

Facility Name & ID Number BRIA OF BELLEVILLE

0034678 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	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			4,115	4,115	8
9	SNF/PED					9
10	ICF	32,965	970	2,349	36,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,965	970	6,464	40,399	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.06%

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 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/88 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 4,115

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number **BRIA OF BELLEVILLE** # **0034678** Report Period Beginning: **01/01/2017** Ending: **12/31/2017**

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		209	568,888	569,097	569,097		569,097			1
2	Food Purchase		7,192		7,192	7,192		7,192			2
3	Housekeeping		1,964	240,087	242,051	242,051		242,051			3
4	Laundry		19,196	161,452	180,648	180,648		180,648			4
5	Heat and Other Utilities			163,233	163,233	163,233	349	163,582			5
6	Maintenance	87,994	43,985	17,650	149,629	149,629	1,384	151,013			6
7	Other (specify):*			27,977	27,977	27,977	224	28,201			7
8	TOTAL General Services	87,994	72,546	1,179,287	1,339,827	1,339,827	1,957	1,341,784			8
	B. Health Care and Programs										
9	Medical Director			71,626	71,626	71,626		71,626			9
10	Nursing and Medical Records	2,814,457	224,944	38,642	3,078,043	3,078,043	24,727	3,102,770			10
10a	Therapy			53,460	53,460	53,460		53,460			10a
11	Activities	114,738	8,524	1,566	124,828	124,828		124,828			11
12	Social Services	71,615	1,312	1,834	74,761	74,761		74,761			12
13	CNA Training										13
14	Program Transportation			1,956	1,956	1,956		1,956			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,000,810	234,780	169,084	3,404,674	3,404,674	24,727	3,429,401			16
	C. General Administration										
17	Administrative	101,273		120,000	221,273	221,273	(42,942)	178,331			17
18	Directors Fees										18
19	Professional Services			302,329	302,329	302,329	(80,999)	221,330			19
20	Dues, Fees, Subscriptions & Promotions			75,349	75,349	75,349	(11,906)	63,443			20
21	Clerical & General Office Expenses	251,127	17,645	145,284	414,056	414,056	33,998	448,054			21
22	Employee Benefits & Payroll Taxes			570,185	570,185	570,185		570,185			22
23	Inservice Training & Education			15,194	15,194	15,194	351	15,545			23
24	Travel and Seminar			26,512	26,512	26,512	3,110	29,622			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			291,893	291,893	291,893	22,640	314,533			26
27	Other (specify):*						38,941	38,941			27
28	TOTAL General Administration	352,400	17,645	1,546,746	1,916,791	1,916,791	(36,807)	1,879,984			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,441,204	324,971	2,895,117	6,661,292	6,661,292	(10,123)	6,651,169			29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	3,232
	CONTRACTED DIETARY SERVICES	565,656
		568,888
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICES	240,087
		240,087
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,394
	CONTRACTED LAUNDRY SERVICES	160,058
		161,452
5	HEAT & OTHER UTILITIES	
	GAS HEAT	17,137
	ELECTRICITY	81,062
	WATER	61,864
	CABLE TV - LOBBY	3,170
		163,233
6	MAINTENANCE	
	GROUPS MAINTENANCE	5,342
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,793
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	10,515
		17,650
7	OTHER	
	SCAVENGER & EXTERMINATING SERVICES	27,977
	SECURITY SERVICE	0
		27,977
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	71,626
		71,626

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	22,685
	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	908
	PHARMACY CONSULTANT XVIII B 39-2	5,985
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	9,064
		38,642
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	20,000
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	10,071
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	17,171
	SPEECH THERAPY CONSULTANT XVIII B 43-2	6,218
		53,460
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,566
		1,566
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,834
	SOCIAL WORKER XVIII B 45-2	0
		1,834
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,956
		1,956
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	120,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,440
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	193,489
	BOOKKEEPING/ADMINISTRATIVE SERVICE	98,400
		302,329
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18,029
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	28,288
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	16,264
	LICENSES & PERMITS XIX F	2,368
	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	6,080
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	1,655
	PATIENT BACKGROUND CHECKS XIX F	2,665
		75,349
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,816
	EQUIPMENT REPAIR & MAINTENANCE	93,482
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	13,600
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	29,313
	MESSENGER SERVICE	4,073
		145,284

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	258,038
	UNEMPLOYMENT COMPENSATION XIX D	69,449
	WORKERS COMPENSATION INSURANCE XIX D	121,452
	HOSPITALIZATION INSURANCE XIX D	105,473
	EMPLOYEE BENEFITS - OTHER XIX D	15,773
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
		570,185
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	15,194
		15,194
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	26,512
		26,512
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	291,893
		291,893
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER **2,895,117**

