

		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: 0057489

Facility Name: BRIA OF WOODRIVER

Address: 393 EDWARDSVILLE RDWOOD RIVER62095
NumberCityZip Code

County: MADISON

Telephone Number: (618) 259-4111Fax #: (618) 259-5791

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: MITCH KOHANANOO

Telephone Number: (847) 675-3585

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(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) 675-3585Fax #: (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 WOODRIVER # 0057489 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	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	106	TOTALS	106	38,690	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				27		1,435	563	2,025	8
9	SNF/PED									9
10	ICF	4,775	19,593	1,597		770		1,863	28,598	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,775	19,593	1,597	27	770	1,435	2,426	30,623	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 79.15%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

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

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 106

Medicare Intermediary NORIDIAN

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 WOODRIVER

0057489

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	175,362	53,100	193,157	421,619		421,619		421,619			1
2	Food Purchase		241,871		241,871		241,871		241,871			2
3	Housekeeping		1,172	218,652	219,824		219,824		219,824			3
4	Laundry		16,753	146,259	163,012		163,012		163,012			4
5	Heat and Other Utilities			155,410	155,410		155,410	847	156,257			5
6	Maintenance	102,367	104,722	45,367	252,456		252,456	9,287	261,743			6
7	Other (specify):* Security, Scavenger			17,614	17,614		17,614	164	17,778			7
8	TOTAL General Services	277,729	417,618	776,459	1,471,806		1,471,806	10,298	1,482,104			8
	B. Health Care and Programs											
9	Medical Director			26,889	26,889		26,889		26,889			9
10	Nursing and Medical Records	2,682,898	228,702	1,228,897	4,140,497		4,140,497	53,886	4,194,383			10
10a	Therapy	185,833		9,824	195,657		195,657		195,657			10a
11	Activities	135,350	1,924	1,821	139,095		139,095		139,095			11
12	Social Services	45,162	2,709		47,871		47,871		47,871			12
13	CNA Training											13
14	Program Transportation			644	644		644		644			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,049,243	233,335	1,268,075	4,550,653		4,550,653	53,886	4,604,539			16
	C. General Administration											
17	Administrative	130,722		165,646	296,368		296,368	(141,205)	155,163			17
18	Directors Fees											18
19	Professional Services			279,856	279,856		279,856	(117,113)	162,743			19
20	Dues, Fees, Subscriptions & Promotions			38,406	38,406		38,406	(13,344)	25,062			20
21	Clerical & General Office Expenses	258,324	9,490	235,536	503,350		503,350	(23,688)	479,662			21
22	Employee Benefits & Payroll Taxes			464,247	464,247		464,247		464,247			22
23	Inservice Training & Education			9,521	9,521		9,521	73	9,594			23
24	Travel and Seminar							2,364	2,364			24
25	Other Admin. Staff Transportation			10,287	10,287		10,287	(631)	9,656			25
26	Insurance-Prop.Liab.Malpractice			253,418	253,418		253,418	1,037	254,455			26
