



Facility Name & ID Number BRIA OF BELLEVILLE

# 0034678 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

**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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			4,027	4,027	8
9	SNF/PED					9
10	ICF	33,149	1,658	918	35,725	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,149	1,658	4,945	39,752	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.79%**

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

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONE

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

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

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

**I. On what date did you start providing long term care at this location?**  
Date started 9/88

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 9/88 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 4,027

Medicare Intermediary ADMINISTAR

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number **BRIA OF BELLEVILLE** # **0034678** Report Period Beginning: **01/01/2018** Ending: **12/31/2018**

**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
	<b>A. General Services</b>										
1	Dietary		204	574,712	574,916	574,916		574,916			1
2	Food Purchase		2,035		2,035	2,035	(172)	1,863			2
3	Housekeeping		2,837	235,212	238,049	238,049		238,049			3
4	Laundry		13,577	159,757	173,334	173,334		173,334			4
5	Heat and Other Utilities			164,292	164,292	164,292		164,292			5
6	Maintenance	104,670	64,266	15,802	184,738	184,738	706	185,444			6
7	Other (specify):*			26,829	26,829	26,829	112	26,941			7
8	<b>TOTAL General Services</b>	<b>104,670</b>	<b>82,919</b>	<b>1,176,604</b>	<b>1,364,193</b>	<b>1,364,193</b>	<b>646</b>	<b>1,364,839</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			68,501	68,501	68,501		68,501			9
10	Nursing and Medical Records	2,789,068	259,302	15,965	3,064,335	3,064,335	17,274	3,081,609			10
10a	Therapy			106,712	106,712	106,712		106,712			10a
11	Activities	86,223	6,613	1,562	94,398	94,398		94,398			11
12	Social Services	85,877	1,748	2,461	90,086	90,086		90,086			12
13	CNA Training										13
14	Program Transportation			3,164	3,164	3,164		3,164			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,961,168</b>	<b>267,663</b>	<b>198,365</b>	<b>3,427,196</b>	<b>3,427,196</b>	<b>17,274</b>	<b>3,444,470</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	108,004			108,004	108,004	74,500	182,504			17
18	Directors Fees										18
19	Professional Services			225,971	225,971	225,971	17,423	243,394			19
20	Dues, Fees, Subscriptions & Promotions			92,673	92,673	92,673	(28,502)	64,171			20
21	Clerical & General Office Expenses	238,388	24,886	131,902	395,176	395,176	2,447	397,623			21
22	Employee Benefits & Payroll Taxes			561,390	561,390	561,390		561,390			22
23	Inservice Training & Education			12,508	12,508	12,508	575	13,083			23
24	Travel and Seminar			20,675	20,675	20,675	2,708	23,383			24
25	Other Admin. Staff Transportation						(5,853)	(5,853)			25
26	Insurance-Prop.Liab.Malpractice			187,364	187,364	187,364	24,883	212,247			26
27	Other (specify):*			248,274	248,274	248,274	(218,037)	30,237			27
28	<b>TOTAL General Administration</b>	<b>346,392</b>	<b>24,886</b>	<b>1,480,757</b>	<b>1,852,035</b>	<b>1,852,035</b>	<b>(129,856)</b>	<b>1,722,179</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,412,230</b>	<b>375,468</b>	<b>2,855,726</b>	<b>6,643,424</b>	<b>6,643,424</b>	<b>(111,936)</b>	<b>6,531,488</b>			<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	
	REPAIRS & MAINTENANCE	5,150
	CONTRACTED DIETARY SERVICES	569,562
		574,712
<b>3</b>	<b>HOUSEKEEPING</b>	
	CONTRACTED HOUSEKEEPING SERVICES	235,212
		235,212
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,949
	CONTRACTED LAUNDRY SERVICES	156,808
		159,757
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	18,325
	ELECTRICITY	78,192
	WATER	64,189
	CABLE TV - LOBBY	3,586
		164,292
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,729
	PAINTING & DECORATING	
	BUILDING REPAIRS	
	MAINTENANCE TRAVEL	
	EQUIPMENT MAINTENANCE & REPAIR	1,693
	ELEVATOR MAINTENANCE & REPAIR	
	OUTSIDE LABOR	
	EXTERMINATING SERVICE	
	FIRE SERVICE	10,380
		15,802
<b>7</b>	<b>OTHER</b>	
	SCAVENGER 7 EXTERMINATING SERVICES	26,829
	SECURITY SERVICE	
		26,829
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	68,501
		68,501