**BRIA OF BELLEVILLE
SCHEDULES
12/31/2017**

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

TOTAL FOOD PURCHASE	7,192
LESS SALES TAX	<u>0</u>
NET FOOD	7,192
TOTAL PATIENT CENSUS	40,399
TIMES 3 MEALS PER DAY	
TOTAL PATIENT MEALS	<u>0</u>
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>34,310</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	0
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	0
NET FOOD	7,192
DIVIDE TOTAL MEALS/YEAR	<u>0</u>
COST PER MEAL	#DIV/0!
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>#DIV/0!</u></u>

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

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			45,122	45,122		45,122	224,964	270,086		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			63,005	63,005		63,005	185,282	248,287		32
33	Real Estate Taxes			2,048	2,048		2,048	64,609	66,657		33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)			34
35	Rent-Equipment & Vehicles			36,764	36,764		36,764	9,963	46,727		35
36	Other (specify):* STORAGE			717	717		717	23,025	23,742		36
37	TOTAL Ownership			627,656	627,656		627,656	27,843	655,499		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		217,120	649,675	866,795		866,795		866,795		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			292,730	292,730		292,730		292,730		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		217,120	942,405	1,159,525		1,159,525		1,159,525		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,441,204	542,091	4,465,178	8,448,473		8,448,473	17,720	8,466,193		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	25,387	30		9
10	Interest and Other Investment Income	(1,519)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,600)	21		18
19	Entertainment		20		19
20	Contributions	(6,080)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(18,029)	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	(88,049)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (101,890)		\$	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)	119,610		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 119,610		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 17,720		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 BELLEVILLE

ID# 0034678

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (88,049)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(88,049)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF BELLEVILLE# 0034678

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	349	0	0	0	0	0	0	0	349	5
6	Maintenance	0	0	0	1,384	0	0	0	0	0	0	0	1,384	6
7	Other (specify):*	0	0	0	224	0	0	0	0	0	0	0	224	7
8	TOTAL General Services	0	0	0	1,957	0	1,957	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	24,727	0	0	0	0	0	0	0	24,727	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	24,727	0	24,727	16						
	C. General Administration													
17	Administrative	0	0	(44,716)	1,774	0	0	0	0	0	0	0	(42,942)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,000	(73,214)	(19,785)	0	0	0	0	0	0	0	(80,999)	19
20	Fees, Subscriptions & Promotions	(24,109)	200	1,268	10,735	0	0	0	0	0	0	0	(11,906)	20
21	Clerical & General Office Expenses	(101,649)	345	56,863	78,439	0	0	0	0	0	0	0	33,998	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	351	0	0	0	0	0	0	0	351	23
24	Travel and Seminar	0	0	0	3,110	0	0	0	0	0	0	0	3,110	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	17,643	3,695	1,302	0	0	0	0	0	0	0	22,640	26
27	Other (specify):*	0	0	21,547	17,394	0	0	0	0	0	0	0	38,941	27
28	TOTAL General Administration	(125,758)	30,188	(34,557)	93,320	0	(36,807)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(125,758)	30,188	(34,557)	120,004	0	(10,123)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	25,387	192,695	1,044	5,838	0	0	0	0	0	0	0	224,964	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,519)	161,869	0	24,932	0	0	0	0	0	0	0	185,282	32
33	Real Estate Taxes	0	64,326	0	283	0	0	0	0	0	0	0	64,609	33
34	Rent-Facility & Grounds	0	(480,000)	0	0	0	0	0	0	0	0	0	(480,000)	34
35	Rent-Equipment & Vehicles	0	0	6,820	3,143	0	0	0	0	0	0	0	9,963	35
36	Other (specify):*	0	22,534	0	491	0	0	0	0	0	0	0	23,025	36
37	TOTAL Ownership	23,868	(38,576)	7,864	34,687	0	27,843	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)	(101,890)	(8,388)	(26,693)	154,691	0	17,720	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PG6-SUPPLEMENTAL						

