FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051334

Facility Name: BRIA OF ALTON

Address: 3523 WICKENHAUSER (Number) ALTON (City) 62002 (Zip Code)

County: MADISON

Telephone Number: (618) 465-8887 **Fax #** (618) 465-1811

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2022

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MITCH KOHANANOO **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 08/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) MITCH KOHANANOO, PARTNER
(Firm Name & Address) ACCOUNTING ASSOCIATES, LLC, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	132	Skilled (SNF)	132	32,076	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	11,907	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	43,983	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF				39		811	326	1,176	8
9	SNF/PED									9
10	ICF	3,606	11,679	1,717		1,098		809	18,909	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,606	11,679	1,717	39	1,098	811	1,135	20,085	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 45.67%

D. How many bed reserve days during this year were paid by the Department? _____ (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2022

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2022 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 132

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	93,223	16,269	164,135	273,627		273,627		273,627			1
2	Food Purchase		161,785		161,785		161,785	(47)	161,738			2
3	Housekeeping			191,632	191,632		191,632		191,632			3
4	Laundry		4,348	127,755	132,103		132,103		132,103			4
5	Heat and Other Utilities			241,239	241,239		241,239	556	241,795			5
6	Maintenance	133,513	58,172	25,774	217,459		217,459	6,092	223,551			6
7	Other (specify):* Scavenger			15,508	15,508		15,508	107	15,615			7
8	**TOTAL General Services**	226,736	240,574	766,043	1,233,353		1,233,353	6,708	1,240,061			8
	B. Health Care and Programs											
9	Medical Director			19,556	19,556		19,556		19,556			9
10	Nursing and Medical Records	1,382,231	154,411	1,184,578	2,721,220		2,721,220	35,341	2,756,561			10
10a	Therapy			27,698	27,698		27,698		27,698			10a
11	Activities	53,144	1,888	2,253	57,285		57,285		57,285			11
12	Social Services	32,658	460	2,253	35,371		35,371		35,371			12
13	CNA Training											13
14	Program Transportation			6	6		6		6			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,468,033	156,759	1,236,344	2,861,136		2,861,136	35,341	2,896,477			16
	C. General Administration											
17	Administrative	91,388			91,388		91,388	19,123	110,511			17
18	Directors Fees											18
19	Professional Services			263,630	263,630		263,630	(180,070)	83,560			19
20	Dues, Fees, Subscriptions & Promotions			42,721	42,721		42,721	(17,779)	24,942			20
21	Clerical & General Office Expenses	187,589	6,510	135,910	330,009		330,009	(19,733)	310,276			21
22	Employee Benefits & Payroll Taxes			314,540	314,540		314,540		314,540			22
23	Inservice Training & Education			5,719	5,719		5,719	49	5,768			23
24	Travel and Seminar			12,980	12,980		12,980	(1,770)	11,210			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			268,061	268,061		268,061	681	268,742			26
27	Other (specify):*			104,745	104,745		104,745	(88,954)	15,791			27
28	**TOTAL General Administration**	278,977	6,510	1,148,306	1,433,793		1,433,793	(288,453)	1,145,340			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,973,746	403,843	3,150,693	5,528,282		5,528,282	(246,404)	5,281,878			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.

Facility Name & ID# BRIA OF ALTON **#0051334 Report Period Beginning: 01/01/2025** **Ending: 08/31/2025**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	28,732	
	REPAIRS & MAINTENANCE		1,007	
	CONTRACTED DIETARY SERVICES		134,396	
				164,135
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		191,632	
				191,632
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE			
	CONTRACTED LAUNDRY SERVICES		127,755	
				127,755
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		9,150	
	ELECTRICITY		92,029	
	WATER		133,710	
	CABLE TV - LOBBY		6,350	
				241,239
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		17,440	
	PAINTING & DECORATING			
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR			
	ELEVATOR MAINTENANCE & REPAIR			
	OUTSIDE LABOR			
	EXTERMINATING SERVICE			
	FIRE SERVICE		8,334	
				25,774
7	**OTHER**			
	SCAVENGER		15,508	
	SECURITY SERVICE			
				15,508
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		19,556	19,556

