

		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: 0051136

Facility Name: BRIA OF PALOS HILLS

Address: 10426 SOUTH ROBERTS PALOS HILLS 60465
Number City Zip Code

County: COOK

Telephone Number: (708) 598-3460 Fax # (708) 443-7411

HFS ID Number:

Date of Initial License for Current Owners: 07/01/10

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ 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) _____ (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 PALOS HILLS

#

0051136

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	150	Skilled (SNF)	150	40,950	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	14,469	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	55,419	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			2,514	454		5,018	5,790	13,776	8
9	SNF/PED									9
10	ICF	4,868	18,775			1,905		2,227	27,775	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,868	18,775	2,514	454	1,905	5,018	8,017	41,551	14

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

74.98%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

07/01/10

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

07/01/10

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter certified beds.

number of certified beds

118

Medicare Intermediary

ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

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

Facility Name & ID Number **BRIA OF PALOS HILLS** # **0051136** 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		28,933	726,448	755,381		755,381		755,381			1
2	Food Purchase		389,377		389,377		389,377	(181)	389,196			2
3	Housekeeping			355,769	355,769		355,769		355,769			3
4	Laundry		21,148	237,179	258,327		258,327		258,327			4
5	Heat and Other Utilities			293,129	293,129		293,129	1,151	294,280			5
6	Maintenance	81,987	106,073	58,324	246,384		246,384	12,602	258,986			6
7	Other (specify):* Security, Scavenger			29,313	29,313		29,313	221	29,534			7
8	TOTAL General Services	81,987	545,531	1,700,162	2,327,680		2,327,680	13,793	2,341,473			8
	B. Health Care and Programs											
9	Medical Director			40,500	40,500		40,500		40,500			9
10	Nursing and Medical Records	5,944,905	602,085	755,339	7,302,329		7,302,329	73,112	7,375,441			10
10a	Therapy	965,352		97,903	1,063,255		1,063,255		1,063,255			10a
11	Activities	94,675	2,130	385	97,190		97,190		97,190			11
12	Social Services	181,202	1,598		182,800		182,800		182,800			12
13	CNA Training											13
14	Program Transportation			1,888	1,888		1,888		1,888			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,186,134	605,813	896,015	8,687,962		8,687,962	73,112	8,761,074			16
	C. General Administration											
17	Administrative	258,985		258,515	517,500		517,500	(228,550)	288,950			17
18	Directors Fees											18
19	Professional Services			464,392	464,392		464,392	(198,022)	266,370			19
20	Dues, Fees, Subscriptions & Promotions			74,975	74,975		74,975	(32,374)	42,601			20
21	Clerical & General Office Expenses	434,138	21,304	221,551	676,993		676,993	(56,930)	620,063			21
22	Employee Benefits & Payroll Taxes			954,227	954,227		954,227		954,227			22
23	Inservice Training & Education			16,780	16,780		16,780	101	16,881			23
24	Travel and Seminar			22,728	22,728		22,728	(5,050)	17,678			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			359,588	359,588		359,588	53,780	413,368			26
27	Other (specify):*			285,666	285,666		285,666	(252,997)	32,669			27
28	TOTAL General Administration	693,123	21,304	2,658,422	3,372,849		3,372,849	(720,042)	2,652,807			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,961,244	1,172,648	5,254,599	14,388,491		14,388,491	(633,137)	13,755,354			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	55,668		CONTRACT NURSING	XVIII C 53-2	711,218
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		11,713
	CONTRACTED DIETARY SERVICES		670,780		PURCHASED SERVICES		
			726,448		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		355,769		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			355,769		PHARMACY CONSULTANT	XVIII B 39-2	8,866
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		237,179		PSYCHIATRIC	XVIII B __-2	9,000
			237,179		RN CONSULTANT	XVIII B 38-2	14,542
5	HEAT & OTHER UTILITIES						
	GAS HEAT		32,034				
	ELECTRICITY		176,376				
	WATER		71,411				755,339
	CABLE TV - LOBBY		13,308				
6			293,129	11	THERAPY		
	MAINTENANCE				PHYSICAL THERAPY SERVICES		
	GROUND MAINTENANCE		27,920		SPEECH THERAPY SERVICES		
	PAINTING & DECORATING				OCCUPATIONAL THERAPY SERVICES		
	BUILDING REPAIRS				REHABILITATION CONSULTANT	XVIII B __-2	
	MAINTENANCE TRAVEL				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	35,212
	EQUIPMENT MAINTENANCE & REPAIR				OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	37,882
	ELEVATOR MAINTENANCE & REPAIR				RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	8,000
	OUTSIDE LABOR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	16,809
	EXTERMINATING SERVICE						
	FIRE SERVICE		30,404				97,903
				12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	385
7			58,324	13			385
	OTHER				SOCIAL SERVICES		
	SCAVENGER		29,313		SOCIAL REHABILITATION SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	
9					SOCIAL WORKER	XVIII B 45-2	
			29,313				0
	MEDICAL DIRECTOR				NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		40,500		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE			
14	PROGRAM TRANSPORTATION			22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	PATIENT TRANSPORTATION		1,888		FICA TAXES	XIX D	596,440
			1,888		UNEMPLOYMENT COMPENSATION	XIX D	60,098
17	ADMINISTRATIVE				WORKERS COMPENSATION INSURANCE	XIX D	83,590
	MANAGEMENT FEES	XIX B	258,515		HOSPITALIZATION INSURANCE	XIX D	199,479
	DIRECTORS FEES				EMPLOYEE BENEFITS - OTHER	XIX D	14,620
18	DIRECTORS FEES		0		EMPLOYEE PHYSICAL EXAMS	XIX D	
19	PROFESSIONAL SERVICES				INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	
	DATA PROCESSING	XIX C	35,064		PENSION/PROFIT SHARING PLANS	XIX D	
	ADMINISTRATIVE CONSULTANTS	XIX C					
	PROFESSIONAL FEES	XIX C	126,928				
	BOOKKEEPING/ADMINISTRATIVE SERVICES		302,400				954,227
			464,392	23	INSERVICE TRAINING & EDUCATION		
20	FEES,SUBSCRIPTIONS,PROMOTIONS				EDUCATION & SEMINARS		16,780
	ENTERTAINMENT & MARKETING	VI 19 XIX F					16,780
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	16,662	24	TRAVEL & SEMINARS		
	EMPLOYEE WANT ADS	XIX F	7,000		EDUCATION & SEMINARS	XIX G	
	CONTRIBUTIONS	VI 20 XIX F	250		TRAVEL	XIX G	22,728
	DUES & SUBSCRIPTIONS	XIX F	13,917				
	LICENSES & PERMITS	XIX F	4,861				22,728
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		25	ADMIN. STAFF TRANSPORTATION		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F			TRANSPORTATION - STAFF		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F					0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	21,587	26	INSURANCE - PROP. LIAB & MALPRACTICE		
	HEALTH CARE WORKER BACKGROUND CHE	XIX F			GENERAL INSURANCE		359,588
	PATIENT BACKGROUND CHECKS	XIX F	10,698				
			74,975				359,588
21	CLERICAL & GENERAL OFFICE EXPENSES			27	OTHER		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,994		BAD DEBTS	VI 24	285,666
	EQUIPMENT REPAIR & MAINTENANCE		129,457				285,666
	OUTSIDE CLERICAL SERVICES						
	PENALTIES / OVERDRAFT CHARGES	VI 18	65,475				
	HOME OFFICE EXPENSE						
	THEFT & DAMAGE LOSS						
	TELEPHONE		19,625				
	MESSENGER SERVICE						
			221,551				

	SCHED REF	TOTAL
EMPLOYEE BENEFITS & PAYROLL TAXES		
FICA TAXES	XIX D	596,440
UNEMPLOYMENT COMPENSATION	XIX D	60,098
WORKERS COMPENSATION INSURANCE	XIX D	83,590
HOSPITALIZATION INSURANCE	XIX D	199,479
EMPLOYEE BENEFITS - OTHER	XIX D	14,620
EMPLOYEE PHYSICAL EXAMS	XIX D	
INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	
PENSION/PROFIT SHARING PLANS	XIX D	
		954,227
INSERVICE TRAINING & EDUCATION		
EDUCATION & SEMINARS		16,780
		16,780
TRAVEL & SEMINARS		
EDUCATION & SEMINARS	XIX G	
TRAVEL	XIX G	22,728
		22,728
ADMIN. STAFF TRANSPORTATION		
TRANSPORTATION - STAFF		
		0
INSURANCE - PROP. LIAB & MALPRACTICE		
GENERAL INSURANCE		359,588
		359,588
OTHER		
BAD DEBTS	VI 24	285,666
		285,666

GRAND TOTAL COLUMN 3 OTHER 5,254,599

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			82,180	82,180		82,180	394,196	476,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,610	13,610		13,610	2,102,267	2,115,877			32
33	Real Estate Taxes			726,722	726,722		726,722	4,533	731,255			33
34	Rent-Facility & Grounds			1,796,231	1,796,231		1,796,231	(1,796,231)				34
35	Rent-Equipment & Vehicles			75,437	75,437		75,437	835	76,272			35
36	Other (specify):* RENT OFFICE/ PARKING			23,650	23,650		23,650	(10,150)	13,500			36
37	TOTAL Ownership			2,717,830	2,717,830		2,717,830	695,450	3,413,280			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		573,622	251,054	824,676		824,676		824,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			785,097	785,097		785,097		785,097			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		573,622	1,036,151	1,609,773		1,609,773		1,609,773			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,961,244	1,746,270	9,008,580	18,716,094		18,716,094	62,313	18,778,407			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	(365,684)	30		9
10	Interest and Other Investment Income	(10,258)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(181)	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	(65,475)	21		18
19	Entertainment		20		19
20	Contributions	(250)	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	(285,666)	27		24
25	Fund Raising, Advertising and Promotional	(16,662)	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	(131,310)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (875,486)		\$	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)	937,799		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 937,799		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 62,313		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	\$ (21,587)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING SALARIES	(101,465)	21	3
4	MARKETING TRAVEL	(8,258)	24	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(131,310)		49

Summary A

09/30/2025

[illegible]

Summary B

09/30/2025

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
	Depreciation	(365,684)	754,966	3,088	1,826	0	0	0	0	0	0	0	394,196
	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	30
	Interest	(10,258)	2,069,971	40,503	2,051	0	0	0	0	0	0	0	2,102,267
	Real Estate Taxes	0	0	0	4,533	0	0	0	0	0	0	0	33
	Rent-Facility & Grounds	0	(1,796,231)	0	0	0	0	0	0	0	0	0	(1,796,231)
	Rent-Equipment & Vehicles	0	0	835	0	0	0	0	0	0	0	0	835
	Other (specify):*	0	0	0	(10,150)	0	0	0	0	0	0	0	(10,150)
	TOTAL Ownership	(375,942)	1,028,706	44,426	(1,740)	0	0	0	0	0	0	0	695,450
	Ancillary Expense												
	E. Special Cost Centers												
	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	38
	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	39
	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	40
	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	41
	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	42
	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	43
	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(875,486)	1,152,501	(215,227)	525	0	0	0	0	0	0	0	62,313

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.

[illegible]

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	\$ 1,796,231	PM NURSING & REHAB		\$	\$ (1,796,231)	1
2	V								2
3	V								3
4	V	30	DEPRECIATION				754,966	754,966	4
5	V	32	INTEREST EXPENSE				2,069,971	2,069,971	5
6	V	19	PROFESSIONAL FEES				71,423	71,423	6
7	V	26	INSURANCE				52,372	52,372	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,796,231			\$ 2,948,732	\$ * 1,152,501	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	BOOKKEEPING/ADM SERVICES	\$ 302,400	BRIA HEALTH SERVICES, LLC		\$	\$ (302,400)	15
16	V	17	MANAGEMENT FEES	258,515				(258,515)	16
17	V								17
18	V	17	MANAGEMENT FEES-RELATED PARTIES				8,998	8,998	18
19	V	17	SALARIES-CFO				20,967	20,967	19
20	V	6	SALARIES-MAINTENANCE				9,680	9,680	20
21	V	10	SALARIES-A/R				73,112	73,112	21
22	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	22
23	V	21	SALARIES-CLERICAL				95,815	95,815	23
24	V	6	MAINTENANCE				2,364	2,364	24
25	V	7	SCAVENGER				221	221	25
26	V	19	PROFESSIONAL FEES				32,906	32,906	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				6,125	6,125	27
28	V	21	OFFICE EXPENSE				11,803	11,803	28
29	V	23	SEMINARS				101	101	29
30	V	24	TRAVEL				3,208	3,208	30
31	V	26	INSURANCE				1,181	1,181	31
32	V	27	EMPLOYEE BENEFITS				32,669	32,669	32
33	V	30	DEPRECIATION				3,088	3,088	33
34	V	32	INTEREST				40,503	40,503	34
35	V	35	AUTO LEASE				398	398	35
36	V	35	EQUIPMENT RENTAL				437	437	36
37	V								37
38	V								38
39	Total			\$ 560,915			\$ 345,688	\$ * (215,227)	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	\$ 10,150	IME REALTY CORPORATION		\$	\$ (10,150)	15
16	V								16
17	V	5	UTILITIES				1,151	1,151	17
18	V	6	MAINTENANCE				558	558	18
19	V	19	PROFESSIONAL FEES				49	49	19
20	V	26	INSURANCE				227	227	20
21	V	30	DEPRECIATION				1,826	1,826	21
22	V	32	INTEREST				2,051	2,051	22
23	V	33	RE TAX				4,533	4,533	23
24	V	21	OFFICE EXPENSE				280	280	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			\$ 10,150			\$ 10,675	\$ * 525	39

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

Facility Name & ID Number

BRIA OF PALOS HILLS

0051136

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	SKOKIE	MANAGEMENT	1
2					SERVICES, LLC		SERVICES	2
3	BRIA OF GENEVA	GENEVA	BRIA OF ELMWOOD	ELMWOOD PARK				3
4					WEISS MGMT	SKOKIE	MANAGEMENT/	4
5	BRIA OF FOREST EDGE	CHICAGO			GROUP, INC		CLERICAL	5
6								6
7	LAKE PARK CENTER	WAUKEGAN			IME REALTY	SKOKIE	CORPORATE	7
8							OFFICE	8
9	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO						9
10		HEIGHTS			PM NURSING &	SKOKIE	REAL ESTATE	10
11					REHAB			11
12	BRIA OF WESTMONT	WESTMONT						12
13					DA WESTMONT	SKOKIE	MGMT CONSULT	13
14	BRIA OF CAHOKIA	CAHOKIA						14
15								15
16	BRIA OF RIVER OAKS	BURNHAM						16
17								17
18	BRIA OF ALTON	ALTON						18
19								19
20	BELLEVILLE HEALTHCARE CENTER	BELLEVILLE						20
21								21
22	BRIA OF COLUMBIA	COLUMBIA						22
23								23
24	BRIA OF GODFREY	GODFREY						24
25								25
26	BRIA OF WOODRIVER	WOODRIVER						26
27								27
28	BRIA OF MASCOUTAH	MASCOUTAH						28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:								\$		1
2	FRED BERKOVITS	MEMBER	REGIONAL DIR					MGMT FEES	8,988	17-7	2
3	MIRYAM CLEVS	RELATIVE	OFFICE CLERK		SEE			SALARY	2,112	21-7	3
4	ARIELLA WEIL	RELATIVE	ACCOUNTS PAYABLE		ATTACHED			SALARY		21-7	4
5					SCHEDULE						5
6	ALLOCATION FROM DA WESTMONT:										6
7	AVRUM WEINFELD	MEMBER	CFO					SALARY	6,000	17-7	7
8	DANIEL WEISS	MEMBER	ADMINISTRATIVE					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 PALOS HILLS # 0051136 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 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	5	UTILITIES	CENSUS DAYS	821,683	19	\$ 22,755	\$	41,551	\$ 1,151	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		41,551	558	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		41,551	49	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		41,551	227	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		41,551	1,826	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		41,551	2,051	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		41,551	4,533	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		41,551	280	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	\$		\$ 10,675	25

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 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	41,551	20,967	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	41,551	9,680	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	41,551	73,112	4
5	21	SALARIES-CLERICAL RELATED	wghtd avr hours	38	19	83,882	83,882	2	2,112	5
6	21	SALARIES-CLERICAL	CENSUS DAYS	821,683	19	1,894,762	1,894,762	41,551	95,815	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		41,551	2,364	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,370		41,551	221	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		41,551	32,906	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		41,551	6,125	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		41,551	11,803	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		41,551	101	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		41,551	3,208	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		41,551	1,181	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		41,551	32,669	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		41,551	3,088	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		41,551	40,503	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		41,551	398	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		41,551	437	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,995	\$ 4,030,510		\$ 345,678	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	RELATED PARTY: PM NURSING & REHAB						\$		\$			\$	1
2	THE PRIVATE BANK	X		LOAN		4/30/21	19,121,000	20,000,000		PRIME+	2,069,971	2	
3												3	
4												4	
5												5	
	Working Capital												
6	BANK FINANCIAL	X		LOC	DEMAND	08/01/10	750,000		PRIME+		13,610	6	
7												7	
8	RELATED PARTY ALLOCATION											8	
9	TOTAL Facility Related						\$ 19,871,000	\$ 20,000,000			\$ 2,083,581	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 19,871,000	\$ 20,000,000			\$ 2,083,581	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.		\$	878,275	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.)				\$	961,629	2
3. Under or (over) accrual (line 2 minus line 1).				\$	83,354	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	643,368	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.				\$	726,722	7
Assessed Value from Real Estate Tax Bill:	2024	3,350,629	8			
Real Estate Tax Bill for Calendar Year:	2020	949,922	9			
	2021	959,209	10			
	2022	989,887	11			
	2023	852,694	12			
	2024	961,629	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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

BRIA OF PALOS HILLS

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0051136

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 23-14-224-001-0000	NURSING HOME	\$ 8,601.38	\$ 8,601.38
2. 23-14-224-002-0000	NURSING HOME	\$ 30,181.96	\$ 30,181.96
3. 23-14-224-003-0000	NURSING HOME	\$ 129,487.43	\$ 129,487.43
4. 23-14-224-004-0000	NURSING HOME	\$ 129,487.43	\$ 129,487.43
5. 23-14-224-009-0000	NURSING HOME	\$ 8,577.28	\$ 8,577.28
6. 23-14-224-010-0000	NURSING HOME	\$ 41,215.70	\$ 41,215.70
7. 23-14-224-011-0000	NURSING HOME	\$ 123,970.37	\$ 123,970.37
8. 23-14-224-012-0000	NURSING HOME	\$ 107,419.40	\$ 107,419.40
9. 23-14-224-017-0000	NURSING HOME	\$ 382,688.53	\$ 382,688.53
10. 10-16-400-033-0000	IME ALLOCATION	\$	\$ 4,533.00
TOTALS		\$ 961,629.48	\$ 966,162.48

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,000 B. General Construction Type: Exterior BRICK Frame Number of Stories

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2012	\$ 812,700	1
2	NURSING HOME		2016	637,703	2
3	TOTALS			\$ 1,450,403	3

Facility Name & ID Number **BRIA OF PALOS HILLS**# **0051136**

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	REEROOFED PROPERTY USING PLY MODIFIED		\$	\$		\$	\$	\$	37
38	BITUMEN; INSTALL 6 NEW RETRO FIT DRAINS	2011	35,700		27.5	757	757	17,685	38
39	INSTALLATION AND WIRING FOR WAP'S	2012	4,730		27.5	100	100	2,315	39
40	CORRIDOR-HANDRAILS, CORNER GUARDS	2012	5,225		27.5	111	111	2,541	40
41	REPLACEMENT OF A/C SOUTHEAST UNIT COMPRESSOR	2012	2,618		5			2,618	41
42	APPLIED A PATCH TO THE FIELD OR WALL FLASHINGS	2012	2,800		27.5	60	60	1,314	42
43	NURSES STATION; 2 BATHROOMS; NORTH, WEST, SOUTH								43
44	CORRIDORS; CAFETERIA-INSTALL NEW CERAMIC TILE,								44
45	VCT AND MILLWORK	2013	36,893		27.5	783	783	16,831	45
46	APPLIED A PATCH TO THE FIELD USING SPMB OR WALL								46
47	FLASHINGS-EAST, SOUTH WING	2013	3,650		27.5	78	78	1,602	47
48	TUB ROOM; TRAINING TOILET; 2 SMALL SHOWER ROOMS								48
49	INSTALLATION OF CERAMIC FLOOR TILE	2013	18,583		27.5	394	394	8,027	49
50	FIRE SPRINKLER SYSTEM REPAIR-LABOT AND MATERIAL								50
51	TO COMPLETE WORK	2013	10,120		27.5	215	215	4,370	51
52	ALZHEIMERS DINNING ROOM; SOUTH CORRIDOR; NORTH								52
53	SHOWER ROOM-INSTALL NEW VCT & MILL WORK	2013	26,867		27.5	570	570	11,521	53
54	REEROOFED PROPERTY USING SINGLE PLY MODIFIED								54
55	BITUMEN ON FRONT PORTION OF THE CENTER AND								55
56	SOUTH WING	2013	79,040		27.5	1,677	1,677	33,890	56
57	REPLACEMENTOF A/C UNIT IN NORTH DIALYSIS ROOM	2013	8,602		27.5	183	183	3,691	57
58	INSTALL NEW FIRE ALARM SYSTEM; SMOKE DETECTOR								58
59	BASE	2013	24,108		27.5	512	512	10,342	59
60	REPLACE WITH NEW PIPE AND FITTINGS OF THE SEWER								60
61	LINE TWO SEPARATE TRENCH EXCAVATIONS	2013	8,425		27.5	179	179	3,583	61
62	INSTALLED NEW WHITE GRANULATED SPMB FLASHING								62
63	AND GRAVEL STOP-REMOVED EXSISTING ROOF	2014	10,150		27.5	215	215	4,197	63
64	NORTHEAST DINING ROOM-INSTALLATION OF BUMPER								64
65	GUARD & CHAIR RAIL	2014	3,428		27.5	73	73	1,422	65
66	INSTALL CONCRETE PAD DEMO; SPOT TUCKPOINT AND								66
67	RESET SILLS AROUND BLDG	2014	16,636		15	647	647	12,569	67
68	REMODEL 5 SHOWER ROOMS; NEW TILE, WALLS,								68
69	LIGHT FIXTURES, PAINT CEILINGS, NEW FIRE DOOR	2014	44,975		27.5	954	954	18,326	69
70	TOTAL (lines 4 thru 69)		\$ 20,957,140	\$ 758,013		\$ 397,804	\$ (360,264)	\$ 6,671,024	70

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

Facility Name & ID Number **BRIA OF PALOS HILLS**# **0051136**

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 20,957,140	\$ 758,013		\$ 397,804	\$ (360,209)	\$ 6,671,024	1
2	INSTALLED NEW CONDESING UNIT ON ROOF	2014	6,300		27.5	134	134	2,529	2
3	INSTALL ACCUTECH DEPARTURE ALERT SYSTEM FOR								3
4	FRONT & BACK DOOR; DELAY LOCKS ON DOUBLE DOOR	2014	11,599		27.5	246	246	4,589	4
5	WIRE UP 10 ROOMS	2015	3,500		27.5	74	74	1,328	5
6	INSTALLATION OF THE FIRE DOORS COMING FROM								6
7	THE KITCHEN	2015	3,835		27.5	81	81	1,396	7
8	INSTALLED CAMERA ADDITIONS AND NURSE CALL								8
9	ADDITIONS	2017	27,800		27.5	590	590	8,046	9
10	WINDOW TREATMENTS, CURTAIN, CUBICLE	2017	18,944		5			18,944	10
11	ROOF REPLACED WITH A NEW SPMB (DINING ROOM)	2018	40,000		27.5	849	849	10,125	11
12	THERAPY ROOM HVAC UPGRADE	2018	18,200		27.5	386	386	4,496	12
13	HOT WATER PERMANENT CORRECTION	2020	18,700		27.5	397	397	3,202	13
14	PHASE I COVID DIALYSIS ROOM REMODEL: DRYWALL,	2021	394,912		30	7,668	7,668	51,510	14
15	FLOORCOVERING INSTALL, SPRINKLER, FIRE ALARM,								15
16	PLUMBING LABOR, PAINTING, ACT, PDI'S, ICU DOORS,								16
17	CONCRETE,, HVAC, ELECTRICAL, DOORS, HARDWARE,								17
18	WINDOWS & OPENINGS, MILLWORK, LIGHTING, TEMP								18
19	DIALYSIS, PDI'S, WALL PROTECTION, OVERHEAD, IDPH								19
20	PLAN REVIEW, ARCHITECTURAL DRAWINGS								20
21	PHASE II COVID UNIT: DRYWALL, ROOFING REPAIR,	2022	2,064,127		30	40,136	40,136	229,347	21
22	FLOORCOVERING INSTALL, SPRINKLER, FIRE ALARM,								22
23	PLUMBING LABOR, PAINTING, ACT, PDI'S, ICU DOORS,								23
24	CONCRETE,, HVAC, ELECTRICAL, DOORS, HARDWARE,								24
25	WINDOWS & OPENINGS, MILLWORK, LIGHTING, TEMP								25
26	DIALYSIS, PDI'S, WALL PROTECTION, OVERHEAD, IDPH								26
27	PLAN REVIEW, ARCHITECTURAL DRAWINGS								27
28	REPLACE DEFECTIVE CONTROLS: 2 VAV(BACNET), 2	2022	13,020		30	253	253	1,519	28
29	FAN POWERED BOXES, 1 UPC CONTROLLER, BAS SPACE								29
30	TEMP, SUPPLY AIR TEMP SENSOR								30
31	SEALED MANY OPEN AREAS ON OLD ROOF SECTION	2022	6,250		15	347	347	1,848	31
32	REPLACE EJECTOR PUMPS	2022	6,200		30	121	121	673	32
33	SEALCOAT AND STRIPE PARKING LOT	2022	13,075		15	725	725	3,863	33
34	TOTAL (lines 1 thru 33)		\$ 23,603,602	\$ 758,013		\$ 449,809	\$ (308,204)	\$ 7,014,437	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 23,603,602	\$ 758,013		\$ 449,809	\$ (308,204)	\$ 7,014,437	1
2	INSTALL VISION LINK II COMPUTER CONSOLE: LABOR,	2022	59,402		30	1,155	1,155	6,105	2
3	PROGRAMMING, TESTING AND TRAINING								3
4	REPAIRED A BROKEN WIRE ON KITCHEN HOOD MODULI	2022	21,432		30	417	417	2,202	4
5	AND RETURNED SYSTEM BACK TO NORMAL								5
6	PATIENT ROOMS: PTAC UNITS FOR INSTALLATION	2022	140,000		30	2,722	2,722	14,000	6
7	ROOF: INSTALL II CRICKETS, APPLY IB SEALER TO ANY	2022	193,300		30	3,758	3,758	17,718	7
8	FAILING SEAMS. SILICONE TOPCOAT TO NEW CRICKETS								8
9	REPLACE STEEL EXIT DOOR	2022	4,380		30	85	85	401	9
10	CLOSE UP EXISTING DOORWAYS AND INSTALL GLASS								10
11	PANE & NEW DOOR HOLLOW METAL	2023	5,156		30	100	100	444	11
12	NEW PLUMBING SYSTEM FOR HAND SINKS INCLUDING								12
13	UNDERGROUND, ROUGH AND TRIM PLUMBING VENT WI	2023	58,500		30	1,138	1,138	5,038	13
14	EXTERIOR FENCE AROUND DUMSTER: INSTALL CHAIN LINK								14
15	WITH TAN PRIVACY SLATS, SETS OF DRIVE GATES	2023	9,900		30	193	193	853	15
16	SHOWER ROOMS: INSTALL TILE FLOORING AND WALL,								16
17	NEW CEMENT BOARD, RED GUARD, NEW BASE, GRAB BAR,								17
18	NEW PLUMBING FIXTURES	2023	100,000		30	1,944	1,944	8,610	18
19	INSTALL EXTERIOR ACCESS PANEL: DEMOLITION, FINISHING								19
20	EXTERIOR CEILING	2023	6,000		30	117	117	517	20
21	RENOVATE PATIENT ROOMS:PLANK FLOORING, WINDOW								21
22	REPLACEMENT,PTAC UNITS, LIGHT FIXTURE	2023	619,803		30	12,052	12,052	53,372	22
23	INSTALLED NEW WATER HEATER IN SOUTH BOILER ROOM								23
24	CYCLED AND TESTED HEATER OPERATING	2023	15,320		30	298	298	1,320	24
25	INSTALL NEW CONTROL PANEL, PUMP AND NEW FLOAT:	2024	9,869		15	383	383	1,040	25
26	FURNISH AND INSTALL 1 PHASE PANEL FOR THE LIFE								26
27	SAFETY BRANCH IN THE ELECTRIC ROOM	2024	8,700		15	338	338	918	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 24,855,364	\$ 758,013		\$ 474,509	\$ (283,504)	\$ 7,126,975	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 761,369	\$ 82,180	\$	\$ (82,180)	3-10	\$ 497,670	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		1,867	1,867				74
75	TOTALS	\$ 761,369	\$ 84,047	\$ 1,867	\$ (82,180)		\$ 497,670	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)	\$ 27,067,136	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 842,060	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 476,376	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (365,684)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,624,645	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?
16. Rental Amount for movable equipment: \$ 59,246 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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	FACILITY	2023 FORD X2CJ	#####	16,191	19
20					20
21	TOTAL		\$ #####	\$ 16,191	21

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

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

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

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

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

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)	\$			

- (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	\$		\$ 112,231	\$		\$ 112,231	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,386			19,386	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			119,437			119,437	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				421,915		421,915	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					91,836		91,836	13
13	Other (specify): IV THERAPY, RENTAL	39-2					59,871		59,871	
14	TOTAL			\$		\$ 251,054	\$ 573,622		\$ 824,676	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 561,809	\$ 1,402,857	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,101)	5,776,115	5,776,115	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,484	177,878	6
7	Other Prepaid Expenses	228,691	228,691	7
8	Accounts Receivable (owners or related parties)	3,268,325	3,418,325	8
9	Other(specify): <u>ESCROWS</u>	102,403	2,204,515	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,088,827	\$ 13,208,381	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,450,403	13
14	Buildings, at Historical Cost		20,302,442	14
15	Leasehold Improvements, at Historical Cost	1,517,522	4,433,521	15
16	Equipment, at Historical Cost	761,369	2,522,772	16
17	Accumulated Depreciation (book methods)	(1,166,269)	(9,877,987)	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) <u>MORTGAGE COSTS NET</u>		248,691	22
23	Other(specify): <u>GOOD WILL NET</u>		90,703	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,112,622	\$ 19,170,545	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,201,449	\$ 32,378,926	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,912,650	\$ 6,912,650	26
27	Officer's Accounts Payable	1,213,717	1,213,717	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	498,268	498,268	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,604,267	2,604,267	32
33	Accrued Interest Payable	158,205	158,205	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>PA LOAN</u>	1,219,600	1,219,600	36
37	<u>TENANT RESERVES</u>		1,787,335	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,606,707	\$ 14,394,042	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,860,360	39
40	Mortgage Payable		20,000,000	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)	\$	\$ 24,860,360	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,606,707	\$ 39,254,402	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,405,258)	\$ (6,875,476)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,201,449	\$ 32,378,926	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (512,887)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (512,887)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(892,371)	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)	\$ (892,371)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,405,258)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF PALOS HILLS

0051136

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	\$ 17,198,339	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,198,339	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	231,856	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 231,856	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***	10,258	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,258	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	QIP PAYMENTS	163,287	28
28a	C.N.A WAGE PASS, IIT REBATE PROGRAM	239,663	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 402,950	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,843,403	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,327,680	31
32	Health Care	8,687,962	32
33	General Administration	3,372,849	33
	B. Capital Expense		
34	Ownership	2,717,830	34
	C. Ancillary Expense		
35	Special Cost Centers	824,676	35
36	Provider Participation Fee	785,097	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,716,094	40
41	Income before Income Taxes (line 30 minus line 40)**	(872,691)	41
42	Income Taxes	(19,680)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (892,371)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 941,965.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,237,276.00	45
46	MMAI-Medicaid is the Primary Payer	902,660.00	46
47	MMAI-Medicare is the Primary Payer	356,127.00	47
48	Private Pay	785,666.00	48
49	Medicare Part A	3,894,112.00	49
50	Other-(specify) HOSPICE	695,822.00	50
51	Other-(specify) INSURANCE	3,384,711.00	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)	\$ 17,198,339	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	1,456	1,725	\$ 134,526	\$ 77.99	1
2	Assistant Director of Nursing	2,232	2,441	118,133	48.40	2
3	Registered Nurses	14,550	15,679	679,559	43.34	3
4	Licensed Practical Nurses	38,874	42,084	1,935,784	46.00	4
5	CNAs & Orderlies	104,810	113,227	2,738,349	24.18	5
6	CNA Trainees					6
7	Licensed Therapist	9,298	9,879	559,297	56.61	7
8	Rehab/Therapy Aides	15,689	17,204	406,055	23.60	8
9	Activity Director					9
10	Activity Assistants	4,884	5,094	94,675	18.59	10
11	Social Service Workers	5,657	5,926	181,202	30.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,794	2,977	81,987	27.54	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	3,000	3,200	185,667	58.02	20
21	Assistant Administrator	1,536	1,600	73,318	45.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,037	15,850	434,138	27.39	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	1,887	2,159	51,290	23.76	31
32	Other Health C: Care Plan Coord	6,127	6,599	287,264	43.53	32
33	Other(specify) Security					33
34	TOTAL (lines 1 - 33)	227,831	245,644	\$ 7,961,244 *	\$ 32.41	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	\$ 55,668	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,866	10-3	39
40	Physical Therapy Consultant	L	35,212	10a-3	40
41	Occupational Therapy Consultant	Y	37,882	10a-3	41
42	Respiratory Therapy Consultant		8,000	10a-3	42
43	Speech Therapy Consultant	F	16,809	10a-3	43
44	Activity Consultant	E	385	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PSYCHIATRIC	S	9,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 171,822		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,402	\$ 83,483		50
51	Licensed Practical Nurses	13,121	575,238		51
52	Certified Nurse Assistants/Aides	1,465	52,497		52
53	TOTAL (lines 50 - 52)	15,988	\$ 711,218		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
BRIA OF PALOS HILLS

0051136

Report Period Beginning: 01/01/2025

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Ending: 09/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EVELYN AMADOR	Administrator	0	\$ 85,667
ONosen OSHODI	Administrator	0	100,000
		0	
		0	
CHRISTINE BECKFORD	Assistant Adm	0	73,318
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 258,985

B. Administrative - Other

Description	Amount
BRIA HEALTH SERVICES MANAGEMENT FEES	258,515
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		464,392
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 83,590
Unemployment Compensation Insurance	60,098
FICA Taxes	596,440
Employee Health Insurance	199,479
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	14,620
EMPLOYEE PHYSICAL EXAMS	
PENSION/PROFIT SHARING PLANS	
INSURANCE - EXECUTIVE LIFE	
TOTAL (agree to Schedule V, line 22, col.8)	

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	892
Association Dues (total from pg 22, #4)	35,504
TRUST/FRANCHISE/CONTRIB/ETC	
MARKETING/ADV/PROMO	16,662
LICENSES/DUES/SUBSCRIPTIONS	4,861
MGMT CO ALLOC	6,125
Less: Public Relations Expense	()
PAC and Lobbying payments	(21,587)
All non-allowable advertising	(16,662)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	22,728
MARKETING TRAVEL	(8,258)
MGMT CO ALLOC	3,208
Seminar Expense	
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

**BRIA OF PALOS HILLS
LEGAL SCHEDULE
1/1/2025-9/30/2025**

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/1/2025	BRIAN A STINES, P.C.	COLLECTIONS	250
2/1/2025	BRIAN A STINES, P.C.	COLLECTIONS	1,264
3/30/2025	BRIAN A STINES, PC	COLLECTIONS	500
5/2/2025	BRIAN A STINES, PC	COLLECTIONS	645
6/29/2025	BRIAN A STINES, PC	COLLECTIONS	6,711
1/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	245
2/28/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS FINAL ORFER FROM IDPH	670
3/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	274
5/1/2025	HINSHAW & CULBERTSON	PREPARED FOR STATUS CONFERENCE IN IDPH	368
5/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	105
1/31/2025	JACKSON LEWIS, P.C.	REVIEW AND PREPARE MOTION FOR EXTENSION	481
2/28/2025	JACKSON LEWIS, P.C.	REVIEW DOCUMENTS THAT HAVE BEEN FILED	72
3/21/2025	JACKSON LEWIS, P.C.	REVIEW COURT CORRESPONDENCE	951
4/16/2025	JACKSON LEWIS, P.C.	REVIEW COURT ORDER WITH RESPECT TO MOTION TO DISMISS	1,584
5/5/2025	JACKSON LEWIS, P.C.	REVIEW SETTLEMENT MATERIALS	1,635
7/1/2025	JACKSON LEWIS, P.C.	APPEARED FOR THE STATUS HEARING	1,326
7/18/2025	JACKSON LEWIS, P.C.	REVIEW THE PRELIMINARY APPROVALORDER	2,997
4/30/2025	SIMON LAW CO	SETTLEMENT	11,250
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
7/31/2024	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
TOTAL			35,528

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

YES
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	13,917
	13,917 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	21,587
	21,587 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	35,504
	35,504 Total
- (5)

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

\$ 55,980 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.

\$ 785,097

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.

\$ N/A 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?

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?

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.