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

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

1	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	\$ 480,000	LINCOLN ASSOCIATES, L.P.		\$	(480,000)	1
2	V	30 DEPRECIATION				192,695	192,695	2
3	V	32 INTEREST EXPENSE				158,568	158,568	3
4	V	32 AMORT LOAN COST				3,301	3,301	4
5	V	33 REAL ESTATE TAXES				64,326	64,326	5
6	V	36 MIP INSURANCE				22,534	22,534	6
7	V	26 INSURANCE				17,643	17,643	7
8	V	19 PROFESSIONAL FEES				12,000	12,000	8
9	V	20 LICENSES & PERMITS				200	200	9
10	V	21 OFFICE EXPENSES				345	345	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 471,612	\$ * (8,388)	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	17 MANAGEMENT FEES	\$ 120,000	WEISS MANAGEMENT GROUP, INC.		\$	\$ (120,000)
16	V	19 BOOKKEEPING/ADM SERVICES	75,000				(75,000)
17	V						
18	V						
19	V	17 ADMINISTRATIVE SALARIES				75,284	75,284
20	V	19 PROFESSIONAL FEES				1,786	1,786
21	V	20 LICENSES & PERMITS				1,268	1,268
22	V	21 OFFICE EXPENSES				56,863	56,863
23	V	26 INSURANCE				3,695	3,695
24	V	27 EMPLOYEE BENEFITS				21,547	21,547
25	V	30 DEPRECIATION (SL)				1,044	1,044
26	V	35 AUTO LEASE				6,820	6,820
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 195,000			\$ 168,307	\$ * (26,693)

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

Facility Name & ID Number

BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$ 23,400	BRIA HEALTH SERVICES, LLC		\$ (23,400)	15
16	V	17	CFO SALARY-A.WEINFELD			1,774	1,774	16
17	V	10	SALARIES-MEDICARE/NURSING			24,170	24,170	17
18	V	21	SALARIES-PURCHASING D.SEGAL			20,545	20,545	18
19	V	21	SALARIES-CLERICAL RELATED PARTIES			2,600	2,600	19
20	V	21	SALARIES-CLERICAL			40,310	40,310	20
21	V	5	UTILITIES			349	349	21
22	V	6	MAINTENANCE			1,384	1,384	22
23	V	7	SCAVENGER			224	224	23
24	V	10	NURSING CONSULTANT			557	557	24
25	V	19	PROFESSIONAL FEES			3,615	3,615	25
26	V	20	DUES,FEES,SUBSCRIPTIONS			10,735	10,735	26
27	V	21	OFFICE EXPENSE			14,984	14,984	27
28	V	23	SEMINARS			351	351	28
29	V	24	TRAVEL			3,110	3,110	29
30	V	26	INSURANCE			1,302	1,302	30
31	V	27	EMPLOYEE BENEFITS			17,394	17,394	31
32	V	30	DEPRECIATION			5,838	5,838	32
33	V	32	INTEREST			24,932	24,932	33
34	V	33	RE TAX			283	283	34
35	V	36	OFFICE RENT-HINSDALE MGMT			491	491	35
36	V	35	STORAGE FEES			1,374	1,374	36
37	V	35	AUTO LEASE			890	890	37
38	V	35	EQUIPMENT RENTAL			879	879	38
39	Total		\$ 23,400			\$ 178,091	\$ * 154,691	39

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

Facility Name & ID Number

BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	MARTIN J. WEISS	45.10	BRIA OF CAHOKIA	CAHOKIA	WEISS MGMT		MANAGEMENT/	2
3	DANIEL WEISS	12.31			GROUP, INC	SKOKIE	CLERICAL	3
4	GARY WEINTRAUB	14.45	BRIA OF FOREST EDGE	CHICAGO				4
5	ILANA FINN	4.69			BRIA HEALTH		MANAGEMENT	5
6	CATHLENE WEISS	5.88	BRIA OF GENEVA	GENEVA	SERVICES, LLC	SKOKIE	SERVICES	6
7	SUZANNE KOENIG	9.18						7
8	NATAN WEISS	8.39	LAKE PARK CENTER	WAUKEGAN	LINCOLN ASSO-		REAL ESTATE	8
9					CIATES, L.P.	SKOKIE		9
10			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				10
11				HEIGHTS				11
12								12
13			BRIA OF PALOS HILLS	PALOS HILLS				13
14								14
15			BRIA OF RIVER OAKS	BURNHAM				15
16								16
17								17
18			BRIA OF WESTMONT	WESTMONT				18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:										1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIVE	45.10	SEE	10	25.00	SALARY	42,729	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	SCHEDULE	10	9.52	SALARY	13,333	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	8.39		10	11.11	SALARY	19,222	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 75,284		13

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

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

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WEISS MANAGEMENT GROUP, INC
 Street Address 5151 CHURCH STREET
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 674-5794
 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	ADMINISTRATIVE SALARIES	PATIENT CENSUS	wgtd avr hours	2	\$ 150,568	\$ 150,568		\$ 75,284	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	84,616	2	3,741	40,399		1,786	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	84,616	2	2,655	40,399		1,268	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	84,616	2	119,103	118,983	40,399	56,863	4
5	26	INSURANCE	PATIENT CENSUS	84,616	2	7,740	40,399		3,695	5
6	27	EMPLOYEE BENEFITS	PATIENT CENSUS	84,616	2	45,132	40,399		21,547	6
7	30	DEPRECIATION (SL)	PATIENT CENSUS	84,616	2	2,187	40,399		1,044	7
8	35	AUTO LEASE	PATIENT CENSUS	84,616	2	14,284	40,399		6,820	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					\$ 345,410	\$ 269,551		\$ 168,307	25

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

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) 674-5794
 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	\$ 96,690	\$ 96,690		\$ 1,774	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	9	312,297	312,297	40,399	24,170	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours	9	164,360	164,360		20,545	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours	9	135,820	135,820		2,600	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	9	520,839	520,839	40,399	40,310	5
6	5	UTILITIES	CENSUS DAYS	9	4,514		40,399	349	6
7	6	MAINTENANCE	CENSUS DAYS	9	17,882		40,399	1,384	7
8	7	SCAVENGER	CENSUS DAYS	9	2,899		40,399	224	8
9	10	NURSING CONSULTANT	CENSUS DAYS	9	7,200		40,399	557	9
10	19	PROFESSIONAL FEES	CENSUS DAYS	9	46,709		40,399	3,615	10
11	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	9	138,710		40,399	10,735	11
12	21	OFFICE EXPENSE	CENSUS DAYS	9	193,606		40,399	14,984	12
13	23	SEMINARS	CENSUS DAYS	9	4,537		40,399	351	13
14	24	TRAVEL	CENSUS DAYS	9	40,190		40,399	3,110	14
15	26	INSURANCE	CENSUS DAYS	9	16,818		40,399	1,302	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	9	224,745		40,399	17,394	16
17	30	DEPRECIATION	CENSUS DAYS	9	75,436		40,399	5,838	17
18	32	INTEREST	CENSUS DAYS	9	322,149		40,399	24,932	18
19	33	RE TAX	CENSUS DAYS	9	3,652		40,399	283	19
20	36	OFFICE RENT-HINSDALE MGMT	CENSUS DAYS	9	6,350		40,399	491	20
21	35	STORAGE FEES	CENSUS DAYS	9	17,757		40,399	1,374	21
22	35	AUTO LEASE	CENSUS DAYS	9	11,494		40,399	890	22
23	35	EQUIPMENT RENTAL	CENSUS DAYS	9	11,352		40,399	879	23
24									24
25	TOTALS				\$ 2,376,006	\$ 1,230,006		\$ 178,091	25

Facility Name & ID Number

BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC				\$	\$			\$	1										
2	BEECH STREET CAPITAL	X	MORTGAGE	\$33,742.90	09/01/13	4,528,900	4,042,144	04/01/39	3.8700	158,568	2									
3	AMORT LOAN COST	X	AMORT OVER LIFE			84,735	70,431			3,301	3									
4											4									
5											5									
Working Capital																				
6	BANK FINANCIAL	X	WORKING CAPITAL	DEMAND			1,000,551		PRIME+	58,502	6									
7		X	INSURANCE FINANCING							4,503	7									
8	RELATED PARTY ALLOCATION									24,932	8									
9	TOTAL Facility Related			\$33,742.90		\$ 4,613,635	\$ 5,113,126			\$ 249,806	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 4,613,635	\$ 5,113,126			\$ 249,806	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,534 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 2016 report.	\$	59,655	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.)	\$	63,730	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,075	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	62,299	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.	\$	66,374	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	61,563	8
	2013	61,481	9
	2014	62,581	10
	2015	64,699	11
	2016	63,730	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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 2016 TAX BILL.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF BELLEVILLE COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0034678

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 2016 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 2016.

(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>08-20.0-204-014</u>	<u>NURSING HOME</u>	\$ <u>849.92</u>	\$ <u>849.92</u>
2. <u>08-20.0-204-015</u>	<u>NURSING HOME</u>	\$ <u>1,197.64</u>	\$ <u>1,197.64</u>
3. <u>08-20.0-207-025</u>	<u>NURSING HOME</u>	\$ <u>2,318.68</u>	\$ <u>2,318.68</u>
4. <u>08-20.0-210-028</u>	<u>NURSING HOME</u>	\$ <u>285.42</u>	\$ <u>285.42</u>
5. <u>08-20.0-210-029</u>	<u>NURSING HOME</u>	\$ <u>59,077.84</u>	\$ <u>59,077.84</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>63,729.50</u></u>	\$ <u><u>63,729.50</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 BELLEVILLE

0034678

Report Period Beginning:

01/01/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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: Item, Use, Square Feet, Year Acquired, Cost, and Index. Rows include NURSING HOME, PARKING LOT, and TOTALS.

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	152		1988	\$ 2,011,351	\$ 63,852	31.5	\$ 63,852	\$	\$ 1,844,801	4
5			2003	1,249,221	45,426	27.5	45,426		656,784	5
6										6
7										7
8	RELATED PARTY ALLOCATION			18,143	617		617			8
	Improvement Type**									
9	VARIOUS		1990	11,158	354	31.5	354		9,652	9
10	VARIOUS		1993	6,676	171	39	171		4,976	10
11	VARIOUS		1994	7,797	200	39	200		5,658	11
12	VARIOUS		1995	13,072	335	39	335		8,602	12
13	CARPET		1996	907	23	39	23		535	13
14	BILLBOARD		1996	900	23	39	23		538	14
15	SMOKE DETECTORS		1996	602	15	39	15		355	15
16	PARKING LOT		1996	8,006	205	39	205		4,895	16
17	AWNING		1996	905	23	39	23		553	17
18	CARPETING		1996	1,512	39	39	39		950	18
19	DOOR LOCKS		1997	2,100	54	39	54		1,192	19
20	WALL PAPER		1997	2,012	52	39	52		1,158	20
21	HANDRAIL		1997	3,217	83	39	83		1,772	21
22	FIRE ALARM SYSTEM		1998	11,636	298	39	298		5,953	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION		1998	9,227	236	39	236		4,721	23
24	PAINTING/WALLPAPERING		1998	2,988	77	39	77		1,538	24
25	REPLACE PVC PIPE IN BASEMENT		1998	1,074	28	39	28		559	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD		1999	6,144	158	39	158		2,612	26
27	INSTALLED A NEW DURO-LAST ROOF		1999	56,400	1,446	39	1,446		23,854	27
28	WALLPAPER		2000	14,896	382	39	382		7,239	28
29	SEWER LINE REPAIR		2000	11,743	301	39	301		5,261	29
30	AIR CONDITIONING UNITS		2000	8,848	227	39	227		3,967	30
31	CONDENSING UNIT ON FREEZER		2000	2,693	69	39	69		1,209	31
32	NEW NURSES STATION		2000	20,379	522	39	522		9,145	32
33	FIRE ALARM SYSTEM		2000	1,826	47	39	47		823	33
34	HOT WATER SYSTEM		2000	3,849	99	20	99		2,747	34
35	TILED FLOORS		2000	54,185	1,389	39	1,389		24,317	35
36			2000	18,490	474	39	474		8,293	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	\$ 13,369	\$	20	\$ 23	\$ 23	\$ 13,369	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		21,550	38
39	ROOF	2001	47,500	1,727	27.5	1,727		28,496	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		5,510	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		7,326	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		6,814	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		32,719	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		22,540	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159		20	1,558	1,558	24,928	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		3,912	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		9,724	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTI	2002	7,245	263	27.5	263		4,131	48
49	LANDSCAPING	2004	7,759		15	517	517	6,915	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	23,002	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	4,396	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250		20	5,263	5,263	73,682	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		1,445	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		1,146	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		13,780	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		4,285	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		3,812	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		17,890	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		8,459	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906		5			17,906	60
61	AIR CONDITIONERS	2007	7,968		5			7,968	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	2,084	27.5	2,084		21,795	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		3,505	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		1,485	64
65	PAINTING	2007	9,986		5			9,986	65
66	GARDEN	2007	60,172	2,188	15	4,012	1,824	40,028	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		1,870	67
68	PAINTING - 30 ROOMS	2008	2,550		5			2,550	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		1,028	69
70	TOTAL (lines 4 thru 69)		\$ 4,283,389	\$ 135,065		\$ 146,207	\$ 11,142	\$ 3,092,611	70