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	
	PURCHASED SERVICES	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	
	PHARMACY CONSULTANT XVIII B 39-2	9,758
	UTILIZATION REVIEW FEES XVIII B __-2	
	PHYSICIANS XVIII B __-2	
	PSYCHIATRIC XVIII B __-2	
	RN CONSULTANT XVIII B 38-2	6,207
		15,965
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	38,518
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	33,614
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	20,319
	SPEECH THERAPY CONSULTANT XVIII B 43-2	14,261
		106,712
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,562
		1,562
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,461
	SOCIAL WORKER XVIII B 45-2	
		2,461
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	3,164
		3,164
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
18	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	12,090
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	213,881
		225,971
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18,230
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	40,714
	CONTRIBUTIONS VI 20 XIX F	
	DUES & SUBSCRIPTIONS XIX F	11,538
	LICENSES & PERMITS XIX F	3,660
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	15,496
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	775
	PATIENT BACKGROUND CHECKS XIX F	2,260
		92,673
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,088
	EQUIPMENT REPAIR & MAINTENANCE	96,851
	OUTSIDE CLERICAL SERVICES	
	PENALTIES / OVERDRAFT CHARGES VI 18	1,460
	HOME OFFICE EXPENSE	
	THEFT & DAMAGE LOSS	
	TELEPHONE	23,818
	MESSENGER SERVICE	6,685
		131,902

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	255,327
	UNEMPLOYMENT COMPENSATION XIX D	58,745
	WORKERS COMPENSATION INSURANCE XIX D	92,450
	HOSPITALIZATION INSURANCE XIX D	131,525
	EMPLOYEE BENEFITS - OTHER XIX D	23,343
	EMPLOYEE PHYSICAL EXAMS XIX D	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	
		561,390
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	12,508
		12,508
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	20,675
		20,675
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	
		0
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	187,364
		187,364
27	<b>OTHER</b>	
	BAD DEBTS VI 24	248,274
		248,274

GRAND TOTAL COLUMN 3 OTHER **2,855,726**

**BRIA OF BELLEVILLE  
SCHEDULES  
12/31/2018**

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

TOTAL FOOD PURCHASE	2,035
LESS SALES TAX	<u>(172)</u>
NET FOOD	1,863

TOTAL PATIENT CENSUS	39,752
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	119,256

ADD # EMPLOYEE MEALS/DAY TIMES # DAYS	<u>34,310</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	119,256
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	119,256

NET FOOD	1,863
DIVIDE TOTAL MEALS/YEAR	<u>119,256</u>

COST PER MEAL	0.02
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFIC	<u><u>0</u></u>

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	
	<b>D. Ownership</b>											
30	Depreciation			58,052	58,052		58,052	214,430	272,482			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,449	61,449		61,449	164,758	226,207			32
33	Real Estate Taxes			2,486	2,486		2,486	65,724	68,210			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			32,125	32,125		32,125	6,640	38,765			35
36	Other (specify):* <b>STORAGE</b>			728	728		728	21,861	22,589			36
37	<b>TOTAL Ownership</b>			634,840	634,840		634,840	(6,587)	628,253			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		185,275	915,055	1,100,330		1,100,330		1,100,330			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,748	304,748		304,748		304,748			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		185,275	1,219,803	1,405,078		1,405,078		1,405,078			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,412,230	560,743	4,710,369	8,683,342		8,683,342	(118,523)	8,564,819			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	13,734	30		9
10	Interest and Other Investment Income	(16,585)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(172)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,460)	21		18
19	Entertainment				19
20	Contributions	(15,496)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(248,274)	27		24
25	Fund Raising, Advertising and Promotional	(18,230)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(75,955)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (362,438)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	243,915		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 243,915		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (118,523)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	

BRIA OF BELLEVILLE

ID# 0034678

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (70,102)	21	1
2	TRAVEL-MARKETING	(5,853)	25	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	<b>Total</b>	(75,955)		49

STATE OF ILLINOIS

Summary A

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

# **0034678**

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

**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	(172)	0	0	0	0	0	0	0	0	0	0	(172)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	706	0	0	0	0	0	0	0	706	6
7	Other (specify):*	0	0	0	112	0	0	0	0	0	0	0	112	7
8	<b>TOTAL General Services</b>	<b>(172)</b>	<b>0</b>	<b>0</b>	<b>818</b>	<b>0</b>	<b>646</b>	<b>8</b>						
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	17,274	0	0	0	0	0	0	0	17,274	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17,274</b>	<b>0</b>	<b>17,274</b>	<b>16</b>						
<b>C. General Administration</b>														
17	Administrative	0	0	69,000	5,500	0	0	0	0	0	0	0	74,500	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,100	1,838	3,485	0	0	0	0	0	0	0	17,423	19
20	Fees, Subscriptions & Promotions	(33,726)	0	98	5,126	0	0	0	0	0	0	0	(28,502)	20
21	Clerical & General Office Expenses	(71,562)	0	477	73,532	0	0	0	0	0	0	0	2,447	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	575	0	0	0	0	0	0	0	575	23
24	Travel and Seminar	0	0	0	2,708	0	0	0	0	0	0	0	2,708	24
25	Other Admin. Staff Transportation	(5,853)	0	0	0	0	0	0	0	0	0	0	(5,853)	25
26	Insurance-Prop.Liab.Malpractice	0	17,759	5,025	2,099	0	0	0	0	0	0	0	24,883	26
27	Other (specify):*	(248,274)	0	14,578	15,659	0	0	0	0	0	0	0	(218,037)	27
28	<b>TOTAL General Administration</b>	<b>(359,415)</b>	<b>29,859</b>	<b>91,016</b>	<b>108,684</b>	<b>0</b>	<b>(129,856)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(359,587)</b>	<b>29,859</b>	<b>91,016</b>	<b>126,776</b>	<b>0</b>	<b>(111,936)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF BELLEVILLE

