

		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: 0057349

Facility Name: BRIA OF MASCOUTAH

Address: 901 NORTH TENTH ST MASCOUTAH 62258

County: SAINT CLAIR

Telephone Number: (618) 566-2183 Fax # (618) 619-7333

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

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 09/30/2025 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)

(Type or Print Name) AVRUM WEINFELD

(Title) CEO

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)

(Date)

Paid Preparer

(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 MASCOUTAH # 0057349 Report Period Beginning: 01/01/2025 Ending: 09/30/2025

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	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>15,015</u>	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	<u>55</u>	TOTALS	<u>55</u>	<u>15,015</u>	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			988	37		884	288	2,197	8
9	SNF/PED									9
10	ICF	2,908	5,604			1,332		1,182	11,026	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,908	5,604	988	37	1,332	884	1,470	13,223	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 88.07%

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 01/01/2022

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 55

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 MASCOUTAH

0057349

Report Period Beginning:

01/01/2025

Ending:

09/30/2025

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	140,381	9,782	26,379	176,542		176,542		176,542			1
2	Food Purchase		117,152		117,152		117,152	(119)	117,033			2
3	Housekeeping	63,713	9,653	13,459	86,825		86,825		86,825			3
4	Laundry	20,537	8,650	8,973	38,160		38,160		38,160			4
5	Heat and Other Utilities			61,138	61,138		61,138	366	61,504			5
6	Maintenance	37,330	69,338	26,616	133,284		133,284	4,011	137,295			6
7	Other (specify):* Scavenger			7,165	7,165		7,165	70	7,235			7
8	TOTAL General Services	261,961	214,575	143,730	620,266		620,266	4,328	624,594			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	1,157,893	105,345	428,594	1,691,832		1,691,832	23,267	1,715,099			10
10a	Therapy	93,078		16,831	109,909		109,909		109,909			10a
11	Activities	65,777	1,056	1,433	68,266		68,266		68,266			11
12	Social Services	36,706	400	1,433	38,539		38,539		38,539			12
13	CNA Training											13
14	Program Transportation			67	67		67		67			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,353,454	106,801	470,358	1,930,613		1,930,613	23,267	1,953,880			16
	C. General Administration											
17	Administrative	78,195			78,195		78,195	15,661	93,856			17
18	Directors Fees											18
19	Professional Services			161,386	161,386		161,386	(75,832)	85,554			19
20	Dues, Fees, Subscriptions & Promotions			28,539	28,539		28,539	(13,832)	14,707			20
21	Clerical & General Office Expenses	48,841	5,425	79,721	133,987		133,987	36,449	170,436			21
22	Employee Benefits & Payroll Taxes			252,299	252,299		252,299		252,299			22
23	Inservice Training & Education			4,549	4,549		4,549	32	4,581			23
24	Travel and Seminar							1,021	1,021			24
25	Other Admin. Staff Transportation			3,645	3,645		3,645		3,645			25
26	Insurance-Prop.Liab.Malpractice			150,612	150,612		150,612	448	151,060			26
27	Other (specify):*			45,251	45,251		45,251	(34,855)	10,396			27
28	TOTAL General Administration	127,036	5,425	726,002	858,463		858,463	(70,908)	787,555			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,742,451	326,801	1,340,090	3,409,342		3,409,342	(43,313)	3,366,029			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	26,379		CONTRACT NURSING	XVIII C 53-2	415,218
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		1,677
	CONTRACTED DIETARY SERVICES				PURCHASED SERVICES		
			26,379		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		13,459		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			13,459		PHARMACY CONSULTANT	XVIII B 39-2	2,873
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		8,973		PSYCHIATRIC	XVIII B __-2	4,500
			8,973		RN CONSULTANT	XVIII B 38-2	4,326
5	HEAT & OTHER UTILITIES						
	GAS HEAT		13,639				
	ELECTRICITY		30,575				
	WATER		13,626				428,594
	CABLE TV - LOBBY		3,298		THERAPY		
			61,138		PHYSICAL THERAPY SERVICES		
6	MAINTENANCE			11	SPEECH THERAPY SERVICES		
	GROUND'S MAINTENANCE		17,610		OCCUPATIONAL THERAPY SERVICES		
	PAINTING & DECORATING				REHABILITATION CONSULTANT	XVIII B __-2	
	BUILDING REPAIRS				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	8,218
	MAINTENANCE TRAVEL				OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	4,746
	EQUIPMENT MAINTENANCE & REPAIR				RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	1,101
	ELEVATOR MAINTENANCE & REPAIR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,766
	OUTSIDE LABOR						
	EXTERMINATING SERVICE						
	FIRE SERVICE		9,006				16,831
				12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,433
7	OTHER			13			1,433
	SCAVENGER		7,165		SOCIAL SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION SERVICES		
					SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,433
			7,165		SOCIAL WORKER	XVIII B 45-2	
9	MEDICAL DIRECTOR			13			1,433
	MEDICAL DIRECTOR FEES		22,000		NURSE AIDE TRAINING		
			22,000		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL	LINE	
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION	67		
		67		
17	ADMINISTRATIVE			
	MANAGEMENT FEES XIX B	0		
18	DIRECTORS FEES			
	DIRECTORS FEES	0		
19	PROFESSIONAL SERVICES			
	DATA PROCESSING XIX C	27,742		
	ADMINISTRATIVE CONSULTANTS XIX C			
	PROFESSIONAL FEES XIX C	42,924		
	BOOKKEEPING/ADMINISTRATIVE SERVICES	90,720		
20		161,386		
	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING VI 19 XIX F			
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,086		
	EMPLOYEE WANT ADS XIX F	7,000		
	CONTRIBUTIONS VI 20 XIX F	400		
	DUES & SUBSCRIPTIONS XIX F	2,874		
	LICENSES & PERMITS XIX F	1,293		
	PUBLIC RELATIONS-PATIENT RELATED XIX F			
	ADVERTISING-YELLOW PAGES VI 28 XIX F			
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F			
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	12,295		
	HEALTH CARE WORKER BACKGROUND CHE XIX F			
	PATIENT BACKGROUND CHECKS XIX F	1,591		
		28,539		
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,790		
	EQUIPMENT REPAIR & MAINTENANCE	64,406		
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES VI 18			
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE	12,525		
	MESSENGER SERVICE			
		79,721		