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

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

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,283,389	\$ 135,065		\$ 146,207	\$ 11,142	\$ 3,092,611	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		956	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		1,636	3
4	WALL AIR CONDITIONS	2009	5,187		5			5,187	4
5	INSTALL NEW COMPRESSOR,CRANK CASE HEATER	2009	3,195	116	27.5	116		1,001	5
6	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		2,503	6
7	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		35,871	7
8	WALLCOVERING, CARPET, PAINTING, BLINDS, CURTAINS	2009	29,344		5			29,344	8
9	WALL AIR CONDITIONS	2010	4,581		5			4,581	9
10	INSTALL STEEL DOOR	2010	10,694	389	27.5	389		2,869	10
11	FIRE PROTECTION WORK-SPRINKLERS PHASE 1	2010	97,653	3,551	27.5	3,551		25,301	11
12	FIRE PROTECTION WORK-SPRINKLERS PHASE 2	2011	97,652	3,551	27.5	3,551		21,750	12
13	WING CORRIDORS-FLOORING,WALLCOVERING,	2011	67,587	2,458	27.5	2,458		17,104	13
14	HANDRAILS,BUNPER GUARDS,SIGNAGE,WALL PROTECTION								14
15	INSTALL NEW CARRIER RTU	2011	4,517	164	27.5	164		1,073	15
16	PAINTING-100 & 200 HALL, LODGING, NURSES STATION	2011	44,405		5			44,405	16
17	WALL AIR CONDITIONS	2011	7,698		5			7,698	17
18	WALL AIR CONDITIONS	2012	4,194	29	5	29		4,194	18
19	REPLACED ROOF TOP UNIT & 5 TON CONDENSING UNIT	2012	9,995	363	27.5	363		1,981	19
20	INSTALL NEW PLASTIC CEMENT, CAP,COTTON MEMBRA-								20
21	NE ON EPDM ROOF	2012	2,595	94	27.5	94		552	21
22	PARKING LOT IMPROVMENTS; CONCRETE PATIO AND								22
23	DRAINAGE	2012	72,786	4,852	15	4,852		24,664	23
24	INSTALLED A 240CFM EXHAUST FAN ON A CURB OVER								24
25	THE NURSES STATION	2013	3,044	111	27.5	111		550	25
26	LOBBY; OFFICES-CARPET INSTALLATION; WALL BASE								26
27	INSTALLATION	2013	7,824	285	27.5	285		1,342	27
28	SEAL COAT PARKING LOT AND STRIPE PARKING SPACES	2013	3,000	200	15	200		933	28
29	100, 200, 300, 400 WINGS- CORRIDOR, RESIDENT ROOMS,								29
30	RESIDENT BATHROOMS-FLOORING	2013	164,523	5,983	27.5	5,983		24,181	30
31	INSTALLATION OF NURSING STATION; AREA BETWEEN 100								31
32	& 200 WINGS;CORRIDOR, RESIDENT ROOM IN CENTER-								32
33	CUSTOM PVT INSTALLATION	2014	75,482	2,745	27.5	2,745		9,722	33
34	TOTAL (lines 1 thru 33)		\$ 5,127,914	\$ 164,676		\$ 175,818	\$ 11,142	\$ 3,362,009	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	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward								
2	100 & 200 WINGS RESIDENT BATHS-INSTALLATION OF								
3	CERAMIC TILE; ACTIVITY ROOM-COVE BASE & PVT INS-								
4	2014	51,277	1,865	27.5	1,865		6,294		4
5	INSTALL A FIRESTONE TPO ROOFING SYSTEM, GRAVE								
6	2014	23,186	843	27.5	843		2,775		6
7	2014	5,737	382	15	382		1,242		7
8	LOBBY, 100 WING: CORRIDOR, NURSE STATION, RESIDENT ROOMS & BATHS, DINING & LIVING .ADMINISTRATOR, ADMISSIONS OFFICE								
9	INSTALLATION OF CARPET TILE, WALLCOVERING, SIGNAGE, HANDRAIL AND BUMPER GUARD, INSTALL METAL FRAMES & WOOD								
10	DOORS, INSTALL NEW PVT AND COVE BASE,CUSTOM DRESSERS & WARDROBES, HEADWALL & DIVIDER UNITS,OVERBED LIGHTS,								
11	WALL SCONCE, CURTAINS & BLINDS,PAINT WALLS, DOORFRAMES AND CEILINGS, INSTALL NEW CERAMIC AND WALL TILE, DEMO								
12	WALL BETWEEN ROOM 101 & 103, CAP ALL PLUMBING IN BATHROOM, CHANGE CONCRETE, INSTALL NEW LIGHT FIXTURES, DRY-								
13	2015	328,421	11,943	27.5	11,943		30,355		13
14	VESTIBULE, THERAPY CORRIDOR, 100 WING SPA, 100 WING GUEST BATHROOM:								
15	2015	9,839	358	27.5	358		1,059		15
16	2015	4,264	284	15	284		805		16
17	ADDITION: THERAPY ROOM, FRONT ENTRIES, NEW								
18	2015	424,500	15,436	27.5	15,436		39,233		18
19	GUEST BATHROOM, ACTIVITY ROOM CORRIDOR,VESTIBULE:								
20	2015	25,003	909	27.5	909		2,538		20
21	2016	12,948	471	27.5	471		687		21
22	FURNISH AND INSTALLATION OF 400A FEEDER OVER								
23	2016	9,500	345	27.5	345		388		23
24	200,500 WING CORRIDOR, ADMISSIONS OFFICE-SIGNAGE,								
25	2016	6,584	239	27.5	239		349		25
26	2017	7,285	77	27.5	77		77		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,036,458	\$ 197,828		\$ 208,970	\$ 11,142	\$ 3,447,811	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	\$ 440,022	\$ 23,566	\$ 53,433	\$ 29,867	3-10	\$ 244,989	71
72	Current Year Purchases	28,399	17,040	1,418	(15,622)	10	1,418	72
73	Fully Depreciated Assets	178,640					178,640	73
74	RELATED PARTY SL DEPRECIATION		6,265	6,265				74
75	TOTALS	\$ 647,061	\$ 46,871	\$ 61,116	\$ 14,245		\$ 425,047	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2005 FORD ECONOCARE	2005	\$ 41,500	\$	\$	\$		\$ 41,500	76
77										77
78										78
79										79
80	TOTALS			\$ 41,500	\$	\$	\$		\$ 41,500	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,923,668	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 244,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 270,086	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,387	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,914,358	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

