

		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: 0057505

Facility Name: BRIA OF GODFREY

Address: 1623 WEST DELMER GODFREY 62035
Number City Zip Code

County: MADISON

Telephone Number: (618) 466-0443 Fax #: (618) 446-1597

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

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 12/31/2025 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 GODFREY # 0057505 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	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	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				42		966	297	1,305	8
9	SNF/PED									9
10	ICF	1,781	9,458	1,372		1,708		2,842	17,161	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,781	9,458	1,372	42	1,708	966	3,139	18,466	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 74.40%

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 07/01/2022

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 68

Medicare Intermediary NORIDIAN

IV. ACCOUNTING BASIS

ACCURAL ☒ 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 GODFREY** # **0057505** 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	133,134	16,914	151,974	302,022		302,022		302,022			1
2	Food Purchase		146,332		146,332		146,332		146,332			2
3	Housekeeping		433	146,643	147,076		147,076		147,076			3
4	Laundry		3,244	107,120	110,364		110,364		110,364			4
5	Heat and Other Utilities			117,270	117,270		117,270	511	117,781			5
6	Maintenance	38,534	87,260	36,091	161,885		161,885	5,600	167,485			6
7	Other (specify):* Scavenger			13,875	13,875		13,875	98	13,973			7
8	TOTAL General Services	171,668	254,183	572,973	998,824		998,824	6,209	1,005,033			8
	B. Health Care and Programs											
9	Medical Director			29,334	29,334		29,334		29,334			9
10	Nursing and Medical Records	1,266,779	102,704	576,108	1,945,591		1,945,591	32,492	1,978,083			10
10a	Therapy	118,288		4,514	122,802		122,802		122,802			10a
11	Activities	93,753	2,533	1,750	98,036		98,036		98,036			11
12	Social Services	48,383	355	2,250	50,988		50,988		50,988			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,527,203	105,592	613,956	2,246,751		2,246,751	32,492	2,279,243			16
	C. General Administration											
17	Administrative	115,541		88,915	204,456		204,456	(70,609)	133,847			17
18	Directors Fees											18
19	Professional Services			193,882	193,882		193,882	(80,554)	113,328			19
20	Dues, Fees, Subscriptions & Promotions			31,538	31,538		31,538	(11,698)	19,840			20
21	Clerical & General Office Expenses	230,214	6,234	172,986	409,434		409,434	(44,534)	364,900			21
22	Employee Benefits & Payroll Taxes			294,679	294,679		294,679		294,679			22
23	Inservice Training & Education			8,621	8,621		8,621	45	8,666			23
24	Travel and Seminar							1,426	1,426			24
25	Other Admin. Staff Transportation			9,092	9,092		9,092	(2,848)	6,244			25
26	Insurance-Prop.Liab.Malpractice			278,974	278,974		278,974	625	279,599			26
27	Other (specify):*			80,565	80,565		80,565	(66,047)	14,518			27
28	TOTAL General Administration	345,755	6,234	1,159,252	1,511,241		1,511,241	(274,194)	1,237,047			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,044,626	366,009	2,346,181	4,756,816		4,756,816	(235,493)	4,521,323			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	27,499		CONTRACT NURSING	XVIII C 53-2	566,073
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		893
	CONTRACTED DIETARY SERVICES		124,475		PURCHASED SERVICES		