27	Other (specify):*			165,462	165,462		165,462	(141,386)	24,076			27
28	TOTAL General Administration	389,046	9,490	1,622,379	2,020,915		2,020,915	(433,893)	1,587,022			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,716,018	660,443	3,666,913	8,043,374		8,043,374	(369,709)	7,673,665			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	37,997		CONTRACT NURSING	XVIII C 53-2	1,211,720
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		1,798
	CONTRACTED DIETARY SERVICES		155,160		PURCHASED SERVICES		
			193,157		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		218,652		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			218,652		PHARMACY CONSULTANT	XVIII B 39-2	5,129
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		146,259		PSYCHIATRIC	XVIII B __-2	
			146,259		RN CONSULTANT	XVIII B 38-2	10,250
5	HEAT & OTHER UTILITIES						
	GAS HEAT		10,229				
	ELECTRICITY		126,866				
	WATER		635				1,228,897
	CABLE TV - LOBBY		17,680		THERAPY		
6			155,410		PHYSICAL THERAPY SERVICES		
	MAINTENANCE				SPEECH THERAPY SERVICES		
	GROUND MAINTENANCE		22,535		OCCUPATIONAL THERAPY SERVICES		
	PAINTING & DECORATING				REHABILITATION CONSULTANT	XVIII B __-2	
	BUILDING REPAIRS				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,578
	MAINTENANCE TRAVEL				OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	2,348
	EQUIPMENT MAINTENANCE & REPAIR		4,123		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	1,703
	ELEVATOR MAINTENANCE & REPAIR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,195
	OUTSIDE LABOR						
	EXTERMINATING SERVICE						
	FIRE SERVICE		18,709				9,824
				11	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,821
7			45,367	12			1,821
	OTHER				SOCIAL SERVICES		
	SCAVENGER		17,614		SOCIAL REHABILITATION SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	
					SOCIAL WORKER	XVIII B 45-2	
9			17,614	13			0
	MEDICAL DIRECTOR				NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		26,889		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL	LINE	
14	PROGRAM TRANSPORTATION		22	
	PATIENT TRANSPORTATION	644		
		644		
17	ADMINISTRATIVE			
	MANAGEMENT FEES XIX B	165,646		165,646
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING XIX C	40,540		
	ADMINISTRATIVE CONSULTANTS XIX C			
	PROFESSIONAL FEES XIX C	97,916		
	BOOKKEEPING/ADMINISTRATIVE SERVICES	141,400		
20		279,856	23	
	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING VI 19 XIX F			
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,867		
	EMPLOYEE WANT ADS XIX F	7,000		
	CONTRIBUTIONS VI 20 XIX F			
	DUES & SUBSCRIPTIONS XIX F	8,957		
	LICENSES & PERMITS XIX F	1,949		
	PUBLIC RELATIONS-PATIENT RELATED XIX F			
	ADVERTISING-YELLOW PAGES VI 28 XIX F			
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F			
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	15,992		
	HEALTH CARE WORKER BACKGROUND CHE XIX F	2,641		
	PATIENT BACKGROUND CHECKS XIX F			
		38,406		
21	CLERICAL & GENERAL OFFICE EXPENSES		27	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	654		
	EQUIPMENT REPAIR & MAINTENANCE	113,796		
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES VI 18	105,324		
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE	15,762		
	MESSENGER SERVICE			
		235,536		