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: \$ **24,925** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2015 FORD T350HD	\$ 982.50	\$ 11,839	17
18					18
19					19
20					20
21	TOTAL		\$ 982.50	\$ 11,839	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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	\$		\$ 280,682	\$		\$ 280,682	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			86,344			86,344	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			282,649			282,649	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				137,314		137,314	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 Other (specify): RENTALS	39-2					79,806		79,806	13
14	TOTAL			\$		\$ 649,675	\$ 217,120		\$ 866,795	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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	\$ 25,067	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 200,000)	4,518,615		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	201,110		6
7	Other Prepaid Expenses	65,235		7
8	Accounts Receivable (owners or related parties)	172,980		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,983,007	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	172,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	158,256		15
16	Equipment, at Historical Cost	688,562		16
17	Accumulated Depreciation (book methods)	(759,275)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 259,569	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,242,576	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,253,431	\$	26
27	Officer's Accounts Payable	1,180,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,150,551		29
30	Accrued Salaries Payable	118,269		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,564		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)	\$ 3,726,815	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,726,815	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,515,761	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,242,576	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,665,134	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,665,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(149,373)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (149,373)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,515,761	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF BELLEVILLE

0034678

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	\$ 8,297,581	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,297,581	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***	1,519	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,519	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,299,100	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,339,827	31
32	Health Care	3,404,674	32
33	General Administration	1,916,791	33
B. Capital Expense			
34	Ownership	627,656	34
C. Ancillary Expense			
35	Special Cost Centers	866,795	35
36	Provider Participation Fee	292,730	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,448,473	40
41	Income before Income Taxes (line 30 minus line 40)**	(149,373)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (149,373)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,700,978	44
45	Private Pay - Net Inpatient Revenue	179,220	45
46	Medicare - Net Inpatient Revenue	2,180,972	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	261,463	47
48	Other-(specify) <u>MANAGED CARE</u>	974,948	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,297,581	49

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

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

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

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

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

0034678

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	1,500	1,620	\$ 81,210	\$ 50.13	1
2	Assistant Director of Nursing	3,864	4,136	114,473	27.68	2
3	Registered Nurses	3,936	4,293	121,751	28.36	3
4	Licensed Practical Nurses	38,446	40,031	932,850	23.30	4
5	CNAs & Orderlies	108,058	112,508	1,342,950	11.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,301	10,814	114,738	10.61	10
11	Social Service Workers	3,378	3,578	71,615	20.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,699	5,170	87,994	17.02	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,848	2,040	101,273	49.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,611	13,311	251,127	18.87	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	1,960	2,080	35,457	17.05	31
32	Other Health C: Care Plan Coord	6,861	7,258	185,766	25.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,462	206,839	\$ 3,441,204 *	\$ 16.64	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	71,626	9-3	36
37	Medical Records Consultant	N	908	10-3	37
38	Nurse Consultant	T	9,064	10-3	38
39	Pharmacist Consultant	H	5,985	10-3	39
40	Physical Therapy Consultant	L	20,000	10a-3	40
41	Occupational Therapy Consultant	Y	10,071	10a-3	41
42	Respiratory Therapy Consultant		17,171	10a-3	42
43	Speech Therapy Consultant	F	6,218	10a-3	43
44	Activity Consultant	E	1,566	11-3	44
45	Social Service Consultant	E	1,834	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 144,443		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	44	\$ 2,645	10-3	50
51	Licensed Practical Nurses	542	20,040	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	586	\$ 22,685		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
KENYA O'NEAL	ADMINISTRATOR		\$ 24,539	Workers' Compensation Insurance	\$ 121,452	IDPH License Fee	\$ 1,990		
AMY L MERRITT	ADMINISTRATOR		76,734	Unemployment Compensation Insurance	69,449	Advertising: Employee Recruitment	28,288		
				FICA Taxes	258,038	Health Care Worker Background Check	1,655		
				Employee Health Insurance	105,473	(Indicate # of checks performed <u>162</u>)			
				Employee Meals	0	Patient Background Checks	258		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	6,080		
				EMPLOYEE BENEFITS - OTHER	15,773	MARKETING/ADV/PROMO	18,029		
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	16,642		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	12,203		
				INSURANCE - EXECUTIVE LIFE	0	TRUST/FRANCHISE/CONTRIB/ETC	(6,080)		
						Less: Public Relations Expense	(0)		
						Non-allowable advertising	(18,029)		
						Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,273	TOTAL (agree to Schedule V, line 22, col.8)		\$ 570,185	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 63,443
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
WEISS MANAGEMENT GROUP MANAGEMENT FEES			\$ 120,000				Out-of-State Travel	\$	
							In-State Travel	26,512	
							MGMT CO ALLOC	3,110	
							Seminar Expense	0	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 120,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 29,622
C. Professional Services			Amount						
Vendor/Payee	Type		Amount						
ALPHA DATA SERVICES	DATA PROCESSING		\$ 8,422						
NATIONAL DATA CARE	DATA PROCESSING		2,018						
KBKB, LTD	ACCOUNTING FEES		12,200						
RICHARD PEELO & ASSOCIAT.	MEDICARE CONSULTANT		4,500						
PERSONNEL PLANNERS	UC CONSULTANT		11,244						
BRIA HEALTH SERVICES	BOOKKEEPING/ADM SVCS		23,400						
WEISS MANAGEMENT GROUP	BOOKKEEPING/ADM SVCS		75,000						
MCCABE KIRSHNER P.C.	ENGAGEMENT OF WTW		1,250						
LEGAL FEES	SEE SCHEDULE		164,295						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 302,329						