			151,974		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		146,643		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			146,643		PHARMACY CONSULTANT	XVIII B 39-2	2,997
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		107,120		PSYCHIATRIC	XVIII B __-2	
			107,120		RN CONSULTANT	XVIII B 38-2	6,145
5	HEAT & OTHER UTILITIES						
	GAS HEAT		7,080				
	ELECTRICITY		67,173				
	WATER		35,267				576,108
	CABLE TV - LOBBY		7,750		THERAPY		
			117,270		PHYSICAL THERAPY SERVICES		
6	MAINTENANCE			11	SPEECH THERAPY SERVICES		
	GROUNDS MAINTENANCE		26,145		OCCUPATIONAL THERAPY SERVICES		
	PAINTING & DECORATING				REHABILITATION CONSULTANT	XVIII B __-2	
	BUILDING REPAIRS				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,401
	MAINTENANCE TRAVEL				OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	1,351
	EQUIPMENT MAINTENANCE & REPAIR				RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	1,022
	ELEVATOR MAINTENANCE & REPAIR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	740
	OUTSIDE LABOR						
	EXTERMINATING SERVICE						
	FIRE SERVICE		9,946				4,514
				12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,750
7	OTHER			13			1,750
	SCAVENGER		13,875		SOCIAL SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION SERVICES		
					SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	2,250
			13,875		SOCIAL WORKER	XVIII B 45-2	
9	MEDICAL DIRECTOR			13			2,250
	MEDICAL DIRECTOR FEES		29,334		NURSE AIDE TRAINING		
			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				FICA TAXES	XIX D	151,826
			0		UNEMPLOYMENT COMPENSATION	XIX D	14,415
17	ADMINISTRATIVE				WORKERS COMPENSATION INSURANCE	XIX D	31,093
	MANAGEMENT FEES	XIX B	88,915		HOSPITALIZATION INSURANCE	XIX D	85,618
	DIRECTORS FEES				EMPLOYEE BENEFITS - OTHER	XIX D	11,727
18	DIRECTORS FEES		0		EMPLOYEE PHYSICAL EXAMS	XIX D	
19	PROFESSIONAL SERVICES				INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	
	DATA PROCESSING	XIX C	37,920		PENSION/PROFIT SHARING PLANS	XIX D	
	ADMINISTRATIVE CONSULTANTS	XIX C					
	PROFESSIONAL FEES	XIX C	60,762				
	BOOKKEEPING/ADMINISTRATIVE SERVICES		95,200				294,679
			193,882	23	INSERVICE TRAINING & EDUCATION		
20	FEES,SUBSCRIPTIONS,PROMOTIONS				EDUCATION & SEMINARS		8,621
	ENTERTAINMENT & MARKETING	VI 19 XIX F					8,621
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,091	24	TRAVEL & SEMINARS		
	EMPLOYEE WANT ADS	XIX F	7,000		EDUCATION & SEMINARS	XIX G	
	CONTRIBUTIONS	VI 20 XIX F			TRAVEL	XIX G	
	DUES & SUBSCRIPTIONS	XIX F	4,038				0
	LICENSES & PERMITS	XIX F	3,902	25	ADMIN. STAFF TRANSPORTATION		
	PUBLIC RELATIONS-PATIENT RELATED	XIX F			TRANSPORTATION - STAFF		9,092
	ADVERTISING-YELLOW PAGES	VI 28 XIX F					9,092
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		26	INSURANCE - PROP. LIAB & MALPRACTICE		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	11,329		GENERAL INSURANCE		278,974
	HEALTH CARE WORKER BACKGROUND CHE	XIX F	2,178				
	PATIENT BACKGROUND CHECKS	XIX F					278,974
			31,538	27	OTHER		
21	CLERICAL & GENERAL OFFICE EXPENSES				BAD DEBTS	VI 24	80,565
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,624				80,565
	EQUIPMENT REPAIR & MAINTENANCE		85,983				
	OUTSIDE CLERICAL SERVICES						
	PENALTIES / OVERDRAFT CHARGES	VI 18	73,653				
	HOME OFFICE EXPENSE						
	THEFT & DAMAGE LOSS						
	TELEPHONE		11,726				
	MESSENGER SERVICE						
			172,986				

	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES	XIX D 151,826
	UNEMPLOYMENT COMPENSATION	XIX D 14,415
	WORKERS COMPENSATION INSURANCE	XIX D 31,093
	HOSPITALIZATION INSURANCE	XIX D 85,618
	EMPLOYEE BENEFITS - OTHER	XIX D 11,727
	EMPLOYEE PHYSICAL EXAMS	XIX D
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D
	PENSION/PROFIT SHARING PLANS	XIX D
		294,679
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	8,621
		8,621
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS	XIX G
	TRAVEL	XIX G
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,092
		9,092
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	278,974
		278,974
27	OTHER	
	BAD DEBTS	VI 24 80,565
		80,565

GRAND TOTAL COLUMN 3 OTHER 2,346,181

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			8,015	8,015		8,015	10,898	18,913			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,930	35,930		35,930	18,810	54,740			32
33	Real Estate Taxes							2,015	2,015			33
34	Rent-Facility & Grounds			495,517	495,517		495,517		495,517			34
35	Rent-Equipment & Vehicles			21,391	21,391		21,391	371	21,762			35
36	Other (specify):* RENT OFFICE			2,800	2,800		2,800	(2,800)				36
37	TOTAL Ownership			563,653	563,653		563,653	29,294	592,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,395	22,282	73,677		73,677		73,677			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			305,720	305,720		305,720		305,720			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		51,395	328,002	379,397		379,397		379,397			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,044,626	417,404	3,237,836	5,699,866		5,699,866	(206,200)	5,493,667			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	8,715	30		9
10	Interest and Other Investment Income	(102)	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	(73,653)	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	(80,565)	27		24
25	Fund Raising, Advertising and Promotional	(3,091)	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	(35,122)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,819)		\$	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)	(22,381)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,381)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (206,200)		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	\$ (11,329)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING SALARIES	(20,945)	21	3
4	MARKETING TRAVEL	(2,848)	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
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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	(35,122)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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	36	RENT OFFICE	\$ 2,800	IME REALTY CORPORATION		\$	\$ (2,800)	1
2	V								2
3	V	5	UTILITIES				511	511	3
4	V	6	MAINTENANCE				248	248	4
5	V	19	PROFESSIONAL FEES				22	22	5
6	V	26	INSURANCE				100	100	6
7	V	30	DEPRECIATION				810	810	7
8	V	32	INTEREST				912	912	8
9	V	33	RE TAX				2,015	2,015	9
10	V	21	OFFICE EXPENSE				124	124	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,800			\$ 4,742	\$ * 1,942	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	19	BOOKKEEPING/ADM SERVICES	\$ 95,200	BRIA HEALTH SERVICES, LLC		\$	\$ (95,200)	15
16	V	17	MANAGEMENT FEES	88,915				(88,915)	16
17	V								17
18	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	18
19	V	17	SALARIES-CFO				9,318	9,318	19
20	V	6	SALARIES-MAINTENANCE				4,302	4,302	20
21	V	10	SALARIES-A/R				32,492	32,492	21
22	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	22
23	V	21	SALARIES-CLERICAL				42,582	42,582	23
24	V	6	MAINTENANCE				1,050	1,050	24
25	V	7	SCAVENGER				98	98	25
26	V	19	PROFESSIONAL FEES				14,624	14,624	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				2,722	2,722	27
28	V	21	OFFICE EXPENSE				5,246	5,246	28
29	V	23	SEMINARS				45	45	29
30	V	24	TRAVEL				1,426	1,426	30
31	V	26	INSURANCE				525	525	31
32	V	27	EMPLOYEE BENEFITS				14,518	14,518	32
33	V	30	DEPRECIATION				1,373	1,373	33
34	V	32	INTEREST				18,000	18,000	34
35	V	35	AUTO LEASE				177	177	35
36	V	35	EQUIPMENT RENTAL				194	194	36
37	V								37
38	V								38
39	Total			\$ 184,115			\$ 159,792	\$ * (24,323)	39

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

Facility Name & ID Number

BRIA OF GODFREY

0057505

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	BRIA HEALTH		MANAGEMENT	1
2					SERVICES, LLC	SKOKIE	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					OFFICE	5
6								6
7	LAKE PARK CENTER	WAUKEGAN			WEISS MGMT	SKOKIE	MANAGEMENT/	7
8					GROUP, INC		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 ALTON	ALTON						18
19								19
20	BELLEVILLE HEALTHCARE CENTER	BELLEVILLE						20
21								21
22	BRIA OF COLUMBIA	COLUMBIA						22
23								23
24	BRIA OF CAHOKIA	CAHOKIA						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 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 GODFREY # 0057505 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	\$	18,466	\$ 511	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		18,466	248	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		18,466	22	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		18,466	100	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		18,466	810	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		18,466	912	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		18,466	2,015	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		18,466	124	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	\$		\$ 4,742	25

Facility Name & ID Number BRIA OF GODFREY # 0057505 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	18,466	9,318	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	18,466	4,302	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	18,466	32,492	4
5	21	SALARIES-CLERICAL RELATED	wghtd avr hours	38	19	83,992	83,992	2	2,112	5
6	21	SALARIES-CLERICAL	CENSUS DAYS	821,683	19	1,894,762	1,894,762	18,466	42,582	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		18,466	1,050	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		18,466	98	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		18,466	14,624	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		18,466	2,722	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		18,466	5,246	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		18,466	45	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		18,466	1,426	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		18,466	525	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		18,466	14,518	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		18,466	1,373	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		18,466	18,000	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		18,466	177	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		18,466	194	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,880,106	\$ 4,030,620		\$ 159,792	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							\$		\$			\$	1
2	FORGE INVESTMENTS LLC	X		WORKING CAPITAL		07/05/22	400,000	400,000	07/05/28	7.0000	20,696	2	
3												3	
4												4	
5												5	
	Working Capital												
6	OPTIMUM BANK	X		LOC		09/01/22	600,000	254,308		PRIME+	15,234	6	
7												7	
8	RELATED PARTY ALLOCATION											8	
9	TOTAL Facility Related						\$ 1,000,000	\$ 654,308			\$ 35,930	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	\$ 654,308			\$ 35,930	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.)

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	536,730	8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023	37,443	12		
	2024	39,198	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.

FACILITY NAME	<u>BRIA OF GODFREY</u>	COUNTY	<u>MADISON</u>
---------------	------------------------	--------	----------------

CONTACT PERSON REGARDING THIS REPORT MITCH KOHANANOO

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,330 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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				\$	1
2					2
3	TOTALS			\$	3

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

0057505

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7	IME-BLDG				31,640	810		810			7
8	RELATED PARTY -IMPR				21,379	543		543			8
	Improvement Type**										
9	WALK IN FREEZER: FURNISH AND INSTALL NEW 3-PHASE										9
10	CONSENER AND BRAZE NECESSARY LINES, NEW SOLENOID										10
11	TXV AND THERMOSTAT AS WELL			2023	13,870		27.5	294	294	1,302	11
12	LABOR, ENG SPR REPAIRS ANTIFREEZE REPLACEMENT			2023	15,665		27.5	354	354	1,566	12
13	ROOF: INSTALL 1.5" ISO BOARD OVER EXISTING ROOF,										13
14	60MIL TPO SYSTEM, TERMINATION BAR AT PERIMETER OF THE										14
15	BULDING			2023	140,000		27.5	2,970	2,970	13,152	15
16	ROOMS 25& 14, TIME CLOCL HALL, SHOWE-DOORS WITH HINGE										16
17	& LOCK PREPS , FIRE RATED METAL DOORS, EXTRA DOORS			2023	5,296		27.5	113	113	499	17
18	RE-CIORCULATING LINE IN CRAWL SPACE + EXTRAS TREE										18
19	THERMOSTATS			2023	14,250		27.5	302	302	1,338	19
20	RE-PIPED 4" SEWER LINE IN CRAWLSPACE			2023	3,300						20
21	DINING ROOM-FURNISH & INSTALL NEW ADP AIR HANDLER			2024	8,657		15	337	337	914	21
22	RESIDENT, SHOWER , THERAPY ROOMS:FLOORING, PAINTING,										22
23	TILE, INSTALL NEW LVP, NEW COVE BASE, LED LIGHTS			2024	325,000		27.5	6,894	6,894	18,712	23
24	REPLACE FEED FOR PANEL			2024	5,984		15	232	232	630	24
25	SANITARY SEWER MODIFICATION: FURNISHED MATERIAL, LABOR,										25
26	EQUIPMENT, AND SUPERVISION			2024	9,998		27.5	212	212	575	26
27	FURNISH AND INSTALL COMPRESSOR FOR KITCHEN AREA			2024	3,828		15	149	149	404	27
28	INSTALL INSULATION FOR WEATHERPROOFING AROUND										28
29	WINDOWS			2024	15,000		27.5	318	318	863	29
30	FURNISH ANA INSTALL NEW AMERICAN STANDARD 5TON										30
31	COOLING ONLY UNIT			2024	15,035		15	585	585	1,587	31
32											32
33											33
34						8,015			(8,015)		34
35											35
36											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

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									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)		\$ 628,902	\$ 9,368		\$ 14,111	\$ 4,743	\$ 41,540	70

**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	\$ 39,721	\$	\$ 3,972	\$ 3,972	8-10	\$ 11,089	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY	6,638	830	830				74
75	TOTALS	\$ 46,359	\$ 830	\$ 4,802	\$ 3,972		\$ 11,089	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)	\$ 675,261	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,198	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,913	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,715	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 52,629	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: SOUTHERN ILLINOIS MASTER TENANT 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. ☐ 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:		68	07/01/22	\$ 495,517	10		3
4	Additions							4
5								5
6								6
7	TOTAL		68		\$ 495,517			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: *

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: \$ 19,697 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	2022 RAM PROMASTER	#####	1,694	18
19					19
20					20
21	TOTAL		\$ #####	\$ 1,694	21

10. Effective dates of current rental agreement:
Beginning 07/01/2022
Ending 06/30/2032

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

	Fiscal Year Ending	Annual Rent
12.	12/2026	\$ 412,165
13.	12/2027	\$ 418,347
14.	12/2028	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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	\$		\$ 8,555	\$		\$ 8,555	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,425			3,425	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			10,302			10,302	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				45,441		45,441	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
	MED.SUPPLIES/LAB/RADIOLOGY	39-2					1,848		1,848	
13	Other (specify): IV THERAPY, RENTAL	39-2					4,106		4,106	13
14	TOTAL			\$		\$ 22,282	\$ 51,395		\$ 73,677	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	\$21,388	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance41,020)	1,100,223		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	124,845		7
8	Accounts Receivable (owners or related parties)	114,625		8
9	Other(specify): ESCROWS	198,148		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,559,229	\$	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	194,514		15
16	Equipment, at Historical Cost	39,721		16
17	Accumulated Depreciation (book methods)	(42,230)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$192,005	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$1,751,234	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$1,183,488	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	654,308		29
30	Accrued Salaries Payable	115,408		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	DUE TO RELATED PARTY	733,430		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$2,686,634	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$2,686,634	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$(935,400)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$1,751,234	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (886,900)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (886,900)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(48,500)	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)	\$ (48,500)	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)	\$ (935,400)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF GODFREY

0057505

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	\$ 5,402,960	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,402,960	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	104,868	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 104,868	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***	102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 102	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	143,436	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 143,436	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,651,366	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	998,824	31
32	Health Care	2,246,751	32
33	General Administration	1,511,241	33
	B. Capital Expense		
34	Ownership	563,653	34
	C. Ancillary Expense		
35	Special Cost Centers	73,677	35
36	Provider Participation Fee	305,720	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,699,866	40
41	Income before Income Taxes (line 30 minus line 40)**	(48,500)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (48,500)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 465,329.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,464,041.00	45
46	MMAI-Medicaid is the Primary Payer	355,352.00	46
47	MMAI-Medicare is the Primary Payer	16,910.00	47
48	Private Pay	509,003.00	48
49	Medicare Part A	695,842.00	49
50	Other-(specify) HOSPICE	737,113.00	50
51	Other-(specify) INSURANCE	159,370.00	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)	\$ 5,402,960	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	1,981	2,109	\$ 122,659	\$ 58.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,393	5,596	263,971	47.17	3
4	Licensed Practical Nurses	4,228	4,603	173,998	37.80	4
5	CNAs & Orderlies	23,328	24,587	577,723	23.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,761	2,808	118,288	42.13	8
9	Activity Director					9
10	Activity Assistants	4,286	4,507	93,753	20.80	10
11	Social Service Workers	2,016	2,084	48,383	23.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,800	7,879	133,134	16.90	15
16	Dishwashers					16
17	Maintenance Workers	1,647	1,759	38,534	21.91	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,016	2,080	115,541	55.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,229	8,811	230,214	26.13	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	1,918	2,109	43,454	20.60	31
32	Other Health C: Care Plan Coord	1,963	2,075	84,974	40.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	67,566	71,007	\$ 2,044,626 *	\$ 28.79	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	\$ 27,499	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	2,997	10-3	39
40	Physical Therapy Consultant	L	1,401	10a-3	40
41	Occupational Therapy Consultant	Y	1,351	10a-3	41
42	Respiratory Therapy Consultant		1,022	10a-3	42
43	Speech Therapy Consultant	F	740	10a-3	43
44	Activity Consultant	E	1,750	11-3	44
45	Social Service Consultant	E	2,250	12-3	45
46	Other(specify) Psychiatric	S	0	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 68,344		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 99,844		50
51	Licensed Practical Nurses		202,592		51
52	Certified Nurse Assistants/Aides		263,637		52
53	TOTAL (lines 50 - 52)		\$ 566,073		53

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

** See instructions.

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

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/3/2025	BRIAN A STINES PC	COLLECTIONS	250
3/1/2025	BRIAN A STINES PC	COLLECTIONS	250
	BRIAN A STINES PC	COLLECTIONS	1,125
1/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	70
2/28/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF PREHEARING NOTICE	479
3/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	210
5/1/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	630
5/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTEND STATUS HEARING	105
6/23/2025	HINSHAW & CULBERTSON	REVIEW AND ANALYSIS OF FINAL ORDER FROM IDPH	99
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
3/1/2025	SCOTT & KRAUS	EDITED AND REVISED DACA AND DAISA	455
5/12/2025	SCOTT & KRAUS	REVIEW CORRESPONDENCE REGARDING DACA & DAISA	725
TOTAL			9,298

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>4,038</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>4,038</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>11,329</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>11,329</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>15,367</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>15,367</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.

\$ 305,720

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? 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?

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?

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.