# 0034678

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,734	196,448	1,059	3,189	0	0	0	0	0	0	0	214,430	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,585)	157,140	0	24,203	0	0	0	0	0	0	0	164,758	32
33	Real Estate Taxes	0	65,724	0	0	0	0	0	0	0	0	0	65,724	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	4,807	1,833	0	0	0	0	0	0	0	6,640	35
36	Other (specify):*	0	21,861	0	0	0	0	0	0	0	0	0	21,861	36
37	<b>TOTAL Ownership</b>	<b>(2,851)</b>	<b>(38,827)</b>	<b>5,866</b>	<b>29,225</b>	<b>0</b>	<b>(6,587)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(362,438)</b>	<b>(8,968)</b>	<b>96,882</b>	<b>156,001</b>	<b>0</b>	<b>(118,523)</b>	<b>45</b>						

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 480,000	LINCOLN ASSOCIATES, L.P.		\$	(480,000)	1
2	V	30 DEPRECIATION				196,448	196,448	2
3	V	32 INTEREST EXPENSE				153,839	153,839	3
4	V	32 AMORT LOAN COST				3,301	3,301	4
5	V	33 REAL ESTATE TAXES				65,724	65,724	5
6	V	36 MIP INSURANCE				21,861	21,861	6
7	V	26 INSURANCE				17,759	17,759	7
8	V	19 PROFESSIONAL FEES				12,100	12,100	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 471,032	\$ * (8,968)	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	\$	WEISS MANAGEMENT GROUP, INC.		\$	\$	15
16	V	19 BOOKKEEPING/ADM SERVICES						16
17	V							17
18	V							18
19	V	17 ADMINISTRATIVE SALARIES				69,000	69,000	19
20	V	19 PROFESSIONAL FEES				1,838	1,838	20
21	V	20 LICENSES & PERMITS				98	98	21
22	V	21 OFFICE EXPENSES				477	477	22
23	V	26 INSURANCE				5,025	5,025	23
24	V	27 EMPLOYEE BENEFITS				14,578	14,578	24
25	V	30 DEPRECIATION (SL )				1,059	1,059	25
26	V	35 AUTO LEASE				4,807	4,807	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 96,882	\$ * 96,882	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 BOOKKEEPING/ADM SERVICES	\$	BRIA HEALTH SERVICES, LLC		\$		15
16	V	17 CFO SALARY-A.WEINFELD				5,500	5,500	16
17	V	10 SALARIES-MEDICARE/NURSING				16,720	16,720	17
18	V	21 SALARIES-PURCHASING D.SEGAL				7,790	7,790	18
19	V	21 SALARIES-CLERICAL RELATED PARTIES				1,626	1,626	19
20	V	21 SALARIES-CLERICAL				51,620	51,620	20
21	V	6 MAINTENANCE				706	706	21
22	V	7 SCAVENGER				112	112	22
23	V	10 NURSING CONSULTANT				554	554	23
24	V	19 PROFESSIONAL FEES				3,485	3,485	24
25	V	20 DUES,FEES,SUBSCRIPTIONS				5,126	5,126	25
26	V	21 OFFICE EXPENSE				12,496	12,496	26
27	V	23 SEMINARS				575	575	27
28	V	24 TRAVEL				2,708	2,708	28
29	V	26 INSURANCE				2,099	2,099	29
30	V	27 EMPLOYEE BENEFITS				15,659	15,659	30
31	V	30 DEPRECIATION				3,189	3,189	31
32	V	32 INTEREST				24,203	24,203	32
33	V	35 AUTO LEASE				997	997	33
34	V	35 EQUIPMENT RENTAL				836	836	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 156,001	\$ * 156,001	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:

01/01/2018

Ending:

12/31/2018

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	MARTIN J. WEISS	45.10	BRIA OF CAHOKIA	CAHOKIA	WEISS MGMT			1
2	DANIEL WEISS	12.31			GROUP, INC	SKOKIE	MANAGEMENT/	2
3	GARY WEINTRAUB	14.45	BRIA OF FOREST EDGE	CHICAGO			CLERICAL	3
4	ILANA FINN	4.69			BRIA HEALTH			4
5	CATHLENE WEISS	5.88	BRIA OF GENEVA	GENEVA	SERVICES, LLC	SKOKIE	MANAGEMENT	5
6	SUZANNE KOENIG	9.18					SERVICES	6
7	NATAN WEISS	8.39	LAKE PARK CENTER	WAUKEGAN	LINCOLN ASSO-			7
8					CIATES, L.P.	SKOKIE	REAL ESTATE	8
9			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				9
10				HEIGHTS				10
11								11
12			BRIA OF PALOS HILLS	PALOS HILLS				12
13								13
14			BRIA OF RIVER OAKS	BURNHAM				14
15								15
16								16
17			BRIA OF WESTMONT	WESTMONT				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 &amp; ID Number

BRIA OF BELLEVILLE

# 0034678

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

## 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	<b>ALLOCATIONS FROM WEISS MANAGEMENT GROUP:</b>								\$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIVE	45.10	SEE	15	38.00	SALARY	45,000	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	SCHEDULE	4	10.00	SALARY	12,000	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	8.39		4	10.00	SALARY	12,000	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 69,000		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:

01/01/2018

Ending: 2/31/2018

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	wghtd avr hours	2	\$ 138,000	\$ 138,000		\$ 69,000	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	2	3,794		39,752	1,838	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	2	203		39,752	98	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	2	985		39,752	477	4
5	26	INSURANCE	PATIENT CENSUS	2	10,374		39,752	5,025	5
6	27	EMPLOYEE BENEFITS	PATIENT CENSUS	2	30,092		39,752	14,578	6
7	30	DEPRECIATION (SL )	PATIENT CENSUS	2	2,187		39,752	1,059	7
8	35	AUTO LEASE	PATIENT CENSUS	2	9,922		39,752	4,807	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				\$ 195,557	\$ 138,000		\$ 96,882	25

Facility Name & ID Number BRIA OF BELLEVILLE

# 0034678

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization BRIA HEALTH SERVICES, LLC  
 Street Address 5151 CHURCH STREET  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	CFO SALARY-A.WEINFELD	wghtd avr hours	9	\$ 99,000	\$ 99,000		\$ 5,500	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	516,944	217,425	217,425	39,752	16,720	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours	9	148,012	148,012		7,790	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours	9	41,826	41,826		1,626	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	516,944	671,273	671,273	39,752	51,620	5
6	6	MAINTENANCE	CENSUS DAYS	516,944	9,177		39,752	706	6
7	7	SCAVENGER	CENSUS DAYS	516,944	1,451		39,752	112	7
8	10	NURSING CONSULTANT	CENSUS DAYS	516,944	7,200		39,752	554	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	516,944	45,319		39,752	3,485	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	516,944	66,654		39,752	5,126	10
11	21	OFFICE EXPENSE	CENSUS DAYS	516,944	162,507		39,752	12,496	11
12	23	SEMINARS	CENSUS DAYS	516,944	7,477		39,752	575	12
13	24	TRAVEL	CENSUS DAYS	516,944	35,214		39,752	2,708	13
14	26	INSURANCE	CENSUS DAYS	516,944	27,300		39,752	2,099	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	516,944	203,639		39,752	15,659	15
16	30	DEPRECIATION	CENSUS DAYS	516,944	41,469		39,752	3,189	16
17	32	INTEREST	CENSUS DAYS	516,944	314,739		39,752	24,203	17
18	35	AUTO LEASE	CENSUS DAYS	516,944	12,960		39,752	997	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	516,944	10,875		39,752	836	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,123,517	\$ 1,177,536		\$ 156,001	25

Facility Name & ID Number

**BRIA OF BELLEVILLE**

# **0034678**

Report Period Beginning:

**01/01/2018**

Ending:

**12/31/2018**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	<b>RELATED PARTY: THE LINCOLN ASSOCIATION, LLC</b>				\$	\$			\$	1										
2	<b>BEECH STREET CAPITAL</b>	X	<b>MORTGAGE</b>	<b>\$33,742.90</b>	<b>09/01/13</b>	<b>4,528,900</b>	<b>3,917,762</b>	<b>4/1/39</b>	<b>3.8700</b>	<b>153,839</b>	2									
3	<b>AMORT LOAN COST</b>	X	<b>AMORT OVER LIFE</b>			<b>84,735</b>	<b>67,130</b>			<b>3,301</b>	3									
4											4									
5											5									
<b>Working Capital</b>																				
6	<b>BANK FINANCIAL</b>	X	<b>WORKING CAPITAL</b>	<b>DEMAND</b>			<b>640,968</b>		<b>PRIME+</b>	<b>59,059</b>	6									
7		X	<b>INSURANCE FINANCING</b>							<b>2,390</b>	7									
8	<b>RELATED PARTY ALLOCATION</b>									<b>24,203</b>	8									
9	<b>TOTAL Facility Related</b>			<b>\$33,742.90</b>		<b>\$ 4,613,635</b>	<b>\$ 4,625,860</b>			<b>\$ 242,792</b>	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					<b>\$</b>	<b>\$</b>			<b>\$</b>	14									
15	<b>TOTALS (line 9+line14)</b>					<b>\$ 4,613,635</b>	<b>\$ 4,625,860</b>			<b>\$ 242,792</b>	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 21,861      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 2017 report.		\$	<b>62,299</b>	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.)		\$	<b>66,179</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,880</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>64,330</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>68,210</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	<b>61,481</b>	8	
	2014	<b>62,581</b>	9	
	2015	<b>64,699</b>	10	
	2016	<b>63,730</b>	11	
	2017	<b>66,179</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**2017 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 \_\_\_\_\_