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,171,862	
	LABORATORY & XRAY EXPENSE		1,545	
	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	4,446	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2	6,725	
				1,184,578
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	11,685	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	6,110	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	3,688	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	6,215	
				27,698
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,253	
				2,253
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	2,253	
	SOCIAL WORKER	XVIII B 45-2		
				2,253
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID# BRIA OF ALTON **#0051334 Report Period Beginning: 01/01/2025** **Ending: 08/31/2025**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		6	
				6
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B		0
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,833	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	35,797	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		196,000	
				263,630
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,748	
	EMPLOYEE WANT ADS	XIX F	7,000	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	4,275	
	LICENSES & PERMITS	XIX F	3,707	
	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	15,992	
	HEALTH CARE WORKER BACKGROUND CHE	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	6,999	
				42,721
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		714	
	EQUIPMENT REPAIR & MAINTENANCE		108,369	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18		
	HOME OFFICE EXPENSE		17,415	
	THEFT & DAMAGE LOSS			
	TELEPHONE		9,412	
	MESSENGER SERVICE			
				135,910

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	154,413	
	UNEMPLOYMENT COMPENSATION	XIX D	52,503	
	WORKERS COMPENSATION INSURANCE	XIX D	51,467	
	HOSPITALIZATION INSURANCE	XIX D	51,237	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,920	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				314,540
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		5,719	
				5,719
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	12,980	
				12,980
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF			
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		268,061	
				268,061
27	**OTHER**			
	BAD DEBTS	VI 24	104,745	
				104,745

GRAND TOTAL COLUMN 3 OTHER **3,150,693**

Facility Name & ID Number BRIA OF ALTON #0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			71	71		71	19,658	19,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,887	53,887		53,887	20,098	73,985			32
33	Real Estate Taxes							2,191	2,191			33
34	Rent-Facility & Grounds			290,837	290,837		290,837		290,837			34
35	Rent-Equipment & Vehicles			45,722	45,722		45,722	404	46,126			35
36	Other (specify):* **RENT OFFICE**			2,800	2,800		2,800	(2,800)				36
37	**TOTAL Ownership**			393,317	393,317		393,317	39,551	432,868			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,137	138,936	174,073		174,073		174,073			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			475,733	475,733		475,733		475,733			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		35,137	614,669	649,806		649,806		649,806			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,973,746	438,980	4,158,679	6,571,405		6,571,405	(206,853)	6,364,552			45

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

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,283	30		9
10	Interest and Other Investment Income	(473)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(17,415)	21		18
19	Entertainment		20		19
20	Contributions		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	(104,745)	27		24
25	Fund Raising, Advertising and Promotional	(4,748)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(75,899)	22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,044)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(20,809)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (20,809)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (206,853)		37

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

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

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

BRIA OF ALTON

ID# 0051334

Report Period Beginning: 01/01/2025

Ending: 08/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (15,992)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING SALARIES	(56,586)	21	3
4	MARKETING TRAVEL	(3,321)	24	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**	(75,899)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(47)	0	0	0	0	0	0	0	0	0	0	(47)	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	556	0	0	0	0	0	0	0	0	0	556	5
6	Maintenance	0	270	5,822	0	0	0	0	0	0	0	0	6,092	6
7	Other (specify):*	0	0	107	0	0	0	0	0	0	0	0	107	7
8	**TOTAL General Services**	(47)	826	5,929	0	0	0	0	0	0	0	0	6,708	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	35,341	0	0	0	0	0	0	0	0	35,341	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	35,341	0	0	0	0	0	0	0	0	35,341	16
	C. General Administration													
17	Administrative	0	0	19,123	0	0	0	0	0	0	0	0	19,123	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24	(180,094)	0	0	0	0	0	0	0	0	(180,070)	19
20	Fees, Subscriptions & Promotions	(20,740)	0	2,961	0	0	0	0	0	0	0	0	(17,779)	20
21	Clerical & General Office Expenses	(74,001)	135	54,133	0	0	0	0	0	0	0	0	(19,733)	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	49	0	0	0	0	0	0	0	0	49	23
24	Travel and Seminar	(3,321)	0	1,551	0	0	0	0	0	0	0	0	(1,770)	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	110	571	0	0	0	0	0	0	0	0	681	26
27	Other (specify):*	(104,745)	0	15,791	0	0	0	0	0	0	0	0	(88,954)	27
28	**TOTAL General Administration**	(202,807)	269	(85,915)	0	0	0	0	0	0	0	0	(288,453)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(202,854)	1,095	(44,645)	0	0	0	0	0	0	0	0	(246,404)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF ALTON # 0051334 **Report Period Beginning:** 01/01/2025 **Ending:** 08/31/2025