SCHED REF	TOTAL	LINE	
		22	EMPLOYEE BENEFITS & PAYROLL TAXES
			FICA TAXES XIX D 129,177
			UNEMPLOYMENT COMPENSATION XIX D 25,741
			WORKERS COMPENSATION INSURANCE XIX D 39,786
			HOSPITALIZATION INSURANCE XIX D 48,746
			EMPLOYEE BENEFITS - OTHER XIX D 8,849
			EMPLOYEE PHYSICAL EXAMS XIX D
			INSURANCE - EXECUTIVE LIFE VI 21/XIX D
			PENSION/PROFIT SHARING PLANS XIX D
			252,299
		23	INSERVICE TRAINING & EDUCATION
			EDUCATION & SEMINARS 4,549
			4,549
		24	TRAVEL & SEMINARS
			EDUCATION & SEMINARS XIX G
			TRAVEL XIX G
			0
		25	ADMIN. STAFF TRANSPORTATION
			TRANSPORTATION - STAFF 3,645
			3,645
		26	INSURANCE - PROP. LIAB & MALPRACTICE
			GENERAL INSURANCE 150,612
			150,612
		27	OTHER
			BAD DEBTS VI 24 45,251
			45,251

GRAND TOTAL COLUMN 3 OTHER

1,340,090

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			8,400	8,400		8,400	24,734	33,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			514	514		514	164,050	164,564			32
33	Real Estate Taxes							17,159	17,159			33
34	Rent-Facility & Grounds			213,937	213,937		213,937	(213,937)				34
35	Rent-Equipment & Vehicles			7,845	7,845		7,845	266	8,111			35
36	Other (specify):* RENT OFFICE			14,000	14,000		14,000	(14,000)				36
37	TOTAL Ownership			244,696	244,696		244,696	(21,728)	222,968			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,649	26,881	58,530		58,530		58,530			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,074	218,074		218,074		218,074			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		31,649	244,955	276,604		276,604		276,604			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,742,451	358,450	1,829,741	3,930,642		3,930,642	(65,041)	3,865,601			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	(60,799)	30		9
10	Interest and Other Investment Income	(35)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	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		21		18
19	Entertainment		20		19
20	Contributions	(400)	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	(45,251)	27		24
25	Fund Raising, Advertising and Promotional	(3,086)	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	(12,295)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (121,985)		\$	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)	56,944		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 56,944		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (65,041)		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	\$ (12,295)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(12,295)		49