TELEPHONE (      ) \_\_\_\_\_ FAX #: (      ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>1,257.42</u>	\$ <u>1,257.42</u>
2. <u>08-20.0-204-015</u>	<u>NURSING HOME</u>	\$ <u>1,228.22</u>	\$ <u>1,228.22</u>
3. <u>08-20.0-207-025</u>	<u>NURSING HOME</u>	\$ <u>2,659.60</u>	\$ <u>2,659.60</u>
4. <u>08-20.0-210-028</u>	<u>NURSING HOME</u>	\$ <u>449.44</u>	\$ <u>449.44</u>
5. <u>08-20.0-210-029</u>	<u>NURSING HOME</u>	\$ <u>60,583.98</u>	\$ <u>60,583.98</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>66,178.66</u></u>	\$ <u><u>66,178.66</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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:

01/01/2018 Ending:

12/31/2018

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? (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).

Empty lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO (X)

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 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Rows include NURSING HOME, PARKING LOT, and TOTALS.

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

Report Period Beginning:

**01/01/2018**

Ending:

**12/31/2018****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	\$	\$ 1,908,653	4
5				2003	1,249,221	45,426	37.5	45,426		702,210	5
6											6
7											7
8		<b>RELATED PARTY ALLOCATION</b>			55,616	1,569		1,569			8
		<b>Improvement Type**</b>									
9		VARIOUS		1990	11,158	354	31.5	354		10,006	9
10		VARIOUS		1993	6,676	171	39	171		5,147	10
11		VARIOUS		1994	7,797	200	39	200		5,858	11
12		VARIOUS		1995	13,072	335	39	335		8,937	12
13		CARPET		1996	907	23	39	23		558	13
14		BILLBOARD		1996	900	23	39	23		561	14
15		SMOKE DETECTORS		1996	602	15	39	15		370	15
16		PARKING LOT		1996	8,006	205	39	205		5,100	16
17		AWNING		1996	905	23	39	23		576	17
18		CARPETING		1996	1,512	39	39	39		989	18
19		DOOR LOCKS		1997	2,100	54	39	54		1,246	19
20		WALL PAPER		1997	2,012	52	39	52		1,210	20
21		HANDRAIL		1997	3,217	83	39	83		1,855	21
22		FIRE ALARM SYSTEM		1998	11,636	298	39	298		6,251	22
23		WALLPAPER & HANDRAILS FOR NURSING STATION		1998	9,227	236	39	236		4,957	23
24		PAINTING/WALLPAPERING		1998	2,988	77	39	77		1,615	24
25		REPLACE PVC PIPE IN BASEMENT		1998	1,074	28	39	28		587	25
26		WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD		1999	6,144	158	39	158		2,770	26
27		INSTALLED A NEW DURO-LAST ROOF		1999	56,400	1,446	39	1,446		25,300	27
28		WALLPAPER		2000	14,896	382	39	382		7,621	28
29		SEWER LINE REPAIR		2000	11,743	301	39	301		5,562	29
30		AIR CONDITIONING UNITS		2000	8,848	227	39	227		4,194	30
31		CONDENSING UNIT ON FREEZER		2000	2,693	69	39	69		1,278	31
32		NEW NURSES STATION		2000	20,379	522	39	522		9,667	32
33		FIRE ALARM SYSTEM		2000	1,826	47	39	47		870	33
34		HOT WATER SYSTEM		2000	3,849	99	20	99		2,846	34
35		TILED FLOORS		2000	54,185	1,389	39	1,389		25,706	35
36				2000	18,490	474	39	474		8,767	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:

01/01/2018 Ending: 12/31/2018

**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	\$	\$	\$ 13,369	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		22,856	38
39	ROOF	2001	47,500	1,727	27.5	1,727		30,223	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		5,844	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		7,770	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		7,227	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		34,702	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		23,906	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159		20	1,558	1,558	26,486	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		4,161	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		10,343	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTI	2002	7,245	263	27.5	263		4,394	48
49	LANDSCAPING	2004	7,759		15	517	517	7,432	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	24,645	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	4,710	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250		20	5,263	5,263	78,945	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		1,561	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		1,238	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		14,886	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		4,629	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		4,118	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		19,326	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		9,138	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		23,879	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		3,847	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		1,627	64
65	PAINTING	2007	9,986		5			9,986	65
66	GARDEN	2007	60,172	2,188	15	4,012	1,824	44,040	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		2,066	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		1,133	69
70	TOTAL (lines 4 thru 69)		\$ 4,320,862	\$ 136,017		\$ 147,136	\$ 11,119	\$ 3,238,178	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:

01/01/2018 Ending: 12/31/2018

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,320,862	\$ 136,017		\$ 147,136	\$ 11,119	\$ 3,238,178	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		1,054	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		1,806	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		1,117	5
6	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		2,796	6
7	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		40,030	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		3,258	10
11	FIRE PROTECTION WORK-SPRINKLERS PHASE 1	2010	97,653	3,551	27.5	3,551		28,852	11
12	FIRE PROTECTION WORK-SPRINKLERS PHASE 2	2011	97,652	3,551	27.5	3,551		25,301	12
13	WING CORRIDORS-FLOORING,WALLCOVERING,	2011	67,587	2,458	27.5	2,458		19,562	13
14	HANDRAILS,BUNPER GUARDS,SIGNAGE,WALL PROTECTION								14
15	INSTALL NEW CARRIER RTU	2011	4,517	164	27.5	164		1,237	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		5			4,194	18
19	REPLACED ROOF TOP UNIT & 5 TON CONDENSING UNIT	2012	9,995	363	27.5	363		2,344	19
20	INSTALL NEW PLASTIC CEMENT, CAP,COTTON MEMBRA-								20
21	NE ON EPDM ROOF	2012	2,595	94	27.5	94		646	21
22	PARKING LOT IMPROVMENTS; CONCRETE PATIO AND								22
23	DRAINAGE	2012	72,786	4,852	15	4,852		29,516	23
24	INSTALLED A 240CFM EXHAUST FAN ON A CURB OVER								24
25	THE NURSES STATION	2013	3,044	111	27.5	111		661	25
26	LOBBY; OFFICES-CARPET INSTALLATION; WALL BASE								26
27	INSTALLATION	2013	7,824	285	27.5	285		1,627	27
28	SEAL COAT PARKING LOT AND STRIPE PARKING SPACES	2013	3,000	200	15	200		1,133	28
29	100, 200, 300, 400 WINGS- CORRIDOR, RESIDENT ROOMS,								29
30	RESIDENT BATHROOMS-FLOORING	2013	164,523	5,983	27.5	5,983		30,164	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		12,467	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,165,387	\$ 165,599		\$ 176,718	\$ 11,119	\$ 3,537,158	34