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	17,283	883	1,492	0	0	0	0	0	0	0	0	19,658	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(473)	992	19,579	0	0	0	0	0	0	0	0	20,098	32
33	Real Estate Taxes	0	2,191	0	0	0	0	0	0	0	0	0	2,191	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	404	0	0	0	0	0	0	0	0	404	35
36	Other (specify):*	0	(2,800)	0	0	0	0	0	0	0	0	0	(2,800)	36
37	**TOTAL Ownership**	16,810	1,266	21,475	0	0	0	0	0	0	0	0	39,551	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)**	(186,044)	2,361	(23,170)	0	0	0	0	0	0	0	0	(206,853)	45

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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 PG OWNERSHIP-1						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	RENT OFFICE	$ 2,800	IME REALTY CORPORATION		$	$ (2,800)	1
2	V	5	UTILITIES				556	556	2
3	V	6	MAINTENANCE				270	270	3
4	V	19	PROFESSIONAL FEES				24	24	4
5	V	26	INSURANCE				110	110	5
6	V	30	DEPRECIATION				883	883	6
7	V	32	INTEREST				992	992	7
8	V	33	RE TAX				2,191	2,191	8
9	V	21	OFFICE EXPENSE				135	135	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,800			$ 5,161	$ * 2,361	14

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

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	BOOKKEEPING/ADM SERVICES	$ 196,000	BRIA HEALTH SERVICES, LLC		$	$ (196,000)	15
16	V								16
17	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	17
18	V	17	SALARIES-CFO				10,135	10,135	18
19	V	6	SALARIES-MAINTENANCE				4,679	4,679	19
20	V	10	SALARIES-A/R				35,341	35,341	20
21	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	21
22	V	21	SALARIES-CLERICAL				46,315	46,315	22
23	V	6	MAINTENANCE				1,143	1,143	23
24	V	7	SCAVENGER				107	107	24
25	V	19	PROFESSIONAL FEES				15,906	15,906	25
26	V	20	DUES,FEES,SUBSCRIPTIONS				2,961	2,961	26
27	V	21	OFFICE EXPENSE				5,706	5,706	27
28	V	23	SEMINARS				49	49	28
29	V	24	TRAVEL				1,551	1,551	29
30	V	26	INSURANCE				571	571	30
31	V	27	EMPLOYEE BENEFITS				15,791	15,791	31
32	V	30	DEPRECIATION				1,492	1,492	32
33	V	32	INTEREST				19,579	19,579	33
34	V	35	AUTO LEASE				193	193	34
35	V	35	EQUIPMENT RENTAL				211	211	35
36	V								36
37	V								37
38	V								38
39	Total			$ 196,000			$ 172,830	$ * (23,170)	39

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

STATE OF ILLINOIS — Ownership Listing-1

BRIA OF ALTON

ID# 0051334

Report Period Beginning: 01/01/2025

Ending: 08/31/2025

BRIA HEALTH SERVIC

N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	DANIEL	T	WEISS	SKOKIE	IL	33.33000		33.33000	1
2	NATAN	S	WEISS	MAALEH ADUN	ISRAEL	16.67000		33.34000	2
3	AVRUM		WEINFELD	CHICAGO	IL	33.33000		33.33000	3
4	AMY		WEISS	MAALEH ADUN	ISRAEL	16.67000			4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

BRIA OF ALTON

ID# **0051334**

Report Period Beginning: **01/01/2025**

Ending: **08/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
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142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	BRIA OF BELLEVILLE	BELLEVILLE	LYDIA CARE CENTER	ROBBINS	BRIA HEALTH	SKOKIE	MANAGEMENT	1
2					SERVICES, LLC		SERVICES	2
3	BRIA OF GENEVA	GENEVA	BRIA OF ELMWOOD	ELMWOOD PARK				3
4					IME REALTY	SKOKIE	CORPORATE	4
5	BRIA OF FOREST EDGE	CHICAGO	BAYSIDE CARE CENTER	WAUKEGAN			OFFICE	5
6								6
7	LAKE PARK CENTER	WAUKEGAN			WEISS MGMT		MANAGEMENT/	7
8					GROUP, INC	SKOKIE	CLERICAL	8
9	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO						9
10		HEIGHTS			DA WESTMONT	SKOKIE	MGMT CONSULT	10
11								11
12	BRIA OF WESTMONT	WESTMONT						12
13								13
14	BRIA OF PALOS HILLS	PALOS HILLS						14
15								15
16	BRIA OF RIVER OAKS	BURNHAM						16
17								17
18	BRIA OF CAHOKIA	CAHOKIA						18
19								19
20	BELLEVILLE HEALTHCARE CENTER	BELLEVILLE						20
21								21
22	BRIA OF COLUMBIA	COLUMBIA						22
23								23
24	BRIA OF GODFREY	GODFREY						24
25								25
26	BRIA OF WOODRIVER	WOODRIVER						26
27								27
28	BRIA OF MASCOUTAH	MASCOUTAH						28
29								29
30								30

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:								$		1
2	ARIELLA WEIL	RELATIVE	ACCOUNTS PAYABLE					SALARY		21-7	2
3	MIRYAM CLEVS	RELATIVE	OFFICE CLERK		SEE			SALARY	2,112	21-7	3
4	FRED BERKOVITS	MEMBER	REGIONAL DIR		ATTACHED			MGMT FEES	8,988	17-7	4
5					SCHEDULE						5
6	ALLOCATION FROM DA WESTMONT:										6
7	AVRUM WEINFELD	MEMBER	CFO	33.33				SALARY	6,000	17-7	7
8	DANIEL WEISS	MEMBER	ADMINISTRATIV	33.33				SALARY	6,000	17-7	8
9											9
10	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										10
11	NATAN WEISS	MEMBER	FINANCE/MGMT	16.67				MGMT FEES	13,500	17-7	11
12	DANIEL WEISS	MEMBER	ADMINISTRATIV	33.33				SALARY	11,902	17-7	12
13								TOTAL	$ 48,502		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 ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 8/31/2025

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 [X] NO [ ]

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

Name of Related Organization: IME REALTY CORPORATION
Street Address: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 933-9200
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	UTILITIES	CENSUS DAYS	821,683	19	22,755		20,085	556	2
3	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		20,085	270	3
4	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		20,085	24	4
5	26	INSURANCE	CENSUS DAYS	821,683	19	5,537		20,085	135	5
6	30	DEPRECIATION	CENSUS DAYS	821,683	19	4,484		20,085	110	6
7	32	INTEREST	CENSUS DAYS	821,683	19	36,102		20,085	883	7
8	33	RE TAX	CENSUS DAYS	821,683	19	40,569		20,085	992	8
9	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	89,649		20,085	2,191	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					$ 211,108	$		$ 5,161	25

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 8/31/2025

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 [X] 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) 933-9200
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	MANAGEMENT FEES-RELATED	wghtd avr hours	40	19	$ 179,753	$	2	$ 8,988	1
2	17	SALARIES-CFO	CENSUS DAYS	821,683	19	414,635	414,635	20,085	10,135	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	20,085	4,679	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	20,085	35,341	4
5	21	SALARIES-CLERICAL RELATED	wghtd avr hours	38	19	83,882	83,882	2	2,112	5
6	21	SALARIES-CLERICAL	CENSUS DAYS	821,683	19	1,894,762	1,894,762	20,085	46,315	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		20,085	1,143	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		20,085	107	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		20,085	15,906	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		20,085	2,961	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		20,085	5,706	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		20,085	49	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		20,085	1,551	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		20,085	571	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		20,085	15,791	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		20,085	1,492	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		20,085	19,579	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		20,085	193	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		20,085	211	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,879,996	$ 4,030,510		$ 172,830	25

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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							$	$			$	1
2	FORGE INVESTMENTS LLC	X		WORKING CAPITAL		07/05/22	400,000	254,308	07/05/28	7.0000	15,234	2
3												3
4												4
5												5
	Working Capital											
6	OPTIMUM BANK	X		LOC		09/01/22	600,000	889,700		PRIME+	38,653	6
7												7
8	RELATED PARTY ALLOCATION											8
9	TOTAL Facility Related						$ 1,000,000	$ 1,144,008			$ 53,887	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 1,144,008			$ 53,887	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* 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.)

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$		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.	$		7

Assessed Value from Real Estate Tax Bill:	2024	713,850	8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

FOR BHF USE ONLY

14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF ALTON COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0051334

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 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-1-08-17-10-105-027	LONG TERM CARE PROPERTY	$ 64,258.04	$ 64,258.04
2.			$	$
3.			$	$
4.			$	$
5.	10-16-400-033-0000	IME ALLOCATION	$ 2,191.00	$ 2,191.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,449.04	$ 66,449.04

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,261 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories 2

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

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? YES

H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? NO

J. 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.

K. 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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7	IME-BLDG			2016	12,760	327		327			7
8	RELATED PARTY -IMPR			2017	44,909	1,146		1,146			8
	Improvement Type**										
9	INSTALL COMPUTER CONSOLE: COMPONENT PARTS,			2022	51,482		15	2,002	2,002	9,724	9
10	PROGRAMMING, TRAINING										10
11	KITCHEN WIF: REPLACED A WALK IN DOOR AND HARDWARE										11
12	ON REACH IN DOOR			2023	5,238		27.5	111	111	491	12
13	GENERAL RENOVATION-PHASE 2										13
14	300 & 400 WINGS, NURSE STATION: FILL AND PATCH ALL										14
15	HOLES, SAND AND PRIME, PAINT ALL WALLS , INSTALL ALL										15
16	NEW COVER BASE, FIX CHAIR RAILS			2023	37,122		15	1,444	1,444	6,394	16
17	WINDOWS: INSTALLATION OF NEW WINDOWS, WINDOW										17
18	BUCK, OF EXTERIOR AND INTERIOR MOULDING, COMPLETE										18
19	WATERPROOFING			2023	134,560		27.5	2,854	2,854	12,640	19
20	PLUMBING: INSTALL 6 CLEAN-OUTS, REPLACE SEWER LATERAL,										20
21	BLACK TOP, ROCK AROUND PIPE, 6" SDR			2023	15,890		27.5	337	337	1,493	21
22	FURNISH AND INSTALL NEW 5-TON ADP AIR HANDLER UNIT,										22
23	NEW FAN CYCLER IN KITCHEN			2023	5,660		27.5	120	120	532	23
24	DINING ROOM: FURNISH AND INSTALLED NEW 15-TON RTU										24
25	IN PLACE, CHARGED UNIT AS NEEDED AND TECTED FUNCTION			2023	31,795		27.5	674	674	2,986	25
26	INSTALL DIRECT DOOR SYSTEM			2023	2,783		27.5	59	59	261	26
27	FURNISH & INSTALL 2 NEW TANKLESS HOT WATER HEATERS			2024	27,995		15	1,089	1,089	2,955	27
28	REPLACE EXISTING WATER HEATER WITH RINNAI DEMAND DU			2024	15,800		15	614	614	1,667	28
29	SHOWER ROOMS-FOUR COMPLETE REMODELS-PLUMBING,										29
30	TILE ALL FLOORING, NEW LIGHT FIXTURES			2024	95,000		27.5	2,015	2,015	5,469	30
31	2 NURSING STATIONS-WILL WRAP AROUND TO SIDE WALL			2024	50,000		27.5	1,061	1,061	2,879	31
32	DIALYSIS UNIT-PLUMBING, ELECTRICAL, LIGHTING, WALL										32
33	FRAMING, FLOORING, ARCHITECTURAL DRAWINGS, FIRE										33
34	SPRINKLERS			2024	114,865		27.5	2,437	2,437	6,614	34
35	GENERATOR-INSTALL A STRUCTURAL CHANNEL, REPLACE THE										35
36				2024	3,878		15	147	147	399	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 ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FURNISH AND INSTALL NEW RTU WITH A CRANE	2024	$ 14,123	$	27.5	$ 300	$ 300	$ 814	37
38	FURNISH AND INSTALL NEW COMPRESSOR	2024	4,370		15	170	170	461	38
39	ROOF FANS WITH W. MOTOR	2024	11,489		15	447	447	1,213	39
40	PATCH DRYWALL IN PATIENT ROOMS AS NEEDED FOR								40
41	TOUCH UP PAINT IN PATIENT ROOMS	2024	36,400		27.5	772	772	2,096	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 716,119	$ 1,473		$ 18,125	$ 16,652	$ 59,087	70

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

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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	$ 10,021	$ 71	$ 702	$ 631	8-10	$ 3,365	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		902	902				74
75	TOTALS	$ 10,021	$ 973	$ 1,604	$ 631		$ 3,365	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 726,140	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,446	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,729	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,283	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 62,452	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 3523 WICKENHAUSER LLC

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. [X] 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:		181	07/01/22	$ 290,837	10		3
4	Additions							4
5								5
6								6
7	TOTAL		181		$ 290,837 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/22
Ending 06/30/32

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 22,925 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	FACILITY	2020 FORD RAM PROMASTER	#######	13,552	18
19	FACILITY	2023 FORD TRANSIT	839.02	9,245	19
20					20
21	TOTAL		$ #######	$ 22,797	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.

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THIS FACILITY HIRES ONLY CERTIFIED NURSING AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	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.

Facility Name & ID Number BRIA OF ALTON

STATE OF ILLINOIS
0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 53,862	$		$ 53,862	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			28,036			28,036	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			57,038			57,038	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				23,795		23,795	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY	39-2					5,707		5,707	
	Other (specify): IV THERAPY, RENTA	39-2					5,635		5,635	13
14	TOTAL			$		$ 138,936	$ 35,137		$ 174,073	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.

STATE OF ILLINOIS

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 08/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 199,512	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 73,963)	498,982		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	176,650		6
7	Other Prepaid Expenses	264		7
8	Accounts Receivable (owners or related parties)	137,290		8
9	Other(specify): REPLACEMENT RESERVE	5,623		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,018,321	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,021		16
17	Accumulated Depreciation (book methods)	(9,828)		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): OPTION DEPOSIT	25,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,193	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,043,514	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,686,087	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	889,700		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,926		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,698,713	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	254,308		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)**	$ 254,308	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,953,021	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,909,507)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,043,514	$	48

*(See instructions.)

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (990,687)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (990,687)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(918,820)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (918,820)	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)**	$ (1,909,507)	24 *

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

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,296,232	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,296,232	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,908	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 71,908	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***	473	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 473	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**QUALITY INSENTIVE**	128,801	28
28a	**CAN WAGE PASS, ITT REBATE PROGRAM**	155,171	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 283,972	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,652,585	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,233,353	31
32	Health Care	2,861,136	32
33	General Administration	1,433,793	33
	B. Capital Expense		
34	Ownership	393,317	34
	C. Ancillary Expense		
35	Special Cost Centers	174,073	35
36	Provider Participation Fee	475,733	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,571,405	40
41	**Income before Income Taxes (line 30 minus line 40)****	(918,820)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (918,820)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 829,305.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,868,677.00	45
46	MMAI-Medicaid is the Primary Payer	422,539.00	46
47	MMAI-Medicare is the Primary Payer	21,807.00	47
48	Private Pay	307,160.00	48
49	Medicare Part A	504,455.00	49
50	Other-(specify) HOSPICE	195,969.00	50
51	Other-(specify) INSURANCE	146,320.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,296,232	56

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,242	1,297	$ 84,842	$ 65.41	1
2	Assistant Director of Nursing	2,605	2,666	106,401	39.91	2
3	Registered Nurses	1,895	1,928	96,964	50.29	3
4	Licensed Practical Nurses	7,769	7,306	328,995	45.03	4
5	CNAs & Orderlies	27,463	29,105	647,905	22.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,444	2,654	53,144	20.02	10
11	Social Service Workers	1,185	1,217	32,658	26.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,683	4,723	93,223	19.74	15
16	Dishwashers					16
17	Maintenance Workers	3,915	4,126	133,513	32.36	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,256	1,300	91,388	70.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,240	5,675	187,589	33.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,120	1,142	28,172	24.67	31
32	Other Health C: Care Plan Coord	2,432	2,576	88,952	34.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	63,249	65,715	$ 1,973,746 *	$ 30.03	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 28,732	1-3	35
36	Medical Director	O	19,556	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,446	10-3	39
40	Physical Therapy Consultant	L	11,685	10a-3	40
41	Occupational Therapy Consultant	Y	6,110	10a-3	41
42	Respiratory Therapy Consultant		3,688	10a-3	42
43	Speech Therapy Consultant	F	6,215	10a-3	43
44	Activity Consultant	E	2,253	11-3	44
45	Social Service Consultant	E	2,253	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 84,938		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,920	$ 168,553		50
51	Licensed Practical Nurses	11,595	553,993		51
52	Certified Nurse Assistants/Aides	16,405	449,316		52
53	TOTAL (lines 50 - 52)	30,920	$ 1,171,862		53

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RIKEESHA D WHITE	Administrator	0	$ 91,388
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,388

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PAYLOCITY	DATA PROCESSING	$ 11,762
QUATUM INFORMATICS	DATA PROCESSING	18,120
NATIONAL DATACARE	DATA PROCESSING	1,951
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN SERV	196,000
DSSI	PROCUREMENT SOLUTIONS	747
INTEGRA SCRIPTS	PHARMACY COST MANAGEI	2,200
KBKB LTD	ACCOUNTING FEES	17,475
GGM ASSOCIATES	ACCOUNTING FEES	3,992
PERSONNEL PLANNERS	UC CONSULTANT	1,050
SEE LEGAL SCHEDULE ATTACHED		10,333
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 263,630

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,467
Unemployment Compensation Insurance	52,503
FICA Taxes	154,413
Employee Health Insurance	51,237
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,920
EMPLOYEE PHYSICAL EXAMS	
PENSION/PROFIT SHARING PLANS	
INSURANCE - EXECUTIVE LIFE	
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,540

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,000
Health Care Worker Background Check	
(Indicate # of checks performed 237)	
Patient Background Checks	6,999
Association Dues (total from pg 22, #4)	20,267
TRUST/FRANCHISE/CONTRIB/ETC	
MARKETING/ADV/PROMO	4,748
LICENSES/DUES/SUBSCRIPTIONS	1,717
MGMT CO ALLOC	2,961
Less: Public Relations Expense	( )
PAC and Lobbying payments	(15,992)
All non-allowable advertising	(4,748)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,942

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	12,980
MARKETING TRAVEL	(3,321)
MGMT CO ALLOC	1,551
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,210

* Attach copy of IMRF notifications

**See instructions.

BRIA OF ALTON
LEGAL SCHEDULE
8/31/2025

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/31/2025	HINSHAW & CULBERTSON	REGULATORY CONSELING	549
2/28/2025	HINSHAW & CULBERTSON	APPEARED & ATTENDED HEARING	420
4/30/2025	HINSHAW & CULBERTSON	REGULATORY CONSELING	86
5/31/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF TYPE A VIOLATION	305
7/31/2025	HINSHAW & CULBERTSON	APPEARED FOR AND ATTENDED STATUS HEARING	1,223
8/31/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF IDPH FINAL ORDER	1,094
9/30/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF TYPE A VIOLATION	785
10/20/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF IDPH PROPOSED COMSENT	331
1/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
2/28/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
3/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
4/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
5/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
6/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
7/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
2/1/2025	BRIAN A STINES	GUARDIANSHIP	640
	TOTAL		**10,333**

Facility Name & ID Number BRIA OF ALTON # 0051334 Report Period Beginning: 01/01/2025 Ending: 08/31/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	4,275
	4,275 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	15,992
	15,992 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	20,267
	20,267 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 10,089 Line 10-2

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 475,733
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? N/A Indicate the amount. $ _____

(12) 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

(13) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____

(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(15) 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.