

		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: <u>0048645</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>BRIA OF CAHOKIA</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3354 JEROME LANE</u> <u>CAHOKIA</u> <u>62206</u>																									
Number City Zip Code																									
County: <u>SAINT CLAIR</u>																									
Telephone Number: <u>(618) 337-9400</u> Fax # <u>(618) 332-1811</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>AVRUM WEINFELD</u></td></tr><tr><td>(Title) <u>CEO</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>MITCH KOHANANOO</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>ACCOUNTING ASSOCIATES, LLC</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>AVRUM WEINFELD</u>	(Title) <u>CEO</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)	Paid Preparer	(Date) _____	(Print Name and Title) <u>MITCH KOHANANOO</u> <u>PARTNER</u>	(Firm Name & Address) <u>ACCOUNTING ASSOCIATES, LLC</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>AVRUM WEINFELD</u>																								
	(Title) <u>CEO</u>																								
	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) <u>MITCH KOHANANOO</u> <u>PARTNER</u>																								
	(Firm Name & Address) <u>ACCOUNTING ASSOCIATES, LLC</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u>																								
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>05/01/00</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																							
Name: <u>MITCH KOHANANOO</u>																									
Telephone Number: <u>(847) 675-3585</u> Email Address: _____																									

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	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	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	133	TOTALS	133	48,545	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				61		1,114	247	1,422	8
9	SNF/PED									9
10	ICF	4,471	30,756	1,511		61		274	37,073	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,471	30,756	1,511	61	61	1,114	521	38,495	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 79.30%

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 ☒

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 05/01/2000

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 05/01/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 49

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2024 Fiscal Year: 12/31/2024

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

Facility Name & ID Number

BRIA OF CAHOKIA

0048645

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	330,965	23,650	74,483	429,098		429,098		429,098			1
2	Food Purchase		307,042		307,042		307,042		307,042			2
3	Housekeeping		901	291,589	292,490		292,490		292,490			3
4	Laundry		7,704	194,355	202,059		202,059		202,059			4
5	Heat and Other Utilities			111,444	111,444		111,444	1,070	112,514			5
6	Maintenance	143,331	66,951	27,918	238,200		238,200	11,714	249,914			6
7	Other (specify):* Security, Scavenger			20,960	20,960		20,960	205	21,165			7
8	TOTAL General Services	474,296	406,248	720,749	1,601,293		1,601,293	12,989	1,614,282			8
	B. Health Care and Programs											
9	Medical Director			29,334	29,334		29,334		29,334			9
10	Nursing and Medical Records	3,619,241	195,195	627,458	4,441,894		4,441,894	67,956	4,509,850			10
10a	Therapy	188,853		11,049	199,902		199,902		199,902			10a
11	Activities	124,561	2,027	3,246	129,834		129,834		129,834			11
12	Social Services	196,025	1,623	3,746	201,394		201,394		201,394			12
13	CNA Training											13
14	Program Transportation			1,480	1,480		1,480		1,480			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,128,680	198,845	676,313	5,003,838		5,003,838	67,956	5,071,794			16
	C. General Administration											
17	Administrative	154,990		483,936	638,926		638,926	(237,438)	401,488			17
18	Directors Fees											18
19	Professional Services			352,475	352,475		352,475	(173,858)	178,617			19
20	Dues, Fees, Subscriptions & Promotions			45,909	45,909		45,909	(15,763)	30,146			20
21	Clerical & General Office Expenses	323,270	9,914	348,738	681,922		681,922	(58,005)	623,917			21
22	Employee Benefits & Payroll Taxes			624,555	624,555		624,555		624,555			22
23	Inservice Training & Education			12,495	12,495		12,495	94	12,589			23
24	Travel and Seminar							2,982	2,982			24
25	Other Admin. Staff Transportation			16,531	16,531		16,531	(1,012)	15,519			25
26	Insurance-Prop.Liab.Malpractice			321,374	321,374		321,374	43,299	364,673			26
27	Other (specify):*			250,906	250,906		250,906	(203,892)	47,014			27
28	TOTAL General Administration	478,260	9,914	2,456,919	2,945,093		2,945,093	(643,593)	2,301,500			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,081,236	615,007	3,853,981	9,550,224		9,550,224	(562,648)	8,987,576			29

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

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

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	35,743		CONTRACT NURSING	XVIII C 53-2	605,570
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		1,872
	CONTRACTED DIETARY SERVICES		38,740		PURCHASED SERVICES		
			74,483		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		291,589		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			291,589		PHARMACY CONSULTANT	XVIII B 39-2	6,929
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		194,355		PSYCHIATRIC	XVIII B __-2	
			194,355		RN CONSULTANT	XVIII B 38-2	13,087
5	HEAT & OTHER UTILITIES						
	GAS HEAT		4,973				
	ELECTRICITY		85,583				
	WATER		12,710				627,458
	CABLE TV - LOBBY		8,178				
6			111,444	11	THERAPY		
	MAINTENANCE				PHYSICAL THERAPY SERVICES		
	GROUND MAINTENANCE		20,525		SPEECH THERAPY SERVICES		
	PAINTING & DECORATING				OCCUPATIONAL THERAPY SERVICES		
	BUILDING REPAIRS				REHABILITATION CONSULTANT	XVIII B __-2	
	MAINTENANCE TRAVEL				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,446
	EQUIPMENT MAINTENANCE & REPAIR		7,393		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	3,054
	ELEVATOR MAINTENANCE & REPAIR				RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	
	OUTSIDE LABOR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,549
	EXTERMINATING SERVICE						
	FIRE SERVICE						11,049
				12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
			27,918		ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,246
7	OTHER			13			3,246
	SCAVENGER		20,960		SOCIAL SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION SERVICES		
					SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	3,746
9			20,960		SOCIAL WORKER	XVIII B 45-2	
							3,746
	MEDICAL DIRECTOR				NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		29,334		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL	LINE	
14	PROGRAM TRANSPORTATION		22	EMPLOYEE BENEFITS & PAYROLL TAXES
	PATIENT TRANSPORTATION	1,480		FICA TAXES XIX D 384,427
		1,480		UNEMPLOYMENT COMPENSATION XIX D 82,274
17	ADMINISTRATIVE		23	WORKERS COMPENSATION INSURANCE XIX D 66,197
	MANAGEMENT FEES XIX B	483,936		HOSPITALIZATION INSURANCE XIX D 76,783
	DIRECTORS FEES			EMPLOYEE BENEFITS - OTHER XIX D 14,874
18	DIRECTORS FEES	0	24	EMPLOYEE PHYSICAL EXAMS XIX D
19	PROFESSIONAL SERVICES			INSURANCE - EXECUTIVE LIFE VI 21/XIX D
	DATA PROCESSING XIX C	42,928		PENSION/PROFIT SHARING PLANS XIX D
	ADMINISTRATIVE CONSULTANTS XIX C		25	
	PROFESSIONAL FEES XIX C	91,147		
	BOOKKEEPING/ADMINISTRATIVE SERVICES	218,400		
20		352,475	26	
	FEES,SUBSCRIPTIONS,PROMOTIONS			INSERVICE TRAINING & EDUCATION
	ENTERTAINMENT & MARKETING VI 19 XIX F			EDUCATION & SEMINARS 12,495
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,473	27	
	EMPLOYEE WANT ADS XIX F	7,000		TRAVEL & SEMINARS
	CONTRIBUTIONS VI 20 XIX F			EDUCATION & SEMINARS XIX G
	DUES & SUBSCRIPTIONS XIX F	11,572	28	TRAVEL XIX G
	LICENSES & PERMITS XIX F	2,257		
	PUBLIC RELATIONS-PATIENT RELATED XIX F			
	ADVERTISING-YELLOW PAGES VI 28 XIX F		29	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F			ADMIN. STAFF TRANSPORTATION
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	19,569		TRANSPORTATION - STAFF 16,531
	HEALTH CARE WORKER BACKGROUND CHE XIX F	3,038	30	
	PATIENT BACKGROUND CHECKS XIX F			INSURANCE - PROP. LIAB & MALPRACTICE
		45,909		GENERAL INSURANCE 321,374
21	CLERICAL & GENERAL OFFICE EXPENSES		31	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,361		
	EQUIPMENT REPAIR & MAINTENANCE	123,145		
	OUTSIDE CLERICAL SERVICES		32	
	PENALTIES / OVERDRAFT CHARGES VI 18	208,122		OTHER
	HOME OFFICE EXPENSE			BAD DEBTS VI 24 250,906
	THEFT & DAMAGE LOSS		33	
	TELEPHONE	16,110		
	MESSENGER SERVICE			
		348,738		

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	384,427
	UNEMPLOYMENT COMPENSATION XIX D	82,274
23	WORKERS COMPENSATION INSURANCE XIX D	66,197
	HOSPITALIZATION INSURANCE XIX D	76,783
	EMPLOYEE BENEFITS - OTHER XIX D	14,874
24	EMPLOYEE PHYSICAL EXAMS XIX D	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	
25		
		624,555
26	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	12,495
		12,495
27	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	
28		
		0
29	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	16,531
		16,531
30	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	321,374
31		321,374
32	OTHER	
	BAD DEBTS VI 24	250,906
		250,906