			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL	LINE	
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES XIX D	279,176		
	UNEMPLOYMENT COMPENSATION XIX D	46,796		
	WORKERS COMPENSATION INSURANCE XIX D	50,524		
	HOSPITALIZATION INSURANCE XIX D	79,787		
	EMPLOYEE BENEFITS - OTHER XIX D	7,964		
	EMPLOYEE PHYSICAL EXAMS XIX D			
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D			
	PENSION/PROFIT SHARING PLANS XIX D			
23		464,247		
	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS	9,521		
24		9,521		
	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS XIX G			
	TRAVEL XIX G			
25		0		
	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF	10,287		
		10,287		
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE	253,418		
27		253,418		
	OTHER			
	BAD DEBTS VI 24	165,462		
		165,462		

GRAND TOTAL COLUMN 3 OTHER 3,666,913

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			1,099	1,099		1,099	25,826	26,925			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,234	15,234		15,234	30,171	45,405			32
33	Real Estate Taxes							3,341	3,341			33
34	Rent-Facility & Grounds			849,685	849,685		849,685		849,685			34
35	Rent-Equipment & Vehicles			58,825	58,825		58,825	617	59,442			35
36	Other (specify):* RENT OFFICE			2,800	2,800		2,800	(2,800)				36
37	TOTAL Ownership			927,643	927,643		927,643	57,155	984,798			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,802	57,581	147,383		147,383		147,383			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			616,717	616,717		616,717		616,717			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		89,802	674,298	764,100		764,100		764,100			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,716,018	750,245	5,268,854	9,735,117		9,735,117	(312,554)	9,422,563			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	22,205	30		9
10	Interest and Other Investment Income	(1,192)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(105,324)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(165,462)	27		24
25	Fund Raising, Advertising and Promotional	(1,867)	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	(16,623)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (268,263)		\$	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)	(44,291)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (44,291)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (312,554)		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	\$ (15,992)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING TRAVEL	(631)	25	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
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	(16,623)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PG OWNERSHIP-1						

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	RENT OFFICE	\$ 2,800	IME REALTY CORPORATION		\$	\$ (2,800)	1
2	V								2
3	V	5	UTILITIES				847	847	3
4	V	6	MAINTENANCE				410	410	4
5	V	19	PROFESSIONAL FEES				35	35	5
6	V	26	INSURANCE				166	166	6
7	V	30	DEPRECIATION				1,346	1,346	7
8	V	32	INTEREST				1,511	1,511	8
9	V	33	RE TAX				3,341	3,341	9
10	V	21	OFFICE EXPENSE				207	207	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,800			\$ 7,863	\$ * 5,063	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	\$ 141,400	BRIA HEALTH SERVICES, LLC		\$	\$ (141,400)	15
16	V	17	MANAGEMENT FEES	165,646				(165,646)	16
17	V								17
18	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	18
19	V	17	SALARIES-CFO				15,453	15,453	19
20	V	6	SALARIES-MAINTENANCE				7,135	7,135	20
21	V	10	SALARIES-A/R				53,886	53,886	21
22	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	22
23	V	21	SALARIES-CLERICAL				70,617	70,617	23
24	V	6	MAINTENANCE				1,742	1,742	24
25	V	7	SCAVENGER				164	164	25
26	V	19	PROFESSIONAL FEES				24,252	24,252	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				4,515	4,515	27
28	V	21	OFFICE EXPENSE				8,700	8,700	28
29	V	23	SEMINARS				73	73	29
30	V	24	TRAVEL				2,364	2,364	30
31	V	26	INSURANCE				871	871	31
32	V	27	EMPLOYEE BENEFITS				24,076	24,076	32
33	V	30	DEPRECIATION				2,275	2,275	33
34	V	32	INTEREST				29,852	29,852	34
35	V	35	AUTO LEASE				294	294	35
36	V	35	EQUIPMENT RENTAL				323	323	36
37	V								37
38	V								38
39	Total			\$ 307,046			\$ 257,692	\$ * (49,354)	39

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

Facility Name & ID Number

BRIA OF WOODRIVER

0057489

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

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

VII. RELATED PARTIES (continued)

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

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

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIA OF WOODRIVER # 0057489 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	CENSUS DAYS	821,683	19	\$ 22,755	\$	30,624	\$ 847	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		30,624	410	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		30,624	35	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		30,624	166	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		30,624	1,346	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		30,624	1,511	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		30,624	3,341	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		30,624	207	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	\$		\$ 7,863	25

Facility Name & ID Number BRIA OF WOODRIVER # 0057489 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	MANAGEMENT FEES-RELATED	wghtd avr hours	40	19	\$ 179,753	\$	2	\$ 8,988	1
2	17	SALARIES-CFO	CENSUS DAYS	821,683	19	414,635	414,635	30,624	15,453	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	30,624	7,135	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	30,624	53,886	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	30,624	70,617	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		30,624	1,742	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,370		30,624	164	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		30,624	24,252	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		30,624	4,515	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		30,624	8,700	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		30,624	73	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		30,624	2,364	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		30,624	871	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		30,624	24,076	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		30,624	2,275	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		30,624	29,852	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		30,624	294	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		30,624	323	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,995	\$ 4,030,510		\$ 257,692	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	OPTIMUM BANK	X		LOC		09/01/22	600,000	254,308		PRIME+	15,234		6
7													7
8	RELATED PARTY ALLOCATION												8
9	TOTAL Facility Related						\$ 600,000	\$ 254,308			\$ 15,234		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$ 600,000	\$ 254,308			\$ 15,234		15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Assessed Value from Real Estate Tax Bill:	2024	1,054,680	8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023	92,062	12		
	2024	97,065	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	BRIA OF WOODRIVER	COUNTY	MADISON
---------------	-------------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT MITCH KOHANANOO

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 Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:30,132

B. General Construction Type:ExteriorBRICK

FrameCONCRETE

Number of Stories2

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)?

YESNOX

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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

0057489

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7	IME-BLDG				52,473	1,346		1,346			7	
8	RELATED PARTY -IMPR				35,453	899		899			8	
	Improvement Type**											
9	INSTALL MICROVISION 500Z CONSOLE/RECEIVER. TWO			2022	42,995		15	1,672	1,672	8,359	9	
10	RELAYS, HDMI, WIFI PROGRAMMING, AUDIBLE ALARM										10	
11	ANNUNCIATIOJ, USB DRIVE, TRANSFORMER										11	
12	REPLACE SECTION OF SEWER LINE: INSTALLED NEW SECTION			2022	21,700		27.5	460	460	2,268	12	
13	OF SIX INCH SOLID CORE PVC PIPE, AND TWO-WAY CLEAN-										13	
14	OUT TEE. BACKFILLED THE TRENCH WITH SAND										14	
15	REMOVE AND REPLACE 28 CURB-MOUNT SKYLIGHTS			2022	26,833		27.5	569	569	2,722	15	
16	HALLWAYS AND LOBBY AREA: PLASTER, PRIME AND										16	
17	PAINT ALL WALLS.			2023	18,000		15	700	700	3,100	17	
18	FRONT ENTRY: REATTACH 2 SOCTLONS OF SOFFIT CEILING,										18	
19	REMOVE AND PERLACE WITH LIKE MATERIALS DAMAGE ON										19	
20	FRONT OVERHANG			2023	2,943		15	114	114	506	20	
21	HALLWAY, CONFERENCE ROOM, LOBBY AREA: INSTALL										21	
22	VINYL PLANK/ COVE BASE			2023	23,949		15	931	931	4,123	22	
23	FURNISH AND INSTALLED (2) RTUS 3-TON AND 2.5 TON			2023	23,182		27.5	492	492	2,178	23	
24	SPRINKLER: CHANGE OUT (371) WET AND (14) DRY FIRE										24	
25	SPRINKLER HEADS THROUGH BUILDING			2023	53,280		27.5	1,130	1,130	5,004	25	
26	FURNISH & INSTALL NEW BOHN EVAPORATOR WITH ELRCTRIC										26	
27	DEFROST, AIR COOLER CONDENSER ON THE ROOF			2024	17,097		15	665	665	1,805	27	
28	RTU: FURNISH & INSTALL 3TON SINGLE PHASE AMERICAN STANDARD										28	
29	PACKAGE UNITS INCLUDES 15 KW ELECTRIC HEATERS			2024	21,214		15	825	825	2,239	29	
30	BACK DOORS-REPLACED THE 2000 HALLWAY MAGLOCKS			2024	10,365		15	403	403	1,094	30	
31	FURNISH & INSTALL 3 NEW BTU RINNAI COMMERCIAL TANKLESS HOT										31	
32	WATER HEATERS WITH EXTERNAL RE-CIRCULATING PUMPS			2024	46,645		15	1,814	1,814	4,923	32	
33	INSTALL 4 CHROME DELTA 1400 SERIES SINGLE HANDLE FAUCI			2024	4,368		15	170	170	461	33	
34	GENERACODEL ET15068GVAC: INSTALL NEW UNIT, ELECTRICA			2024	89,529		27.5	1,899	1,899	5,154	34	
35	KITCHEN RTU COMPRESSOR:FURNISH & INSTALL COPELAND 5TON SCROLL										35	
36	2-STAGE COMPRESSOR INCLUDES FILTER DRIED			2024	5,498		15	214	214	580	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	ALL RESIDENT ROOMS: FLOORING, PAINT, DRYWALL,		\$	\$		\$	\$	\$	37
38	CERAMIC TILE, INSTALL NEW LVP & COVE BASE	2024	395,000		27.5	8,379	8,379	22,743	38
39	FURNISH AND INSTALL 3TON AMERICAN STANDARD								39
40	PACKAGE UNIT	2024	12,566		15	489	489	1,327	40
41	INSTALL NEW PTACS AT BUILDING PATIENT ROOMS	2024	47,050		27.5	998	998	2,708	41
42									42
43									43
44									44
45				1,099			(1,099)		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)		\$ 950,140	\$ 3,344		\$ 24,167	\$ 20,823	\$ 71,292	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	\$ 13,820	\$	\$ 1,382	\$ 1,382	8-10	\$ 3,584	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY	1,376	11,007	11,007				74
75	TOTALS	\$ 15,196	\$ 11,007	\$ 12,389	\$ 1,382		\$ 3,584	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)	\$ 965,336	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,351	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,556	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,205	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 74,876	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SOUTHERN ILLINOIS MASTER TENANT LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		106	07/01/22	\$ 849,685	10		3
4	Additions							4
5								5
6								6
7	TOTAL		106		\$ 849,685			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: \$ 38,242 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18	FACILITY	2022 RAM PROMASTER	#####	20,583	18
19					19
20					20
21	TOTAL		\$ #####	\$ 20,583	21