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

Facility Name &amp; ID Number BRIA OF BELLEVILLE

# 0034678

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,165,387	\$ 165,599		\$ 176,718	\$ 11,119	\$ 3,537,158	1
2	<b>100 &amp; 200 WINGS RESIDENT BATHS-INSTALLATION OF</b>								2
3	<b>CERAMIC TILE; ACTIVITY ROOM-COVE BASE &amp; PVT INS-</b>								3
4	<b>TALLATION; BUILD 2 NEW WALLS WITH METAL</b>	2014	51,277	1,865	27.5	1,865		8,159	4
5	<b>INSTALL A FIRESTONE TPO ROOFING SYSTEM, GRAVE</b>								5
6	<b>GUARD,ROOF FLASHING OVER THE TOP FLANGE</b>	2014	23,186	843	27.5	843		3,618	6
7	<b>INSTALL NEW SIGN &amp; CABINET TO EXISTING STRUCTUR</b>	2014	5,737	382	15	382		1,624	7
8	<b>LOBBY, 100 WING: CORRIDOR, NURSE STATION, RESIDENT ROOMS &amp; BATHS, DINING &amp; LIVING .ADMINISTRATOR, ADMISSIONS OFFICI</b>								8
9	<b>INSTALLATION OF CARPET TILE, WALLCOVERING, SIGNAGE, HANDRAIL AND BUMPER GUARD, INSTALL METAL FRAMES &amp; WOOD</b>								9
10	<b>DOORS, INSTALL NEW PVT AND COVE BASE,CUSTOM DRESSERS &amp; WARDROBES, HEADWALL &amp; DIVIDER UNITS,OVERBED LIGHTS,</b>								10
11	<b>WALL SCONCE, CURTAINS &amp; BLINDS,PAINT WALLS, DOORFRAMES AND CEILINGS, INSTALL NEW CERAMIC AND WALL TILE, DEMO</b>								11
12	<b>WALL BETWEEN ROOM 101 &amp; 103, CAP ALL PLUMBING IN BATHROOM, CHANGE CONCRETE, INSTALL NEW LIGHT FIXTURES, DRY-</b>								12
13	<b>WALL, CUSTOM KITCHENETTE, RECEPTION DESK</b>	2015	328,421	11,943	27.5	11,943		42,298	13
14	<b>VESTIBULE, THERAPY CORRIDOR, 100 WING SPA, 100 WING GUEST BATHROOM:</b>								14
15	<b>WALLCOVERING, MILLWORK BASE, TILE, HANDRAIL</b>	2015	9,839	358	27.5	358		1,417	15
16	<b>INSTALL INTERIOR SIGNAGE-150 NORTH 27TH STREET</b>	2015	4,264	284	15	284		1,089	16
17	<b>ADDITION: THERAPY ROOM, FRONT ENTRIES, NEW</b>								17
18	<b>BATHROOMS/SHOWER ROOM</b>	2015	424,500	15,436	27.5	15,436		54,669	18
19	<b>GUEST BATHROOM, ACTIVITY ROOM CORRIDOR,VESTIBULE:</b>								19
20	<b>INSTALL NEW CERAMIC FLOOR, PVT &amp; MILWORK BASE</b>	2015	25,003	909	27.5	909		3,447	20
21	<b>100/200 NURSE CALL SYSTEM RE-WIRE</b>	2016	12,948	471	27.5	471		1,158	21
22	<b>FURNISH AND INSTALLATION OF 400A FEEDER OVER</b>								22
23	<b>HEAD ON ROOF FROM MDP TO SUB PANEL</b>	2016	9,500	345	27.5	345		733	23
24	<b>200,500 WING CORRIDOR, ADMISSIONS OFFICE-SIGNAGE,</b>								24
25	<b>INSTALL NEW CERAMIC TILE, WALLCOVERING</b>	2016	6,584	239	27.5	239		588	25
26	<b>INSTALLED NEW CARRIER DUCTLESS MINI SPLIT UNIT</b>	2017	7,285	265	27.5	265		342	26
27	<b>INSTALLED A NEW GAF TPO ROOFING SYSTEM</b>	2018	164,475	3,240	27.5	3,240		3,240	27
28	<b>REMOVE AND REPLACE DUET WORK ON ROOFTOP UNIT</b>	2018	19,521	325	27.5	325		325	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,257,927	\$ 202,504		\$ 213,623	\$ 11,119	\$ 3,659,865	34

\*\*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:

**01/01/2018**

Ending:

**12/31/2018**

**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	\$ 452,011	\$ 15,093	\$ 54,256	\$ 39,163	3-10	\$ 284,253	71
72	Current Year Purchases	38,472	38,472	1,924	(36,548)	10	1,924	72
73	Fully Depreciated Assets	195,050					195,050	73
74	<b>RELATED PARTY SL DEPRECIATION</b>		2,679	2,679				74
75	<b>TOTALS</b>	\$ 685,533	\$ 56,244	\$ 58,859	\$ 2,615		\$ 481,227	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	<b>FACILITY</b>	<b>2005 FORD ECONOCARE</b>	<b>2005</b>	\$ 41,500	\$	\$	\$		\$ 41,500	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 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)	\$ 7,183,609	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 258,748	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 272,482	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,734	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,182,592	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	<b>TOTALS</b>	\$	\$	\$	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 BELLEVILLE

# 0034678

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

**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	<b>TOTAL</b>				\$			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: \$ 19,876

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	<u>FACILITY</u>	<u>2015 FORD T350HD</u>	\$ <u>982.50</u>	\$ <u>12,249</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>982.50</b>	\$ <b>12,249</b>	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 379,678	\$		\$ 379,678	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			102,594			102,594	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			432,783			432,783	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				102,737		102,737	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): <b>RENTALS</b>	39-2					56,427 26,111		56,427 26,111	13
14	<b>TOTAL</b>			\$		\$ 915,055	\$ 185,275		\$ 1,100,330	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 **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 26,819	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000 )	4,937,783		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,460		6
7	Other Prepaid Expenses	57,665		7
8	Accounts Receivable (owners or related parties)	188,990		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,287,717	\$	10
	<b>B. Long-Term Assets</b>			
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	158,257		15
16	Equipment, at Historical Cost	727,034		16
17	Accumulated Depreciation (book methods)	(817,327)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 239,990	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,527,707	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,761,665	\$	26
27	Officer's Accounts Payable	1,370,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	790,968		29
30	Accrued Salaries Payable	123,109		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,048		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,065,790	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,065,790	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,461,917	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,527,707	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,515,761</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,515,761</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(53,844)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (53,844)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,461,917</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,612,913	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,612,913	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	16,585	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,585	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,629,498	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,364,193	31
32	Health Care	3,427,196	32
33	General Administration	1,852,035	33
<b>B. Capital Expense</b>			
34	Ownership	634,840	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,100,330	35
36	Provider Participation Fee	304,748	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,683,342	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(53,844)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (53,844)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,101,768	44
45	Private Pay - Net Inpatient Revenue	320,526	45
46	Medicare - Net Inpatient Revenue	2,436,059	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	239,334	47
48	Other-(specify) <u>MANAGED CARE</u>	515,226	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,612,913	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: 01/01/2018