Summary A

09/30/2025

[illegible]

Summary B

09/30/2025

[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	34	RENT	\$ 213,937	MASCOUTAH 10TH STREET LP		\$	\$ (213,937)	1
2	V								2
3	V								3
4	V	32	AMORT LOAN COST				24,518	24,518	4
5	V	19	PROFESSIONAL FEES				4,400	4,400	5
6	V	30	DEPRECIATION				83,968	83,968	6
7	V	32	INTEREST				126,024	126,024	7
8	V	33	RE TAX				15,716	15,716	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 213,937			\$ 254,626	\$ * 40,689	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	\$ 90,720	BRIA HEALTH SERVICES, LLC		\$	\$ (90,720)	15
16	V								16
17	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	17
18	V	17	SALARIES-CFO				6,673	6,673	18
19	V	6	SALARIES-MAINTENANCE				3,081	3,081	19
20	V	10	SALARIES-A/R				23,267	23,267	20
21	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	21
22	V	21	SALARIES-CLERICAL				30,492	30,492	22
23	V	6	MAINTENANCE				752	752	23
24	V	7	SCAVENGER				70	70	24
25	V	19	PROFESSIONAL FEES				10,472	10,472	25
26	V	20	DUES,FEES,SUBSCRIPTIONS				1,949	1,949	26
27	V	21	OFFICE EXPENSE				3,756	3,756	27
28	V	23	SEMINARS				32	32	28
29	V	24	TRAVEL				1,021	1,021	29
30	V	26	INSURANCE				376	376	30
31	V	27	EMPLOYEE BENEFITS				10,396	10,396	31
32	V	30	DEPRECIATION				983	983	32
33	V	32	INTEREST				12,890	12,890	33
34	V	35	AUTO LEASE				127	127	34
35	V	35	EQUIPMENT RENTAL				139	139	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 90,720			\$ 117,576	\$ * 26,856	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	\$ 14,000	IME REALTY CORPORATION		\$	\$ (14,000)	15
16	V								16
17	V	5	UTILITIES				366	366	17
18	V	6	MAINTENANCE				178	178	18
19	V	19	PROFESSIONAL FEES				16	16	19
20	V	26	INSURANCE				72	72	20
21	V	30	DEPRECIATION				582	582	21
22	V	32	INTEREST				653	653	22
23	V	33	RE TAX				1,443	1,443	23
24	V	21	OFFICE EXPENSE				89	89	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			\$ 14,000			\$ 3,399	\$ * (10,601)	39

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

Facility Name & ID Number

BRIA OF MASCOUTAH

0057349

Report Period Beginning:

01/01/2025

Ending:

09/30/2025

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					MASCOUTAH 10TH			6
7	LAKE PARK CENTER	WAUKEGAN			STREET LP	SKOKIE	REAL ESTATE	7
8								8
9	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO			WEISS MGMT		MANAGEMENT/	9
10		HEIGHTS			GROUP, INC	SKOKIE	CLERICAL	10
11								11
12	BRIA OF WESTMONT	WESTMONT			DA WESTMONT	SKOKIE	MGMT CONSULT	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 GODFREY	GODFREY						24
25								25
26	BRIA OF WOODRIVER	WOODRIVER						26
27								27
28	BRIA OF CAHOKIA	CAHOKIA						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	ACCOUNTS PAYAB	ACCOUNTS PAYABLE					SALARY		21-7	2
3	MIRYAM CLEVS	OFFICE CLERK	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	MEMBER	33.33				SALARY	6,000	17-7	7
8	DANIEL WEISS	MEMBER	MEMBER	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 MASCOUTAH # 0057349 Report Period Beginning: 01/01/2025 Ending: 9/30/2025

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	\$	13,223	\$ 366	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		13,223	178	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		13,223	16	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	5,537		13,223	89	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	4,484		13,223	72	5
6	32	INTEREST	CENSUS DAYS	821,683	19	36,102		13,223	582	6
7	33	RE TAX	CENSUS DAYS	821,683	19	40,569		13,223	653	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	89,649		13,223	1,443	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	\$		\$ 3,399	25

Facility Name & ID Number BRIA OF MASCOUTAH # 0057349 Report Period Beginning: 01/01/2025 Ending: 9/30/2025

