,441
- (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. \$ 45,056 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. \$ 375,879
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.