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	2026	\$ 749,258
13.	2027	\$ 760,497
14.	2028	\$

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THIS FACILITY HIRES ONLY CERTIFIED NURSING AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 17,531	\$		\$ 17,531	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,293			6,293	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			33,757			33,757	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				72,261		72,261	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					8,659		8,659	13
13	Other (specify): IV THERAPY, RENTAL	39-2					8,882		8,882	
14	TOTAL			\$		\$ 57,581	\$ 89,802		\$ 147,383	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	\$ 373,887	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,301)	1,889,831		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	111,805		7
8	Accounts Receivable (owners or related parties)	737,977		8
9	Other(specify): <u>ESCROWS</u>	282,873		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,396,373	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	39,820		16
17	Accumulated Depreciation (book methods)	(14,586)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,234	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,421,607	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,554,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	254,308		29
30	Accrued Salaries Payable	294,705		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO RELATED PARTY</u>	356,377		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,460,288	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,460,288	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 961,319	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,421,607	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 816,343	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 816,343	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	144,976	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)	\$ 144,976	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)	\$ 961,319	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF WOODRIVER

0057489

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,236,971	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,236,971	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	175,592	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 175,592	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***	1,192	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,192	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	470,055	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 470,055	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,883,810	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,471,806	31
32	Health Care	4,550,653	32
33	General Administration	2,020,915	33
	B. Capital Expense		
34	Ownership	927,643	34
	C. Ancillary Expense		
35	Special Cost Centers	147,383	35
36	Provider Participation Fee	616,717	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,735,117	40
41	Income before Income Taxes (line 30 minus line 40)**	148,693	41
42	Income Taxes	(3,717)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 144,976	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,288,080.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,314,855.00	45
46	MMAI-Medicaid is the Primary Payer	433,869.00	46
47	MMAI-Medicare is the Primary Payer	18,991.00	47
48	Private Pay	225,546.00	48
49	Medicare Part A	1,141,649.00	49
50	Other-(specify) HOSPICE	505,382.00	50
51	Other-(specify) INSURANCE	308,599.00	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)	\$ 9,236,971	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	1,956	2,130	\$ 122,848	\$ 57.68	1
2	Assistant Director of Nursing	3,955	4,229	226,467	53.55	2
3	Registered Nurses	7,828	9,082	358,784	39.50	3
4	Licensed Practical Nurses	17,001	18,920	824,555	43.58	4
5	CNAs & Orderlies	40,952	46,451	1,008,268	21.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,912	4,284	185,833	43.38	8
9	Activity Director					9
10	Activity Assistants	7,144	7,709	135,350	17.56	10
11	Social Service Workers	1,520	1,887	45,162	23.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,435	8,709	175,362	20.14	15
16	Dishwashers					16
17	Maintenance Workers	3,960	4,341	102,367	23.58	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,744	2,072	130,722	63.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,153	10,119	258,324	25.53	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	1,625	1,810	41,941	23.17	31
32	Other Health C: Care Plan Coord	1,872	2,032	100,035	49.23	32
33	Other(specify) Security					33
34	TOTAL (lines 1 - 33)	111,057	123,775	\$ 3,716,018 *	\$ 30.02	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	\$ 37,997	1-3	35
36	Medical Director	O	26,889	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,129	10-3	39
40	Physical Therapy Consultant	L	3,578	10a-3	40
41	Occupational Therapy Consultant	Y	2,348	10a-3	41
42	Respiratory Therapy Consultant		1,703	10a-3	42
43	Speech Therapy Consultant	F	2,195	10a-3	43
44	Activity Consultant	E	1,821	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) Psychiatric	S	0	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 81,660		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 174,080		50
51	Licensed Practical Nurses		263,170		51
52	Certified Nurse Assistants/Aides		774,470		52
53	TOTAL (lines 50 - 52)		\$ 1,211,720		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBRIA OF WOODRIVER# 0057489Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CASSANDRA LINDOW	Administrator	0	\$ 108,599
LATISHA CRIDER	Administrator		16,931
CARLA RIVA	Administrator		5,192
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 130,722

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	\$ 165,646
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		\$
SCHEDULE ATTACHED		279,856
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 279,856

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 50,524
Unemployment Compensation Insurance	46,796
FICA Taxes	279,176
Employee Health Insurance	79,787
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	7,964
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)	2,641
Patient Background Checks	
Association Dues (total from pg 22, #4)	24,117
TRUST/FRANCHISE/CONTRIB/ETC	
MARKETING/ADV/PROMO	1,867
LICENSES/DUES/SUBSCRIPTIONS	2,781
MGMT CO ALLOC	4,515
Less: Public Relations Expense (	
PAC and Lobbying payments	(15,992)
All non-allowable advertising	(1,867)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
MARKETING TRAVEL	
MGMT CO ALLOC	2,364
Seminar Expense	
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,364

* Attach copy of IMRF notifications

**See instructions.

**BRIA OF WOODRIVER
LEGAL EXPENSES
1/1/2025-12/31/2025**

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/3/2025	BRIAN A STINES	DEFENSE OF CITATION	310
2/1/2025	BRIAN A STINES		110
3/30/2025	BRIAN A STINES		759
6/29/2025	BRIAN A STINES		750
1/31/2025	HINSHAW & CULBERTSON	CORRESPONDENCE TO CLIENT	85
2/28/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF IDPH PREHEARING NOTICE	686
3/31/2025	HINSHAW & CULBERTSON	PREPARE FOR STATUS CONFERENCE IN IDPH	114
5/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS	210
6/23/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF A VIOLATION AND 2567	562
1/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
2/28/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
3/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
4/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
5/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
6/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
7/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
3/1/2025	SCOTT & KRAUS	EDITED AND REVISED DACA AND DAISA	455
5/12/2025	SCOTT & KRAUS	REVIEW CORRESPONDENCE REGARDING DACA & DAISA	725
TOTAL			9,666

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>8,125</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>8,125</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>15,992</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>15,992</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>24,117</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>24,117</u> Total
- (5)

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

\$ Line 10-2
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 616,717

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.