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	13,223	6,673	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	13,223	3,081	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	13,223	23,267	4
5	21	SALARIES-CLERICAL RELATED	wghtd avr hours	38	19	83,882	1,894,762	2	2,112	5
6	21	SALARIES-CLERICAL	CENSUS DAYS	821,683	19	1,894,762	46,742	13,223	30,492	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		13,223	752	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		13,223	70	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		13,223	10,472	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		13,223	1,949	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		13,223	3,756	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		13,223	32	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		13,223	1,021	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		13,223	376	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		13,223	10,396	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		13,223	983	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		13,223	12,890	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		13,223	127	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		13,223	139	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,996	\$ 3,993,370		\$ 117,576	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	REALTY: MASCOUTAH 10TH STREET LP						\$				\$	1
2	BANK FINANCIAL		X	COMMERCIAL LOAN 1		12/27/23	1,651,000	1,600,694	12/27/26	6.6250	108,382	2
3			X	COMMERCIAL LOAN 2		12/27/23	254,000	219,514	12/27/26	7.6250	17,642	3
4	LOAN COSTS			AMORTIZATION OVER LIFE OF LOAN			73,553	24,181			24,518	4
5												5
	Working Capital											
6	BANK FINANCIAL	X		LOC		1/3/2024	2,000,000			PRIME+	514	6
7												7
8	RELATED PARTY ALLOCATION										13,543	8
9	TOTAL Facility Related						\$ 3,978,553	\$ 1,844,389			\$ 164,599	9
	B. Non-Facility Related*											
10	INTEREST INCOME										(35)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (35)	14
15	TOTALS (line 9+line14)						\$ 3,978,553	\$ 1,844,389			\$ 164,564	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.		\$	17,150	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.)				\$	16,030	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,120)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	16,836	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.				\$	15,716	7
Assessed Value from Real Estate Tax Bill:	2024	197,177	8			
Real Estate Tax Bill for Calendar Year:	2020		9			
	2021		10			
	2022		11			
	2023	15,308	12			
	2024	16,030	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 MASCOUTAH</u>	COUNTY	<u>SAINT CLAIR</u>
---------------	--------------------------	--------	--------------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,712 B. General Construction Type: Exterior BRICK Frame 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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	NURSING HOME			2023		\$ 50,000	
2							
3	TOTALS					\$ 50,000	

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

0057349

Report Period Beginning:

01/01/2025

Ending:

09/30/2025

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	55		2023		\$ 1,600,000	\$ 40,028	40	\$ 23,333	\$ (16,695)	\$ 24,429
5										
6										
7	IME-BLDG		2016		1,040	215		215		
8	RELATED PARTY -IMPR		2017		17,075	755		755		
	Improvement Type**									
9	FURNISHED AND INSTALLED 5-TON HEAT PUMP, AIR HANDLER,									
10	HEAT STRIPS AND ADAPTED TO DUSTWORK			2023	11,500		27.5	244	244	1,080
11	SPRINKLER: REPLACE AIR COMPRESSOR WITH A TANK STYLE									
12	AND ASCOUTED FITTINGS			2023	8,355		27.5	177	177	785
13	FIRE ALARM: REPLACE SMOKE DEDECTORS			2023	28,964		27.5	614	614	2,720
14	DINING ROOM PATIO, SOUTH ENTRANCE: INSTALL DOUBLE									
15	DOORS, EXIT DEVICE TRIM,GASKETING,SWEEP, CLOSER			2023	13,507		27.5	286	286	1,268
16	INSTALLED UNIMAC 75LB TUMBLER			2024	6,072		15	236	236	641
17	RE-PIPE THE P-TRAP, WYE & CRACKED SECTION OF									
18	SEWER LINE UP TO THE MAIN SEWER			2024	6,899		15	268	268	728
19	FURNISH AND INSTALL NEW 50-GALLON NG BRADFORD									
20	WHITE WATER IN PLACE			2024	2,516		15	98	98	266
21	KITCHEN-REPLACEMENT WALK-IN-COOLER			2024	5,047		15	196	196	532
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33						43,940			(43,940)	
34										
35										
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)		\$ 1,700,975	\$ 84,938		\$ 26,424	\$ (58,514)	\$ 32,451	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	\$ 91,967	\$ 8,400	\$ 6,115	\$ (2,285)	8-10	\$ 24,381	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		595	595				74
75	TOTALS	\$ 91,967	\$ 8,995	\$ 6,710	\$ (2,285)		\$ 24,381	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)	\$ 1,842,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,933	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,134	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (60,799)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 56,832	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: \$ 7,845
- 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.

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 17,803	\$		\$ 17,803	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,220			2,220	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			6,858			6,858	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				21,277		21,277	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
	MED.SUPPLIES/LAB/RADIOLOGY	39-2					7,907		7,907	13
13	Other (specify): IV THERAPY, RENTAL	39-2					2,465		2,465	
14	TOTAL			\$		\$ 26,881	\$ 31,649		\$ 58,530	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	\$ 411,257	\$ 220,493	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 22,089)	1,222,367	1,222,367	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,836	80,836	6
7	Other Prepaid Expenses	31,395	31,395	7
8	Accounts Receivable (owners or related parties)	85,050	85,050	8
9	Other(specify): R/E/T ESCROW		5,652	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,830,905	\$ 1,645,793	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50	13
14	Buildings, at Historical Cost		1,600,000	14
15	Leasehold Improvements, at Historical Cost	82,860	82,860	15
16	Equipment, at Historical Cost	91,967	366,967	16
17	Accumulated Depreciation (book methods)	(96,040)	(275,858)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec LOAN COST-NET		24,181	22
23	Other(specify): REPLACEMENT RESERVE	3,208	3,208	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 81,995	\$ 1,801,408	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,912,900	\$ 3,447,201	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 870,546	\$ 974,147	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,716	62,716	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,935	107,935	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		16,836	32
33	Accrued Interest Payable		10,573	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,041,197	\$ 1,172,207	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,820,208	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)	\$	\$ 1,820,208	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,041,197	\$ 2,992,415	46
47	TOTAL EQUITY(page 18, line 24)	\$ 871,703	\$ 454,786	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,912,900	\$ 3,447,201	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 635,617	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 635,617	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	236,086	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)	\$ 236,086	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)	\$ 871,703	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF MASCOUTAH

0057349

Report Period Beginning: 01/01/2025

Ending: 09/30/2025

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	\$ 3,980,869	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,980,869	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	58,601	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 58,601	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***	35	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	QIP PAYMENTS	52,572	28
28a	C.N.A. WAGE PASS, ITT REBATE PROGRAM	83,371	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 135,943	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,175,448	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	620,266	31
32	Health Care	1,930,613	32
33	General Administration	858,463	33
	B. Capital Expense		
34	Ownership	244,696	34
	C. Ancillary Expense		
35	Special Cost Centers	58,530	35
36	Provider Participation Fee	218,074	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,930,642	40
41	Income before Income Taxes (line 30 minus line 40)**	244,806	41
42	Income Taxes	(8,720)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 236,086	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 763,847.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,468,127.00	45
46	MMAI-Medicaid is the Primary Payer	257,210.00	46
47	MMAI-Medicare is the Primary Payer	26,612.00	47
48	Private Pay	365,774.00	48
49	Medicare Part A	638,785.00	49
50	Other-(specify) HOSPICE	309,789.00	50
51	Other-(specify) INSURANCE	150,725.00	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)	\$ 3,980,869	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	1,616	1,705	\$ 81,835	\$ 48.00	1
2	Assistant Director of Nursing	2,675	2,808	124,849	44.46	2
3	Registered Nurses	1,931	2,132	89,146	41.81	3
4	Licensed Practical Nurses	8,079	8,631	302,459	35.04	4
5	CNAs & Orderlies	20,345	21,883	459,905	21.02	5
6	CNA Trainees					6
7	Licensed Therapist	1,788	1,921	93,078	48.45	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,397	3,701	65,777	17.77	10
11	Social Service Workers	1,516	1,618	36,706	22.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,636	8,016	140,381	17.51	15
16	Dishwashers					16
17	Maintenance Workers	1,536	1,600	37,330	23.33	17
18	Housekeepers	3,523	3,662	63,713	17.40	18
19	Laundry	1,251	1,300	20,537	15.80	19
20	Administrator	1,504	1,666	78,195	46.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,110	2,351	48,841	20.77	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	1,520	1,622	34,934	21.54	31
32	Other Health C: Care Plan Coord	1,540	1,596	64,765	40.58	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	61,967	66,212	\$ 1,742,451 *	\$ 26.32	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	\$ 26,379	1-3	35
36	Medical Director	O	22,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,873	10-3	39
40	Physical Therapy Consultant	L	8,218	10a-3	40
41	Occupational Therapy Consultant	Y	4,746	10a-3	41
42	Respiratory Therapy Consultant		1,101	10a-3	42
43	Speech Therapy Consultant	F	2,766	10a-3	43
44	Activity Consultant	E	1,433	11-3	44
45	Social Service Consultant	E	1,433	12-3	45
46	Other(specify) Psychiatric	S	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 75,449		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,999	\$ 121,183		50
51	Licensed Practical Nurses	3,055	134,092		51
52	Certified Nurse Assistants/Aides	6,475	159,943		52
53	TOTAL (lines 50 - 52)	11,529	\$ 415,218		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
AMY SUYDAM	Administrator	0	\$ 78,195
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,195
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
NATIONAL DATACARE CORP	DATA PROCESSING	\$	1,652
PAYLOCITY	DATA PROCESSING		5,705
QUANTIUM INFORMATICS	DATA PROCESSING		20,385
INTEGRA SCRIPTS	PHARMACY COST MGMT		2,475
BRIA HEALTH SERVICES	BOOKKEEPING/ADM		90,720
DSSI	PROCUREMENT SERVICES		798
KBKB LTD	ACCOUNTING		15,050
GGM ASSOCIATES	MEDICARE CONSULTANT		4,283
PERSONNEL PLANNERS	UC CONSULTANT		750
QUALITY REHAB MANAGEMENT	LEADING RISK CONSULTANCY		12,000
LEGAL SCHEDULE ATTACHED			7,568
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 161,386
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	39,786
Unemployment Compensation Insurance			25,741
FICA Taxes			129,177
Employee Health Insurance			48,746
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
EMPLOYEE BENEFITS - OTHER			8,849
EMPLOYEE PHYSICAL EXAMS			
PENSION/PROFIT SHARING PLANS			
INSURANCE - EXECUTIVE LIFE			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 252,299
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)			
Patient Background Checks			1,591
Association Dues (total from pg 22, #4)			15,169
TRUST/FRANCHISE/CONTRIB/ETC			
MARKETING/ADV/PROMO			3,086
LICENSES/DUES/SUBSCRIPTIONS			1,293
MGMT CO ALLOC			1,949
Less: Public Relations Expense (			)
PAC and Lobbying payments			(12,295)
All non-allowable advertising			(3,086)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 14,707
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
MGMT CO ALLOC			1,021
Seminar Expense			
Entertainment Expense (			)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	1,021

*** Attach copy of IMRF notifications**

****See instructions.**

BRIA OF MASCOUTAH
LEGAL EXPENSES
1/1/2025-9/30/2025

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
3/1/2025	BRIAN A. STINES, P.C.	COLLECTIONS	500
5/1/2025	BRIAN A. STINES, P.C.	COLLECTIONS	123
6/29/2025	BRIAN A. STINES, P.C.	COLLECTIONS	500
7/1/2025	BRIAN A. STINES, P.C.	COLLECTIONS	750
2/28/2025	HINSHAW CULBERTSON	REVIEW & ANALYSIS OF FINAL ORDER FROM IDPH	318
5/31/2025	HINSHAW CULBERTSON	SETTLEMENT NEGOTIATIONS	105
5/1/2025	HINSHAW CULBERTSON	REGULATORY COUNSELIN	57
6/23/2025	HINSHAW CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	315
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
TOTAL			<u>7,568</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>2,874</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>2,874</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>12,295</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>12,295</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>15,169</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>15,169</u> Total
- (5)

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

\$	<u>9,961</u>	Line	<u>10-2</u>
----	--------------	------	-------------
- (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.

\$	<u>218,074</u>
----	----------------

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.

\$	<u> </u>	Has any meal income been offset against related costs?	<u> </u>	Indicate the amount.	\$	<u> </u>
----	----------	--	----------	----------------------	----	----------
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g. Does the facility transport residents to and from day training?

NO

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

\$ N/A
- (13)

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

NO

Firm Name:
- (14)

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

YES
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

YES

See page 39 of the instructions for details.

Attach invoices and a summary of services for all architect and appraisal fees.