GRAND TOTAL COLUMN 3 OTHER **3,853,981**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			40,838	40,838		40,838	48,903	89,741			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							234,564	234,564			32
33	Real Estate Taxes							88,571	88,571			33
34	Rent-Facility & Grounds			959,625	959,625		959,625	(778,759)	180,866			34
35	Rent-Equipment & Vehicles			15,786	15,786		15,786	10,246	26,032			35
36	Other (specify):* RENT OFFICE			5,600	5,600		5,600	31,354	36,954			36
37	TOTAL Ownership			1,021,849	1,021,849		1,021,849	(365,121)	656,728			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,454	48,643	109,097		109,097		109,097			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			778,759	778,759		778,759		778,759			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		60,454	827,402	887,856		887,856		887,856			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,081,236	675,461	5,703,232	11,459,929		11,459,929	(927,769)	10,532,160			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(57,345)	30		9
10	Interest and Other Investment Income	(356)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(208,122)	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	(250,906)	27		24
25	Fund Raising, Advertising and Promotional	(2,473)	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	(20,979)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (540,181)		\$	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)	(387,588)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (387,588)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (927,769)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (19,069)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	MARKETING TRAVEL	(1,910)	25	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	(20,979)		49

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.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 778,759	JEROME LANE, LLC		\$	\$ (778,759)	1
2	V								2
3	V	30	DEPRECIATION				101,680	101,680	3
4	V	32	INTEREST EXPENSE				190,466	190,466	4
5	V	32	AMORT LOAN COST				4,900	4,900	5
6	V	33	REAL ESTATE TAXES				84,357	84,357	6
7	V	19	PROFESSIONAL FEES				11,200	11,200	7
8	V	36	INSURANCE-MIP				36,954	36,954	8
9	V	26	INSURANCE-HAZARD				34,509	34,509	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 778,759			\$ 464,066	\$ * (314,693)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$ 245,000	WEISS MANAGEMENT GROUP		\$	\$ (245,000)	15
16	V								16
17	V	17	ADMINISTRATIVE SALARIES				120,777	120,777	17
18	V	17	MANAGEMENT FEES				97,244	97,244	18
19	V	19	PROFESSIONAL FEES				2,711	2,711	19
20	V	20	LICENSES & PERMITS				86	86	20
21	V	21	OFFICE EXPENSES				47,716	47,716	21
22	V	26	INSURANCE				7,481	7,481	22
23	V	27	EMPLOYEE BENEFITS				16,649	16,649	23
24	V	35	AUTO LEASE				9,469	9,469	24
25	V	25	TRANSPORTATION				898	898	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 245,000			\$ 303,031	\$ * 58,031	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	\$ 218,400	BRIA HEALTH SERVICES, LLC		\$	\$ (218,400)	15
16	V	17	MANAGEMENT FEES	238,936				(238,936)	16
17	V								17
18	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	18
19	V	17	SALARIES-CFO				19,489	19,489	19
20	V	6	SALARIES-MAINTENANCE				8,998	8,998	20
21	V	10	SALARIES-A/R				67,956	67,956	21
22	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	22
23	V	21	SALARIES-CLERICAL				89,058	89,058	23
24	V	6	MAINTENANCE				2,197	2,197	24
25	V	7	SCAVENGER				205	205	25
26	V	19	PROFESSIONAL FEES				30,585	30,585	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				5,693	5,693	27
28	V	21	OFFICE EXPENSE				10,971	10,971	28
29	V	23	SEMINARS				94	94	29
30	V	24	TRAVEL				2,982	2,982	30
31	V	26	INSURANCE				1,098	1,098	31
32	V	27	EMPLOYEE BENEFITS				30,365	30,365	32
33	V	30	DEPRECIATION				2,870	2,870	33
34	V	32	INTEREST				37,647	37,647	34
35	V	35	AUTO LEASE				370	370	35
36	V	35	EQUIPMENT RENTAL				407	407	36
37	V								37
38	V								38
39	Total			\$ 457,336			\$ 322,085	\$ * (135,251)	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	36	OFFICE RENT	\$ 5,600	IME REALTY CORPORATION		\$	\$ (5,600)	15
16	V								16
17	V	5	UTILITIES				1,070	1,070	17
18	V	6	MAINTENANCE				519	519	18
19	V	19	PROFESSIONAL FEES				46	46	19
20	V	26	INSURANCE				211	211	20
21	V	30	DEPRECIATION				1,698	1,698	21
22	V	32	INTEREST				1,907	1,907	22
23	V	33	RE TAX				4,214	4,214	23
24	V	21	OFFICE EXPENSE				260	260	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 5,600			\$ 9,925	\$ * 4,325	39

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

Facility Name & ID Number

BRIA OF CAHOKIA

0048645

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	WEISS MGMT		MANAGEMENT/	1
2					GROUP, INC	SKOKIE	CLERICAL	2
3	BRIA OF GENEVA	GENEVA	BRIA OF ELMWOOD	ELMWOOD PARK				3
4					BRIA HEALTH		MANAGEMENT	4
5	BRIA OF FOREST EDGE	CHICAGO			SERVICES, LLC	SKOKIE	SERVICES	5
6								6
7	LAKE PARK CENTER	WAUKEGAN			JEROME LANE,		REAL ESTATE	7
8					LLC	SKOKIE		8
9	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO						9
10		HEIGHTS			IME REALTY	SKOKIE	CORPORATE	10
11							OFFICE	11
12	BRIA OF WESTMONT	WESTMONT						12
13					DA WESTMONT	SKOKIE	MGMT CONSULT	13
14	BRIA OF PALOS HILLS	PALOS HILLS						14
15								15
16	BRIA OF RIVER OAKS	BURNHAM						16
17								17
18	BRIA OF ALTON	ALTON						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

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 WEISS MANAGEMENT GROUP:								\$		1
2	MARTIN WEISS	MEMBER	PRESIDENT	30.00				SALARY	79,200	17-7	2
3	DANIEL WEISS	MEMBER	MANAGEMENT	30.00	SEE			SALARY	11,902	17-7	3
4	NATAN WEISS	MEMBER	FINANCE/MGMT	15.00	ATTACHED			MGMT FEE	13,500	17-7	4
5					SCHEDULE						5
6	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:										6
7	MIRYAM CLEVS	RELATIVE	OFFICE CLERK					SALARY	2,112	21-7	7
8	FRED BERKOVITS	MEMBER	REGIONAL DIR					MGMT FEE	8,988	17-7	8
9	ARIELLA WEIL	RELATIVE	ACCOUNTS PAYABLE					SALARY		21-7	9
10	ALLOCATION FROM DA WESTMONT:										10
11	AVRUM WEINFELD	MEMBER	CFO					SALARY	3,000	17-7	11
12	DANIEL WEISS	MEMBER	ADMINISTRATIVE					SALARY	6,000	17-7	12
13								TOTAL	\$ 124,702		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 CAHOKIA # 0048645 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMINISTRATIVE SALARIES	CENSUS DAYS	79,431	2	\$ 248,400	\$ 248,400	38,621	\$ 120,777	1
2	17	MANAGEMENT FEES	CENSUS DAYS	79,431	2	200,000		38,621	97,244	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	79,431	2	5,575		38,621	2,711	3
4	20	LICENSES & PERMITS	CENSUS DAYS	79,431	2	176		38,621	86	4
5	21	OFFICE EXPENSES	CENSUS DAYS	79,431	2	98,136		38,621	47,716	5
6	26	INSURANCE	CENSUS DAYS	79,431	2	15,386		38,621	7,481	6
7	27	EMPLOYEE BENEFITS	CENSUS DAYS	79,431	2	34,241		38,621	16,649	7
8	35	AUTO LEASE	CENSUS DAYS	79,431	2	19,474		38,621	9,469	8
9	25	TRANSPORTATION	CENSUS DAYS	79,431	2	1,847		38,621	898	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					\$ 623,235	\$ 248,400		\$ 303,031	25

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ☒ 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	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	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	38,621	19,489	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	38,621	8,998	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	38,621	67,956	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	38,621	89,058	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		38,621	2,197	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		38,621	205	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		38,621	30,585	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		38,621	5,693	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		38,621	10,971	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		38,621	94	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		38,621	2,982	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		38,621	1,098	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		38,621	30,365	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		38,621	2,870	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		38,621	37,647	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		38,621	370	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		38,621	407	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,996	\$ 4,030,510		\$ 322,085	25

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	CENSUS DAYS	821,683	19	\$ 22,755	\$	38,621	\$ 1,070	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		38,621	519	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		38,621	46	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		38,621	211	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		38,621	1,698	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		38,621	1,907	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		38,621	4,214	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		38,621	260	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					\$ 211,108	\$		\$ 9,925	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY: JEROME LANE, LLC						\$		\$			\$	1		
2	CAMBRIDGE REALTY	X		MORTGAGE	\$41,556.58	11/01/16		6,705,000	5,623,438	10/01/51	3.3500	190,843	2		
3	LOAN COSTS	X		AMORT OVER LIFE OF LOAN				171,492	126,575			4,900	3		
4													4		
5													5		
	Working Capital														
6													6		
7													7		
8	RELATED PARTY ALLOCATION											39,554	8		
9	TOTAL Facility Related				\$41,556.58		\$	6,876,492	\$	5,750,013			\$	235,297	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	6,876,492	\$	5,750,013			\$	235,297	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	59,069	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.)				\$	71,006	2
3. Under or (over) accrual (line 2 minus line 1).				\$	11,937	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	72,420	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.				\$		6
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.				\$	84,357	7
Assessed Value from Real Estate Tax Bill:	2024	337,381	8			
Real Estate Tax Bill for Calendar Year:	2020	56,061	9			
	2021	49,326	10			
	2022	48,112	11			
	2023	58,484	12			
	2024	71,006	13			
				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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,723 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		2014	\$ 350,000	1
2					2
3	TOTALS			\$ 350,000	3

12/31/2025

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	133		2014		\$ 2,668,552	\$ 101,680	27.5	\$ 56,606	\$ (45,075)	\$ 1,095,410	4
5											5
6											6
7	IME-BLDG				66,177	1,698		1,698			7
8	RELATED PARTY -IMPR				44,713	1,135		1,135			8
	Improvement Type**										
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2006	30,000		27.5	636	636	20,474	9
10	AIR CONDITIONS			2006	947		5			947	10
11	INSTALLATIONS OF EXHAUST SYSTEM			2007	3,340		27.5	71	71	2,244	11
12	AIR CONDITIONS			2007	11,065		5			11,065	12
13	INSTALLATION OF ROOFTOP UNIT			2007	4,140		27.5	88	88	2,749	13
14	CALLCARE STATION REPLACEMENT			2007	3,122		27.5	67	67	2,067	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIO			2007	6,870		15			6,870	15
16	INSTALLATION OF DOORS- FRONT ENTRANCE, VESTIBULE			2007	11,640		27.5	247	247	7,491	16
17	PAINTING			2007	7,587		5			7,587	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS			2007	14,027		5			14,027	18
19	BUILDING RENOVATION AND REMODELING:			2007	228,253		27.5	4,842	4,842	146,288	19
20	A,B,C,D-WINGS CORRIDOR, RESIDENT ROOMS, THERAPY										20
21	ROOM, LOBBY, RECEPTION, ACTIVITY ROOM, HALL-LIGHT										21
22	FIXTURES, FLOORING, CEILING GRID & TILE, HANDRAILS,										22
23	CORNER GUARDS, NURSES STATION B-WING CORRIDOR										23
24	D-WING RESIDENT ROOM-FLOORING			2008	34,382		27.5	729	729	21,719	24
25	SHOWER-VARIOUS DIFFERENT AREAS			2008	16,266		27.5	345	345	10,220	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2008	26,400		27.5	560	560	16,440	26
27	INSTALLED NEW OFFICE, SIDEWALK TO THE OFFICE			2008	29,175		27.5	619	619	18,170	27
28	INSTALLATION OF ALARM SYSTEM			2008	42,875		27.5	909	909	26,568	28
29	INSTALLATION OF DOORS- OXYGEN ROOM, COURTYARD			2008	6,147		27.5	131	131	3,836	29
30	AIR CONDITIONS, WATER HEATER			2008	5,513		5			5,513	30
31	REPLACE EXISTING SPRINKLER PIPING			2008	9,498		27.5	201	201	5,764	31
32	SEALING PARKING LOT			2008	2,500		15			2,500	32
33	WALL AIR CONDITIONS			2009	6,308		5			6,308	33
34	WANDERGUARD E. STANDARD, BUMPER GUARD			2009	10,612		27.5	225	225	6,095	34
35	LOUNGE, RESIDENT & ACTIVITY ROOMS-FLOORING			2010	16,410		27.5	348	348	9,278	35
36				2010	6,712		5			6,712	36

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

Facility Name & ID Number **BRIA OF CAHOKIA**# **0048645**

Report Period Beginning:

01/01/2025

Ending:

12/31/2025**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL DOORS AND HARDWARE	2010	\$ 2,966	\$	27.5	\$ 63	\$ 63	\$ 1,625	37
38	INSTALL ACCELERATOR, REPLACE DRY PENDENT	2010	3,218		27.5	68	68	1,760	38
39	RANCH STYLE GARAGE	2010	15,515		27.5	329	329	8,437	39
40	NEW LAUNDRY ROOM-INSTALL DOORS,CONCRETE SLAB	2010	28,249		27.5	599	599	15,020	40
41	FOOTING FOR PERMIT, ELECTRICAL, WIRING, WINDOW, TILE								41
42	WALL AIR CONDITIONS	2011	6,639		5			6,639	42
43	SEAL COATING PARKING LOT	2011	20,931		15	814	814	20,112	43
44	INSTALLED QUARTER BARREL STYLE AWNINGS	2011	2,955		27.5	62	62	1,529	44
45	RESIDENT ROOMS-CUSTOM BUILT-IN WARDROBES	2011	18,278		27.5	388	388	9,504	45
46	INSTALL RTU & DUST RUN FROM ATTIC INTO ADM OFFICE	2011	12,989		27.5	275	275	6,588	46
47	SHOWER ROOM: FOUR PIESE FIBERGLASS SHOWER;	2011	12,163		27.5	258	258	6,096	47
48	FULL PLYWOOD BACKING ON ALL WALLS; POLYESTER								48
49	GELCOAT FINISH								49
50	WALL AIR CONDITIONS	2012	12,123		5			12,123	50
51	INSTALLED 35 GALLON GREASE TRAP IN THE FLOOR	2012	13,900		27.5	295	295	6,629	51
52	REPLACED PIPE IN ATTIC, INSTALLED COMPRESSOR	2012	12,100		27.5	257	257	5,702	52
53	WALL AIR CONDITIONS	2013	6,903		5			6,903	53
54	SPRINKLERS	2013	91,610		27.5	1,943	1,943	40,666	54
55	CARPET FOR COFFICES AND LOBBY INSET; WALK-OFF								55
56	CARPET; WALL BASE	2013	5,794		5			5,794	56
57	PLASTER CEILING-INSTALL 2 EXPANSION JOINTS; ATTIC								57
58	SPACE-RE-INSULATE WITH 6" BLOWN	2013	10,338		27.5	219	219	4,371	58
59	WALL AIR CONDITIONS	2014	10,764		5			10,764	59
60	INSTALL REDUCED PRESSURE BACKFLOW PREVENTER								60
61	ON FIRE SPRINKLER SERVICE	2014	8,815		27.5	187	187	3,571	61
62	POUR AND FINISH PAD AND WALKWAY	2015	18,283		27.5	388	388	6,844	62
63	INSTALLED A NEW DURO-LAST ROOFING SYSTEM	2015	18,397		27.5	390	390	6,439	63
64	INSTALL SUBPANELS AND FEED PTAC UNITS	2015	21,640		27.5	459	459	7,575	64
65	BUID OUT NEW MAINTENANCE WORKSHOP AND 3	2022	49,000		27.5	1,040	1,040	5,421	65
66	OFFICES: CONCRETE, ELECTRICAL, INSULATION, HVAC								66
67	SPRINKLER PROJECT	2022	98,250		27.5	2,084	2,084	10,867	67
68	REPLACE DOORS AT PHYSICAL THEROPY OPENING								68
69	AND ROOM 54	2023	3,870		27.5	82	82	364	69
70	TOTAL (lines 4 thru 69)		\$ 3,818,921	\$ 104,513		\$ 79,657	\$ (24,856)	\$ 1,667,685	70

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

Facility Name & ID Number **BRIA OF CAHOKIA**# **0048645**

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	
1	Totals from Page 12A, Carried Forward		\$ 3,818,921	\$ 104,513		\$ 79,657	\$ (24,856)	\$ 1,667,685	1
2	RELATED PARTY: JEROME LANE, LLC								2
3	INSTALLED A NEW DURO-LAST ROOFING SYSTEM	2016	66,725		27.5	1,415	1,415	15,971	3
4	A AND C WING CORRIDOR-INSTALLATION OF TILE	2018	17,043		27.5	361	361	4,079	4
5	INSTALL A DIRECT ACCESS/AIPHONE AND DOOR LOCKS	2018	16,704		27.5	354	354	3,996	5
6	COMPLETE & FURNISH MUD WORK & REPAINT	2018	18,255		5			18,255	6
7	23 RESIDENT ROOMS-INSTALLATION OF VINYL TILE AND								7
8	ACRYLIC CEMENT FLOOR	2018	27,152		27.5	576	576	6,498	8
9									9
10									10
11	INTERIOR SEWER LINE SPOT REPAIR IN FOYER/KITCHEN	2023	8,539		27.5	181	181	801	11
12	FURNISH & INSTALL FIRE PROTECTION PIPING FOR A LIGHT								12
13	HAZARD RESIDENTIAL & OFFICE AREA	2023	147,376		27.5	3,126	3,126	13,844	13
14	REPAIRS ON BACK ROOF COATING ON FRONT ROOF	2023	60,813		27.5	1,290	1,290	5,712	14
15	REPLACE EXISTING DOOR-NEW EXIT DEVICE & PASSAGE								15
16	TRIM, THRESHOLD, WEATHERSTRIP, SWEEP, & CLOSER	2023	3,755		27.5	80	80	354	16
17	INSTALL MOP SINK IN EACH OF (2) ROOMS THAT HAVE								17
18	THE SOILED LINEN WATER CLOSETS, THE ICE MACHINE,								18
19	INSTALL 3/4 HOT AND COLD LINE TO THE NEW MOP	2024	19,231		27.5	408	408	1,107	19
20	INSTALL A BOOSTER PUMP SYSTEM FOR THE DOMESTIC								20
21	WATER SYSTEM IN THE SPRINKLER ROOM	2024	14,368		15	559	559	1,517	21
22									22
23									23
24									24
25				40,838			(40,838)		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,218,882	\$ 145,351		\$ 88,006	\$ (57,345)	\$ 1,739,818	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 519,313	\$	\$	\$	5-10	\$ 383,305	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY	13,883	1,735	1,735				74
75	TOTALS	\$ 533,196	\$ 1,735	\$ 1,735	\$		\$ 383,305	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2008 FORD WAGON	2008	\$ 37,400	\$	\$	\$		\$ 37,400	76
77	ADMINISTRATIVE	2007 LAND ROVER/RANGE	2010	33,484					33,484	77
78	FACILITY	2022 FORD TRANSIT VAN	2022	73,480				5	44,088	78
79										79
80	TOTALS			\$ 144,364	\$	\$	\$		\$ 114,972	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)	\$ 5,246,442	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,086	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,741	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (57,345)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,238,095	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 15,786 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					18
19			N/A		19
20					20
21	TOTAL		\$	\$	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.

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.		\$

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THIS FACILITY HIRES ONLY CERTIFIED NURSING AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 14,279	\$		\$ 14,279	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,250			13,250	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			21,114			21,114	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				49,753		49,753	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): IV THERAPY, RENTAL	39-2 39-2					6,894 3,807		6,894 3,807	13
14	TOTAL			\$		\$ 48,643	\$ 60,454		\$ 109,097	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 720,628	\$ 957,131	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 46,068)	2,371,556	2,371,556	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		47,419	6
7	Other Prepaid Expenses	233,159	233,159	7
8	Accounts Receivable (owners or related parties)	545,799	545,799	8
9	Other(specify): ESCROWS, REPL RESERVE	34,396	531,150	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,905,538	\$ 4,686,214	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		2,668,552	14
15	Leasehold Improvements, at Historical Cost	1,293,561	1,439,439	15
16	Equipment, at Historical Cost	663,677	949,177	16
17	Accumulated Depreciation (book methods)	(1,239,379)	(2,722,631)	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) CONSTRUCTION		115,000	22
23	Other(specify): LOAN COST-NET		126,575	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 717,859	\$ 2,926,112	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,623,397	\$ 7,612,326	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,917,928	\$ 1,917,928	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		139,320	29
30	Accrued Salaries Payable	382,941	382,941	30
31	Accrued Taxes Payable (excluding real estate taxes)		72,420	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,699	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PA LOAN	727,900	727,900	36
37	DUE TO RELATED PARTIES	439,716	439,716	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,468,485	\$ 3,695,924	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,484,118	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)	\$	\$ 5,484,118	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,468,485	\$ 9,180,042	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,154,912	\$ (1,567,716)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,623,397	\$ 7,612,326	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,379,884	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,379,884	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(224,972)	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)	\$ (224,972)	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)	\$ 1,154,912	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF CAHOKIA

0048645

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,670,919	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,670,919	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,873	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 142,873	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***	356	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 356	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	457,864	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 457,864	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,272,012	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,601,293	31
32	Health Care	5,003,838	32
33	General Administration	2,945,093	33
	B. Capital Expense		
34	Ownership	1,021,849	34
	C. Ancillary Expense		
35	Special Cost Centers	109,097	35
36	Provider Participation Fee	778,759	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,459,929	40
41	Income before Income Taxes (line 30 minus line 40)**	(187,917)	41
42	Income Taxes	(37,055)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (224,972)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,143,656.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	8,001,230.00	45
46	MMAI-Medicaid is the Primary Payer	400,197.00	46
47	MMAI-Medicare is the Primary Payer	48,287.00	47
48	Private Pay	26,450.00	48
49	Medicare Part A	857,971.00	49
50	Other-(specify) HOSPICE	71,720.00	50
51	Other-(specify) INSURANCE	121,408.00	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)	\$ 10,670,919	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,884	1,956	\$ 142,247	\$ 72.72	1
2	Assistant Director of Nursing	2,672	2,792	137,961	49.41	2
3	Registered Nurses	1,893	2,091	100,959	48.28	3
4	Licensed Practical Nurses	25,811	28,472	1,166,565	40.97	4
5	CNAs & Orderlies	67,842	78,237	1,925,409	24.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,661	12,684	188,853	14.89	8
9	Activity Director					9
10	Activity Assistants	6,472	7,244	124,561	17.20	10
11	Social Service Workers	4,145	4,442	196,025	44.13	11
12	Dietician					12
13	Food Service Supervisor	1,828	1,992	52,919	26.57	13
14	Head Cook	7,752	8,373	137,773	16.45	14
15	Cook Helpers/Assistants	8,862	9,636	140,273	14.56	15
16	Dishwashers					16
17	Maintenance Workers	5,649	6,158	143,331	23.28	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,312	1,419	154,990	109.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,528	8,119	323,270	39.82	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	1,969	2,092	51,881	24.80	31
32	Other Health C: Care Plan Coord	1,888	2,103	94,219	44.80	32
33	Other(specify) Security					33
34	TOTAL (lines 1 - 33)	159,168	177,810	\$ 5,081,236 *	\$ 28.58	34

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	\$ 35,743	1-3	35
36	Medical Director	O	29,334	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,929	10-3	39
40	Physical Therapy Consultant	L	5,446	10A-3	40
41	Occupational Therapy Consultant	Y	3,054	10A-3	41
42	Respiratory Therapy Consultant		0	10A-3	42
43	Speech Therapy Consultant	F	2,549	10A-3	43
44	Activity Consultant	E	3,246	11-3	44
45	Social Service Consultant	E	3,746	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 90,047		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 269,184		50
51	Licensed Practical Nurses		174,730		51
52	Certified Nurse Assistants/Aides		161,656		52
53	TOTAL (lines 50 - 52)		\$ 605,570		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBRIA OF CAHOKIA# 0048645Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

ALICIA BAUER

Administrator

0

\$ 154,990

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 154,990

B. Administrative - Other

Description

Amount

WEISS MGMT GROUP, INC

MANAGEMENT FEES

\$ 245,000

MANAGEMENT FEES

238,936

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 483,936

C. Professional Services

Vendor/Payee

Type

Amount

\$

SCHEDULE ATTACHED

352,475

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 352,475

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 66,197

Unemployment Compensation Insurance

82,274

FICA Taxes

384,427

Employee Health Insurance

76,783

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

EMPLOYEE BENEFITS - OTHER

14,874

EMPLOYEE PHYSICAL EXAMS

PENSION/PROFIT SHARING PLANS

INSURANCE - EXECUTIVE LIFE

TOTAL (agree to Schedule V, line 22, col.8)

\$ 624,555

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

\$

Advertising: Employee Recruitment

7,000

Health Care Worker Background Check

(Indicate # of checks performed)

3,038

Patient Background Checks

Association Dues (total from pg 22, #4)

23,491

TRUST/FRANCHISE/CONTRIB/ETC

500

MARKETING/ADV/PROMO

2,473

LICENSES/DUES/SUBSCRIPTIONS

9,407

MGMT CO ALLOC

5,779

Less: Public Relations Expense

()

PAC and Lobbying payments

(19,069)

All non-allowable advertising

(2,473)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 30,146

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

MARKETING TRAVEL

MGMT CO ALLOC

2,982

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 2,982

* Attach copy of IMRF notifications

**See instructions.

BRIA OF CAHOKIA
LEGAL EXPENSES
1/1/2025-12/31/2025

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/31/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,615
2/28/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,742
3/31/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,785
4/30/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,828
5/31/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,700
6/30/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,785
7/31/2025	GARY A. WEINTRAUB, P.C.	CONSULTATION REGARDING COMPLIANCE WITH OBRA	1,658
1/31/2025	HINSHAW & CULBERTSON LLP	APPEARED & ATTENDED IDPH STATUS HEARINGS	219
2/28/2025	HINSHAW & CULBERTSON LLP	SETTLEMENT NEGOTIATIONS WITH IDPH	1,440
5/1/2025	HINSHAW & CULBERTSON LLP	REVIEW AND ANALYSIS OF IDPH PROPOSED AGREEMENT	912
5/31/2025	HINSHAW & CULBERTSON LLP	REVIEW AND ANALYSIS OF CMS PROPOSED AGREEMENT	350
6/23/2025	HINSHAW & CULBERTSON LLP	DRAFT NOTICE OF HEARING AND REQUEST FOR HEARING	1,614
4/18/2025	JACKON LEWIS	EVALUATE SETTLEMENT NEGOTIATIONS	3,711
5/15/2025	JACKON LEWIS	REVIEW STATUS OF SETTLEMENT NEGOTIATIONS	3,585
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
5/31/2025	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
6/25/2025	KANSAS PAYMENT CENTER	SETTLEMENT	8,465
TOTAL			<u>37,309</u>

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
<u>HEALTH CARE COUNCIL OF IL (HCCI)</u>	<u>4,422</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>4,422</u> 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.

<u>HEALTH CARE COUNCIL OF IL (HCCI)</u>	<u>19,069</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>19,069</u> Total
- (4)

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

<u>HEALTH CARE COUNCIL OF IL (HCCI)</u>	<u>23,491</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>23,491</u> Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$ 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.

\$ 778,759

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?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$ N/A NO
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name:

NO
- (14)

Have all costs which do not relate to the provision of long term care been adjusted 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.