* Attach copy of IMRF notifications

**See instructions.

BRIA OF BELLEVILLE
 SCHEDULE-LEGAL
 12/31/2017

DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,091
2/28/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,078
3/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,140
4/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,100
5/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	4,078
6/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,053
7/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
8/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
9/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
10/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
11/30/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
12/31/2017	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	700
1/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,568
2/28/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,698
3/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,730
4/30/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,503
5/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,730
6/30/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,795
7/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,568
8/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,340
9/30/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,698
10/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,568
11/30/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,730
12/31/2017	GARY A. WEINTRAUB,P.C.	CONSULTATIONS REGARDING COMPLIANCE WITH PROVISIONS & REQUIREMENTS OF OBRA	2,470
1/27/2017	HEPLERBROOM LLC	RESIDENT ESTATE	2,457
2/22/2017	HEPLERBROOM LLC	RESIDENT ESTATE	277
3/21/2017	HEPLERBROOM LLC	RESIDENT ESTATE	76
4/21/2017	HEPLERBROOM LLC	GENERAL FILE	934
4/21/2017	HEPLERBROOM LLC	RESIDENT ESTATE	438
3/21/2017	HEPLERBROOM LLC	GENERAL FILE	182
5/10/2017	HEPLERBROOM LLC	GENERAL FILE	1,416
7/21/2017	HEPLERBROOM LLC	GENERAL FILE	1,194
8/23/2017	HEPLERBROOM LLC	GENERAL FILE	132
9/22/2017	HEPLERBROOM LLC	GENERAL FILE	66
9/22/2017	HEPLERBROOM LLC	RESIDENT ESTATE	241
9/21/2017	HEPLERBROOM LLC	GUARDIANSHIP	572
10/20/2017	HEPLERBROOM LLC	GUARDIANSHIP	658
11/17/2017	HEPLERBROOM LLC	REGARDING HEARING ON PETITION	372
12/19/2017	HEPLERBROOM LLC	GUARDIANSHIP	727
5/8/2017	JACKSON LEWIS P.C.	CONSULTATION CAP FEE	749
3/24/2017	JACKSON LEWIS P.C.	CONSULTATION CAP FEE	143
12/6/2017	DRINKERBIDDLE & REATH	HIPAA COMPLIANCE	550
11/17/2017	SB2 INC	BRIA-002 MONTHLY PROJECT	500
12/1/2017	SB2 INC	BRIA-002 MONTHLY PROJECT	500
12/31/2017	SB2 INC	MPIL- BRIA	172
12/31/2017	SB2 INC	BRIA-002 MONTHLY PROJECT	500
9/30/2017	CHUBB GROUP OF INSURANCE COMPANIES	GENERAL LEGAL MATTERS	258
3/17/2017	MANDEL & MANDEL	SETTLEMENT FEES	100
2/23/2017	GREENSFELDER, HEMKER & GALE	GENERAL LEGAL MATTERS	5,300
2/28/2017	GREENSFELDER, HEMKER & GALE	GENERAL LEGAL MATTERS	5,324
4/26/2017	SKIDELSKY & ASSOCIATES	2016 REAL ESTATE ASSESSMENT & TAXES	585
		LEGAL SETTLEMENT	94,741
TOTAL			<u>164,295</u>

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$ 15,504
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? NO
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,457 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. \$ 292,730
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ #DIV/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