

Facility Name & ID Number BRIA OF WESTMONT

0050120 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,162	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,914	5,914	8
9	SNF/PED					9
10	ICF	44,324	4,236	939	49,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,324	4,236	6,853	55,413	14

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

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

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

YES NO

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

YES NO

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

Date started 09/03/08

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

YES Date 09/03/08 NO

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

YES NO If YES, enter number of beds certified 125 and days of care provided 5,914

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	60,709	20,711	740,255	821,675	821,675		821,675			1
2	Food Purchase		84,984		84,984	84,984		84,984			2
3	Housekeeping		49,980	349,410	399,390	399,390		399,390			3
4	Laundry		16,206	358,575	374,781	374,781		374,781			4
5	Heat and Other Utilities			284,363	284,363	284,363	726	285,089			5
6	Maintenance	104,751	121,178	43,118	269,047	269,047	2,533	271,580			6
7	Other (specify):*			16,719	16,719	16,719		16,719			7
8	TOTAL General Services	165,460	293,059	1,792,440	2,250,959	2,250,959	3,259	2,254,218			8
	B. Health Care and Programs										
9	Medical Director			63,000	63,000	63,000		63,000			9
10	Nursing and Medical Records	3,640,122	336,319	74,212	4,050,653	4,050,653	57,577	4,108,230			10
10a	Therapy			13,065	13,065	13,065		13,065			10a
11	Activities	112,516	3,088	1,805	117,409	117,409		117,409			11
12	Social Services	87,241	1,602	1,376	90,219	90,219		90,219			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,839,879	341,009	153,458	4,334,346	4,334,346	57,577	4,391,923			16
	C. General Administration										
17	Administrative	154,290		792,000	946,290	946,290	(548,203)	398,087			17
18	Directors Fees										18
19	Professional Services			106,459	106,459	106,459	(23,690)	82,769			19
20	Dues, Fees, Subscriptions & Promotions			159,671	159,671	159,671	(107,108)	52,563			20
21	Clerical & General Office Expenses	307,015	38,829	188,631	534,475	534,475	61,948	596,423			21
22	Employee Benefits & Payroll Taxes			683,468	683,468	683,468	(6,133)	677,335			22
23	Inservice Training & Education			2,048	2,048	2,048	1,408	3,456			23
24	Travel and Seminar			8,210	8,210	8,210	6,183	14,393			24
25	Other Admin. Staff Transportation						(2,769)	(2,769)			25
26	Insurance-Prop.Liab.Malpractice			248,748	248,748	248,748	2,426	251,174			26
27	Other (specify):*			248,180	248,180	248,180	(218,595)	29,585			27
28	TOTAL General Administration	461,305	38,829	2,437,415	2,937,549	2,937,549	(834,533)	2,103,016			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,466,644	672,897	4,383,313	9,522,854	9,522,854	(773,697)	8,749,157			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	13,370
	REPAIRS & MAINTENANCE	0
	CONTRACTED DIETARY SERVICES	726,885
		740,255
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICES	349,410
		349,410
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
	CONTRACTED LAUNDRY SERVICES	358,575
		358,575
5	HEAT & OTHER UTILITIES	
	GAS HEAT	20,413
	ELECTRICITY	97,119
	WATER	160,173
	CABLE TV - LOBBY	6,658
		284,363
6	MAINTENANCE	
	GROUNDS MAINTENANCE	16,008
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	27,110
		43,118
7	OTHER	
	SCAVENGER & EXTERMINATING SERVICES	16,719
	SECURITY SERVICE	0
		16,719
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	63,000
		63,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	2,166
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	845
	PHARMACY CONSULTANT XVIII B 39-2	16,848
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	54,353
		74,212
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,221
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	3,781
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	652
	SPEECH THERAPY CONSULTANT XVIII B 43-2	1,411
		13,065
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,805
		1,805
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,376
	SOCIAL WORKER XVIII B 45-2	0
		1,376
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	792,000
	792,000	
	DIRECTORS FEES	
18	DIRECTORS FEES	0
	0	
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,108
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	51,851
	BOOKKEEPING/ADMINISTRATIVE SERVICES	42,500
	106,459	
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	103,510
	EMPLOYEE WANT ADS XIX F	18,132
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	23,345
	LICENSES & PERMITS XIX F	3,659
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	8,775
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,650
	PATIENT BACKGROUND CHECKS XIX F	600
		159,671
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,961
	EQUIPMENT REPAIR & MAINTENANCE	139,167
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	46,163
	MESSANGER SERVICE	1,340
		188,631

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

GRAND TOTAL COLUMN 3 OTHER

4,383,313

**BRIA OF WESTMONT
SCHEDULES
12/31/2016**

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

TOTAL FOOD PURCHASE	84,984
LESS SALES TAX	<u>0</u>
NET FOOD	84,984
TOTAL PATIENT CENSUS	55,413
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	166,239
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>39,528</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	166,239
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	166,239
NET FOOD	84,984
DIVIDE TOTAL MEALS/YEAR	<u>166,239</u>
COST PER MEAL	0.51
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number

BRIA OF WESTMONT

#0050120

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			252,636	252,636		252,636	148,896	401,532			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			526,023	526,023		526,023	62,876	588,899			32
33	Real Estate Taxes							103,275	103,275			33
34	Rent-Facility & Grounds			832,512	832,512		832,512	(832,512)				34
35	Rent-Equipment & Vehicles			79,984	79,984		79,984	7,125	87,109			35
36	Other (specify):* OFFICE RENT			15,600	15,600		15,600	36,141	51,741			36
37	TOTAL Ownership			2,206,755	2,206,755		2,206,755	(974,199)	1,232,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		419,129	952,392	1,371,521		1,371,521		1,371,521			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			419,376	419,376		419,376		419,376			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		419,129	1,371,768	1,790,897		1,790,897		1,790,897			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,466,644	1,092,026	7,961,836	13,520,506		13,520,506	(1,747,896)	11,772,610			45

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

VI. ADJUSTMENT DETAIL

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

		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	(22,130)	30		9
10	Interest and Other Investment Income	(2,581)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(325,613)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(8,775)	20		20
21	Owner or Key-Man Insurance	(6,133)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(248,180)	27		24
25	Fund Raising, Advertising and Promotional	(103,510)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(562,079)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,279,001)		\$	30

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)	(468,895)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (468,895)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,747,896)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

BRIA OF WESTMONT

ID# 0050120

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (59,310)	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	2
3	TRANSPORTATION STAFF-MARKETING	(2,769)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(562,079)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF WESTMONT# 0050120

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	547	179	0	0	0	0	0	0	0	726	5
6	Maintenance	0	0	1,731	802	0	0	0	0	0	0	0	2,533	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	2,278	981	0	3,259	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	57,577	0	0	0	0	0	0	0	57,577	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	57,577	0	57,577	16						
	C. General Administration													
17	Administrative	0	0	(560,575)	12,372	0	0	0	0	0	0	0	(548,203)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,700	1,430	(33,820)	0	0	0	0	0	0	0	(23,690)	19
20	Fees, Subscriptions & Promotions	(112,285)	0	0	5,177	0	0	0	0	0	0	0	(107,108)	20
21	Clerical & General Office Expenses	(59,310)	0	0	121,258	0	0	0	0	0	0	0	61,948	21
22	Employee Benefits & Payroll Taxes	(6,133)	0	0	0	0	0	0	0	0	0	0	(6,133)	22
23	Inservice Training & Education	0	0	0	1,408	0	0	0	0	0	0	0	1,408	23
24	Travel and Seminar	0	0	0	6,183	0	0	0	0	0	0	0	6,183	24
25	Other Admin. Staff Transportation	(2,769)	0	0	0	0	0	0	0	0	0	0	(2,769)	25
26	Insurance-Prop.Liab.Malpractice	0	0	434	1,992	0	0	0	0	0	0	0	2,426	26
27	Other (specify):*	(248,180)	0	3,604	25,981	0	0	0	0	0	0	0	(218,595)	27
28	TOTAL General Administration	(428,677)	8,700	(555,107)	140,551	0	(834,533)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(428,677)	8,700	(552,829)	199,109	0	(773,697)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF WESTMONT# 0050120

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(22,130)	168,577	1,710	739	0	0	0	0	0	0	0	148,896	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(328,194)	376,440	1,395	13,235	0	0	0	0	0	0	0	62,876	32
33	Real Estate Taxes	0	99,849	2,797	629	0	0	0	0	0	0	0	103,275	33
34	Rent-Facility & Grounds	0	(832,512)	0	0	0	0	0	0	0	0	0	(832,512)	34
35	Rent-Equipment & Vehicles	0	0	4,271	2,854	0	0	0	0	0	0	0	7,125	35
36	Other (specify):*	0	49,499	(15,600)	2,242	0	0	0	0	0	0	0	36,141	36
37	TOTAL Ownership	(850,324)	(138,147)	(5,427)	19,699	0	(974,199)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,279,001)	(129,447)	(558,256)	218,808	0	(1,747,896)	45						

Facility Name & ID Number

BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 - SUPPLEMENTAL						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 832,512	WESTMONT REAL ESTATE, LLC		\$	(832,512)	1
2	V	30 DEPRECIATION (SL)				168,577	168,577	2
3	V	32 INTEREST				372,709	372,709	3
4	V	32 AMORT LOAN COST				3,731	3,731	4
5	V	33 REAL ESTATE TAXES				99,849	99,849	5
6	V	36 MIP INSURANCE				49,499	49,499	6
7	V	19 ACCOUNTING FEES				8,700	8,700	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 832,512			\$ 703,065	\$ * (129,447)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 15,600	IME REALTY		\$	\$ (15,600)
16	V						
17	V	5 UTILITIES				547	547
18	V	6 MAINTENANCE				1,669	1,669
19	V	6 ALARM SERVICE				62	62
20	V	19 ACCOUNTING FEES				155	155
21	V	26 INSURANCE				434	434
22	V	30 DEPRECIATION (SL)				1,710	1,710
23	V	32 INTEREST				1,395	1,395
24	V	33 RE TAX				2,797	2,797
25	V	35 STORAGE FEES				4,271	4,271
26	V						
27	V						
28	V	17 MANAGEMENT FEES	792,000	DA WESTMONT			(792,000)
29	V	17 OFFICER SALARIES-A. WEINFELD				21,234	21,234
30	V	17 OFFICER SALARIES-D. WEISS				21,234	21,234
31	V	17 ADMIN CONSULTANT-SHIRLEY HOLT				122,163	122,163
32	V	17 ADMIN CONSULTANT-A.R.M.				66,794	66,794
33	V	19 ACCOUNTING FEES				1,275	1,275
34	V	27 PAYROLL TAXES				3,604	3,604
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 807,600			\$ 249,344	\$ * (558,256)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 BOOKKEEPING/ADM SERVICES	\$ 42,500	BRIA HEALTH SERVICES, LLC		\$	\$ (42,500)
16	V	20 WANT ADS/BACKGR CKS	5,562				(5,562)
17	V						
18	V	17 CFO SALARY-A.WEINFELD				12,372	12,372
19	V	10 SALARIES-MEDICARE/NURSING				57,577	57,577
20	V	21 SALARIES-PURCHASING D.SEGAL				20,599	20,599
21	V	21 SALARIES-CLERICAL				81,088	81,088
22	V	5 UTILITIES				179	179
23	V	6 MAINTENANCE				802	802
24	V	19 PROFESSIONAL FEES				8,680	8,680
25	V	20 WANT ADS/BACKGR CKS				10,739	10,739
26	V	21 OFFICE EXPENSE				19,571	19,571
27	V	23 SEMINARS				1,408	1,408
28	V	24 TRAVEL				6,183	6,183
29	V	26 INSURANCE				1,992	1,992
30	V	27 EMPLOYEE BENEFITS				25,981	25,981
31	V	30 DEPRECIATION				739	739
32	V	32 INTEREST				13,235	13,235
33	V	33 RE TAX				629	629
34	V	36 OFFICE RENT-HINSDALE MGMT				2,242	2,242
35	V	35 STORAGE FEES				1,311	1,311
36	V	35 AUTO LEASE				1,543	1,543
37	V						
38	V						
39	Total		\$ 48,062			\$ 266,870	\$ * 218,808

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

Facility Name & ID Number

BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

IME REALTY CORP.

Street Address

6765 N. LINCOLN AVE.

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 674-5795

Fax Number

(847) 674-5794

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.

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	5	UTILITIES	INCOME	131,420	6	\$ 4,608	\$ 15,600	\$ 547	1
2	6	MAINTENANCE	INCOME	131,420	6	14,061	15,600	1,669	2
3	6	ALARM SERVICE	INCOME	131,420	6	520	15,600	62	3
4	19	ACCOUNTING FEES	INCOME	131,420	6	1,305	15,600	155	4
5	26	INSURANCE	INCOME	131,420	6	3,656	15,600	434	5
6	30	DEPRECIATION (SL)	INCOME	131,420	6	14,406	15,600	1,710	6
7	32	INTEREST	INCOME	131,420	6	11,748	15,600	1,395	7
8	33	RE TAX	INCOME	131,420	6	23,559	15,600	2,797	8
9	35	STORAGE FEES	INCOME	131,420	6	35,982	15,600	4,271	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 109,845	\$	\$ 13,040	25

Facility Name & ID Number BRIA OF WESTMONT

0050120 Report Period Beginning: 01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DA WESTMONT
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

1	2	3	4	5	6	7	8	9	
Schedule V 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	156,578	3	\$ 60,000	\$ 55,413	\$ 21,234	1
2	17	OFFICER SALARIES-D. WEISS	CENSUS DAYS	156,578	3	60,000	55,413	21,234	2
3	17	ADMIN CONSUL.SHIRLEY HOLT	CENSUS DAYS	156,578	1	122,163	55,413	122,163	3
4	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	156,578	3	188,737	55,413	66,794	4
5	19	ACCOUNTING FEES	CENSUS DAYS	156,578	3	3,605	55,413	1,275	5
6	27	PAYROLL TAXES	CENSUS DAYS	156,578	3	10,184	55,413	3,604	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 444,689	\$ 120,000	\$ 236,304	25

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization BRIA HEALTH SERVICES, LLC
 Street Address 6865 N LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	CFO SALARY-A.WEINFELD	CENSUS DAYS	470,242	8	\$ 105,000	\$ 55,413	\$ 12,372	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	470,242	8	488,618	55,413	57,577	2
3	21	SALARIES-PURCHASING D.SEGA	CENSUS DAYS	470,242	8	174,808	55,413	20,599	3
4	21	SALARIES-CLERICAL	CENSUS DAYS	470,242	8	688,130	55,413	81,088	4
5	5	UTILITIES	CENSUS DAYS	470,242	8	1,521	55,413	179	5
6	6	MAINTENANCE	CENSUS DAYS	470,242	8	6,806	55,413	802	6
7	19	PROFESSIONAL FEES	CENSUS DAYS	470,242	8	73,657	55,413	8,680	7
8	20	WANT ADS/BACKGR CKS	CENSUS DAYS	470,242	8	91,117	55,413	10,739	8
9	21	OFFICE EXPENSE	CENSUS DAYS	470,242	8	166,089	55,413	19,571	9
10	23	SEMINARS	CENSUS DAYS	470,242	8	11,949	55,413	1,408	10
11	24	TRAVEL	CENSUS DAYS	470,242	8	52,475	55,413	6,183	11
12	26	INSURANCE	CENSUS DAYS	470,242	8	16,909	55,413	1,992	12
13	27	EMPLOYEE BENEFITS	CENSUS DAYS	470,242	8	220,477	55,413	25,981	13
14	30	DEPRECIATION	CENSUS DAYS	470,242	8	6,293	55,413	739	14
15	32	INTEREST	CENSUS DAYS	470,242	8	112,306	55,413	13,235	15
16	33	RE TAX	CENSUS DAYS	470,242	8	5,338	55,413	629	16
17	36	OFFICE RENT-HINSDALE MGMT	CENSUS DAYS	470,242	8	19,029	55,413	2,242	17
18	35	STORAGE FEES	CENSUS DAYS	470,242	8	11,121	55,413	1,311	18
19	35	AUTO LEASE	CENSUS DAYS	470,242	8	13,087	55,413	1,543	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,264,730	\$ 1,456,556	\$ 266,870	25

Facility Name & ID Number

BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	RELATED PARTY: WESTMONT REAL ESTATE, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY	X		MORTGAGE	\$67,995.96	01/31/12	10,881,400	9,831,334	12/01/41	3.7500	372,709	2						
3	LOAN COSTS	X		AMORTIZE OVER LIFE OF LOAN			111,302	92,926			3,731	3						
4	BRICKYARD BANK	X		WORKING CAPITAL	\$16,970.55	11/10/14	2,000,000	1,809,291	11/10/17	6.0000	113,326	4						
5	MB FINANCIAL	X		LOAN	\$16,250.00	10/29/14	3,900,000	3,835,000	08/05/20	4.7500	46,977	5						
	Working Capital																	
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	09/05/08	2,000,000	1,670,000		PRIME+	27,273	6						
7	F & M WEISS	X		WORKING CAPITAL		12/01/15	600,000	533,350	05/01/21	2.2000	12,834	7						
8	RELATED PARTY ALLOCATION										14,630	8						
9	TOTAL Facility Related				\$101,216.51		\$ 19,492,702	\$ 17,771,901			\$ 591,480	9						
	B. Non-Facility Related*																	
10	GOODWILL		X	GOODWILL	\$42,088.99	09/08	7,500,000	5,328,782	09/33	6.0000	325,613	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related				\$42,088.99		\$ 7,500,000	\$ 5,328,782			\$ 325,613	14						
15	TOTALS (line 9+line14)						\$ 26,992,702	\$ 23,100,683			\$ 917,093	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 49,499 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.	\$	95,973	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.)	\$	97,424	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,451	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	98,398	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 \$ <u>200</u> For <u> </u> 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.	\$	99,849	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	91,252	8
	2012	96,000	9
	2013	98,535	10
	2014	95,023	11
	2015	97,424	12

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

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL. THE PAYMENT ON LINE 2 APPLIES TO THE 2015 TAX BILL.

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF WESTMONT COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and another column. Rows include NURSING HOME (1995, \$349,103), PARKING LOT (2006, \$410,723), and TOTALS (\$759,826).

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	\$ 1,478	\$	39	\$ 38	\$ 38	\$ 733	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	2,640	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	669	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	559	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	2,358	41
42	THE PARKING LOT	1998	42,711		15			42,711	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223		39	160	160	3,023	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	5,909	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	4,831	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,576	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	673	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	1,304	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	4,035	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	1,065	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	1,222	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	1,284	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	1,353	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	531	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	3,168	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	1,193	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	2,771	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	2,118	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	16,176	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	2,480	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,700	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	2,743	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	68,442	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	17,561	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	60,009	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	4,979	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	6,814	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	216,688	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	21,840	69
70	TOTAL (lines 4 thru 69)		\$ 13,363,617	\$ 226,963		\$ 272,453	\$ 45,490	\$ 3,870,865	70

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

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 14,568,377	\$ 249,789		\$ 319,998	\$ 70,209	\$ 4,511,955	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		1,116	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		888	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		906	4
5	2ND FLOOR CORRIDOR-CARPET, WALLCOVERING	2009	103,122		5			103,122	5
6	WALL AIR CONDITIONS	2009	9,397		5			9,397	6
7	1ST FLOOR RESIDENT ROOMS-WINDOW TREATMENTS	2009	16,265		5			16,265	7
8	INSTALLATION OF SIGNAGE	2009	8,020	535	15	535		3,879	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		670	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		1,083	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		1,520	11
12	WALL AIR CONDITIONS	2010	7,612		5			7,612	12
13	1ST FLOOR DINING ROOM-WALLCOVERING, BLINDS	2010	19,660		5			19,660	13
14	A-WING RESIDENT ROOM-BUIT-IN WARDROBES	2010	11,222	408	27.5	408		2,550	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		1,450	15
16	1ST FLOOR DINING ROOM.MEDICAL RECORDS.2ND FLOOR								16
17	DINING ROOM,ACTIVITY ROOM,BEAUTY SHOP, UTILITY								17
18	ROOM-FLOORING. WINDOW TREATMENTS	2011	19,818	1,141	5	1,141		19,818	18
19	INSTALL WATER HEATER	2011	11,585	421	27.5	421		2,438	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOO	2011	6,150	224	27.5	224		1,279	20
21	INSTALL FIRE ALARM SMOKES, HEATS, AV DEVCIE	2011	85,377	3,105	27.5	3,105		17,466	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	535	27.5	535		2,920	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	91	27.5	91		489	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	336	27.5	336		1,694	24
25	INSTALL ACCUTECH SYSTEM FOR FRONT DOOR	2012	4,814	175	27.5	175		853	25
26	DELAYED EGRESS LOCKING SYSTEM FOR 1ST FLOOR	2012	12,600	458	27.5	458		2,195	26
27	ROOM F-16 -INSTALL NEW PVT & COVE BASE	2012	5,316	193	27.5	193		860	27
28	PLASTER, PRIME & PAINT ALL ROOMS & BATH	2012	10,631	387	27.5	387		1,661	28
29	WEST PARKING LOT-SEALCOAT, CRACK FILLING,								29
30	STRIPING, ASPHALTING	2013	4,460	297	15	297		1,064	30
31	EMPLOYEE ENTRANCE DOOR & FRAME REPLACEMENT	2013	3,254	118	27.5	118		379	31
32	2ND FLOOR CORRIDOR-CEILINGS ; REMODEL MEN BATH								32
33	ROOM ON THE 1ST FLOOR: TILE, VANITY, FAUSET	2013	15,433	561	27.5	561		1,753	33
34	TOTAL (lines 1 thru 33)		\$ 14,976,975	\$ 259,770		\$ 329,979	\$ 70,209	\$ 4,736,942	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 14,976,975	\$ 259,770		\$ 329,979	\$ 70,209	\$ 4,736,942	1
2	1ST & 2ND FLOOR LOBBY, FRONT CORRIDOR,RESIDENT								2
3	CORRIDORS: FLOORING,WALLCOVERING,PAINTING	2013	124,977	4,545	27.5	4,545		16,097	3
4	REMODEL 7 BATHROOMS IN PATIOS ROOMS ON THE 1ST								4
5	FLOOR: PLUMBING, ELECTRIC, OUTLETS FOR LIGHTS	2014	16,150	587	27.5	587		1,737	5
6	RESIDENT ROOMS: CURTAIN, WINDOW TREATMENTS	2014	15,035	2,887	5	2,887		10,705	6
7									7
8	BUILDING RENOVATION :	2016	605,378	11,924	27.5	11,924		11,924	8
9	PRIVATE ROOMS, SEMI PRIVATE ROOMS,SOUTH NURSES STATION AND MEDICINE ROOM, A B C -WINGS CORRIDOR, BATHROOM &								9
10	SHOWER ROOMS-CLOSET INSERTS,UNITS OF ROOM DIVIDERS,FLOORING, WALLS & CEILINGS, NEW TILE, PLUMBING,								10
11	ELECTRIC, PAINTING,WINDOW TREATMENTS,SIGNAGE, INSTALL KEY PAD AT SECOND FLOOR HALL STATION								11
12	2ND FLOOR CORRIDOR: INSTALLATION OF CUSTOM TILE,								12
13	MILLWORK BASE	2016	51,474	546	27.5	546		546	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,789,989	\$ 280,259		\$ 350,468	\$ 70,209	\$ 4,777,951	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 318,742	\$ 34,580	\$ 32,050	\$ (2,530)	3-10	\$ 127,317	71
72	Current Year Purchases	291,945	108,684	18,875	(89,809)	5-8	18,875	72
73	Fully Depreciated Assets	1,039,637					1,039,637	73
74	RELATED PARTY SL DEPRECIATION		139	139				74
75	TOTALS	\$ 1,650,324	\$ 143,403	\$ 51,064	\$ (92,339)		\$ 1,185,829	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 18,200,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 423,662	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 401,532	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,130)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,963,780	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ \$ _____
 13. _____ \$ _____
 14. _____ \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 64,905 Description: SEE ATTACHED SCHEDULE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY</u>	<u>2014 FORD E350</u>	\$ <u>#####</u>	\$ <u>15,079</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>15,079</u>	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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 385,149	\$		\$ 385,149	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			146,527			146,527	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			420,716			420,716	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				319,682		319,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					42,541		42,541	12
13	MEDICAL SUPPLIES, RENTALS, Other (specify): RESPIRATORY	39-2					56,906		56,906	13
14	TOTAL			\$		\$ 952,392	\$ 419,129		\$ 1,371,521	14

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

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (418,380)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,000</u>)	3,494,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,342		6
7	Other Prepaid Expenses	168,834		7
8	Accounts Receivable (owners or related parties)	336,473		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,703,672	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,976,963		14
15	Leasehold Improvements, at Historical Cost	656,852		15
16	Equipment, at Historical Cost	553,317		16
17	Accumulated Depreciation (book methods)	(429,538)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe GOODWILL)	7,500,000		22
23	Other(specify): AMORT OF GOODWILL	(4,166,667)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,090,927	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,794,599	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 979,526	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,031		28
29	Short-Term Notes Payable	1,670,000		29
30	Accrued Salaries Payable	103,774		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,345		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,774,676	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,506,423		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,506,423	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,281,099	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 513,500	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,794,599	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,813,523	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,813,527	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(980,027)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(320,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,300,027)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 513,500	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF WESTMONT

0050120

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,512,794	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,512,794	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,581	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,581	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	29,147	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,147	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,544,522	30

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

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

**TAX RETURN PREPARED ON CASH BASIS

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.

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

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

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

0050120

Report Period Beginning: **01/01/2016**

Ending:

12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,024	2,072	\$ 117,290	\$ 56.61	1
2	Assistant Director of Nursing	2,624	2,744	79,386	28.93	2
3	Registered Nurses	28,997	30,010	1,021,555	34.04	3
4	Licensed Practical Nurses	22,449	23,927	702,912	29.38	4
5	CNAs & Orderlies	103,357	107,939	1,431,706	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,483	8,982	112,516	12.53	10
11	Social Service Workers	3,984	4,160	87,241	20.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,635	4,682	60,709	12.97	15
16	Dishwashers					16
17	Maintenance Workers	5,487	5,863	104,751	17.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,216	1,536	102,790	66.92	20
21	Assistant Administrator	1,592	1,616	51,500	31.87	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,993	16,789	307,015	18.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,824	2,120	37,516	17.70	31
32	Other Health C: Care Plan Coord	6,664	7,200	249,757	34.69	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,329	219,640	\$ 4,466,644 *	\$ 20.34	34

* 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	\$ 13,370	1-3	35
36	Medical Director	O	63,000	9-3	36
37	Medical Records Consultant	N	845	10-3	37
38	Nurse Consultant	T	54,353	10-3	38
39	Pharmacist Consultant	H	16,848	10-3	39
40	Physical Therapy Consultant	L	7,221	10a-3	40
41	Occupational Therapy Consultant	Y	3,781	10a-3	41
42	Respiratory Therapy Consultant		652	10a-3	42
43	Speech Therapy Consultant	F	1,411	10a-3	43
44	Activity Consultant	E	1,805	11-3	44
45	Social Service Consultant	E	1,376	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 164,662		49

C. CONTRACT NURSES

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

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

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
1/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	340
2/29/2016	STONE , MCGUIRE & SIEGEL	EVALUATE GOVERNMENT "HEAT INITIATIVE" STATUS	448
3/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	458
4/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,648
5/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	448
6/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,000
7/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,977
8/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,021
9/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	808
10/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
11/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	822
12/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	623
11/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	590
12/2/2016	GARY A. WEINTRAUB,P.C.	COMPLIANCE LEGAL	295
5/20/2016	LANER MUCHIN	2015 UNION ELECTIONS	563
3/14/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	2,597
4/12/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	1,166
5/9/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	742
6/10/2016	DUANE MORRIS	GENERAL LEGAL CONSULTANTS	1,431
10/31/2016	BOTHLAW DENNIS E. BOTH	CHICAGO CUT CONCRETE V. WESTMONT NURSING	1,182
3/9/2016	LAW OFFICES FIELD AND GOLDBERG	LOAN MODIFICATION	128
11/23/2015	LAW OFFICES FIELD AND GOLDBERG	VOID CHECK	(1,170)
1/30/2016	MEYERS & FLOWERS	GUARDIANSHIP	65
12/20/2016	THOMPSON COBURN	WESTMONT NURSING LOAN	870
11/29/2016	CT LIEN SOLUTIONS	FEDERAL TAX LIEN SEARCH	130
TOTAL			<u>19,001</u>

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$ 17,309
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? 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. \$ 50,918 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT CONVALESCENT CENTER, # 0030015 09/03/08
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 419,376
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee 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 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