Ending:

12/31/2018

**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	2,032	2,080	\$ 93,184	\$ 44.80	1
2	Assistant Director of Nursing	2,068	2,232	86,196	38.62	2
3	Registered Nurses	7,510	7,882	244,039	30.96	3
4	Licensed Practical Nurses	34,903	37,231	885,130	23.77	4
5	CNAs & Orderlies	100,791	105,515	1,274,072	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,178	7,420	86,223	11.62	10
11	Social Service Workers	3,957	4,214	85,877	20.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,335	5,737	104,670	18.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,984	2,080	108,004	51.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,113	14,900	238,388	16.00	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	5,859	6,076	170,990	28.14	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,690	197,447	\$ 3,412,230 *	\$ 17.28	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	68,501	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	6,207	10-3	38
39	Pharmacist Consultant	H	9,758	10-3	39
40	Physical Therapy Consultant	L	38,518	10a-3	40
41	Occupational Therapy Consultant	Y	33,614	10a-3	41
42	Respiratory Therapy Consultant		20,319	10a-3	42
43	Speech Therapy Consultant	F	14,261	10a-3	43
44	Activity Consultant	E	1,562	11-3	44
45	Social Service Consultant	E	2,461	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 195,201		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		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53



BRIA OF BELLEVILLE  
LEGAL SCHEDULE  
12/31/2018

DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
3/7/2018	CHUBB GROUP OF INSURANCE COMPANIES	EEOC CLAIMS CORRESPONDENCES	2,903
3/26/2018	CHUBB GROUP OF INSURANCE COMPANIES	COURT DOCUMENTS	2,416
3/26/2018	CHUBB GROUP OF INSURANCE COMPANIES	COURT DOCUMENTS	3,268
4/24/2018	CHUBB GROUP OF INSURANCE COMPANIES	COURT DOCUMENTS	2,811
8/31/2018	CHUBB GROUP OF INSURANCE COMPANIES	EEOC CLAIMS	151
9/4/2018	CHUBB GROUP OF INSURANCE COMPANIES	EEOC CLAIMS	86
7/27/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	12,052
8/23/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	3,636
9/26/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	7,515
11/1/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	1,227
12/1/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	323
12/19/2018	CNA DEDUCTIBLE RECOVERY GROUP	DEDUCTABLE RECOVERY	2,815
2/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,633
3/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,535
4/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,763
5/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,340
6/1/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,470
7/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,763
8/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,633
9/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,535
10/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,633
11/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,535
12/2/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,730
12/31/2018	GARY A WEINTRAUB PC	CONSULTATIONS RE COMPLIANCE AND REQ OF OBRA	2,405
3/15/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	4,538
5/7/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	4,457
6/7/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	5,498
7/10/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	3,079
8/9/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	553
9/14/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	5,035
10/4/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	1,770
11/6/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	5,616
12/5/2018	GREENBERG TRAUIG	RESEARCH & COURT CASE PREP	4,991
1/1/2018	HEPLER BROOM LLC	INVOLUNTARY DISCHARGE	1,400
1/8/2018	HEPLER BROOM LLC	COURT CORRESPONDENCE & RESEARCH	384
1/8/2018	HEPLER BROOM LLC	GUARDIANSHIP PETITION	666
12/18/2018	HEPLER BROOM LLC		1,643
9/18/2018	SANDBERG PHOENIX & VONGONTARD PC	ANALYSIS & COURT PREP	1,003
10/5/2018	SANDBERG PHOENIX & VONGONTARD PC	ANALYSIS & COURT PREP	1,864
12/7/2018	SANDBERG PHOENIX & VONGONTARD PC	ANALYSIS & COURT PREP	4,616
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	550
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	171
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	506
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
9/4/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
9/4/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	173
11/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
11/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
2/27/2018	SKIDELSKY AND ASSOCIATES	REAL ESTATE TAXES AND ASSESSMENT	150
1/1/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
2/28/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
3/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
4/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
5/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
6/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
7/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
8/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
9/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
10/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
11/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
12/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
	CNA INSURANCE	LEGAL SEELEMANT	50,000
<b>TOTAL</b>			<b>183,234</b>

Facility Name & ID Number **BRIA OF BELLEVILLE**# **0034678**Report Period Beginning: **01/01/2018**Ending: **12/31/2018****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 \$ 10,388
- (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. \$ 27,493 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. \$ 304,748  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees