FOR BHF USE

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048645

Facility Name: BRIA OF CAHOKIA

Address: 3354 JEROME LANE (Number) CAHOKIA (City) 62206 (Zip Code)

County: ST CLAIR

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 05/01/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA **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 1/1/2020 to 12/31/2020 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) MARTIN WEISS
(Title) MEMBER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	133	TOTALS	133	48678	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,100	2,100	8
9	SNF/PED					9
10	ICF	35,186	356	1,412	36,954	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,186	356	3,512	39,054	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.23%

D. How many bed reserve days during this year were paid by the Department?
0 (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 5/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 2,100

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	225,951	42,031	19,500	287,482		287,482		287,482			1
2	Food Purchase		253,225		253,225		253,225		253,225			2
3	Housekeeping	331,679	58,716		390,395		390,395		390,395			3
4	Laundry	43,218	42,585	919	86,722		86,722		86,722			4
5	Heat and Other Utilities			122,964	122,964		122,964		122,964			5
6	Maintenance	90,137	34,788	16,322	141,247		141,247	742	141,989			6
7	Other (specify):*			33,938	33,938		33,938	150	34,088			7
8	TOTAL General Services	690,985	431,345	193,643	1,315,973		1,315,973	892	1,316,865			8
	B. Health Care and Programs											
9	Medical Director			6,817	6,817		6,817		6,817			9
10	Nursing and Medical Records	2,726,986	268,086	84,309	3,079,381		3,079,381	59,801	3,139,182			10
10a	Therapy			49,346	49,346		49,346		49,346			10a
11	Activities	130,725	8,014	2,341	141,080		141,080		141,080			11
12	Social Services	188,958	3,527	2,446	194,931		194,931		194,931			12
13	CNA Training											13
14	Program Transportation			62	62		62		62			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,046,669	279,627	145,321	3,471,617		3,471,617	59,801	3,531,418			16
	C. General Administration											
17	Administrative	112,256		210,000	322,256		322,256	(158,364)	163,892			17
18	Directors Fees											18
19	Professional Services			375,203	375,203		375,203	(220,284)	154,919			19
20	Dues, Fees, Subscriptions & Promotions			58,383	58,383		58,383	(10,383)	48,000			20
21	Clerical & General Office Expenses	193,525	17,083	154,894	365,502		365,502	68,259	433,761			21
22	Employee Benefits & Payroll Taxes			539,844	539,844		539,844		539,844			22
23	Inservice Training & Education			30,141	30,141		30,141	231	30,372			23
24	Travel and Seminar							2,686	2,686			24
25	Other Admin. Staff Transportation			5,223	5,223		5,223		5,223			25
26	Insurance-Prop.Liab.Malpractice			239,200	239,200		239,200	25,773	264,973			26
27	Other (specify):*			513,864	513,864		513,864	(473,113)	40,751			27
28	TOTAL General Administration	305,781	17,083	2,126,752	2,449,616		2,449,616	(765,195)	1,684,421			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,043,435	728,055	2,465,716	7,237,206		7,237,206	(704,502)	6,532,704			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.

Facility Name & ID# BRIA OF CAHOKIA **#0048645 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	18,782	
	REPAIRS & MAINTENANCE		718	
	CONTRACTED DIETARY SERVICES		0	
				19,500
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		919	
	CONTRACTED LAUNDRY SERVICES		0	
				919
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		4,821	
	ELECTRICITY		71,551	
	WATER		39,133	
	CABLE TV - LOBBY		7,459	
				122,964
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,097	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		717	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		11,508	
				16,322
7	**OTHER**			
	SCAVENGER		33,938	
	SECURITY SERVICE		0	
				33,938
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		6,817	6,817

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	60,382	
	LABORATORY & XRAY EXPENSE		2,119	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	13,050	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	360	
	PHARMACY CONSULTANT	XVIII B 39-2	8,398	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2		
				84,309
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	21,867	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B 41-2	17,915	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	2,880	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	6,684	
				49,346
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,341	
				2,341
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	2,446	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,446
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# BRIA OF CAHOKIA **#0048645 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		62	
				62
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	210,000	210,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,899	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	122,904	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		239,400	
				375,203
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,470	
	EMPLOYEE WANT ADS	XIX F	22,290	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	13,524	
	LICENSES & PERMITS	XIX F	3,046	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	11,277	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	975	
	PATIENT BACKGROUND CHECKS	XIX F	3,801	
				58,383
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,468	
	EQUIPMENT REPAIR & MAINTENANCE		101,640	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		45,130	
	MESSENGER SERVICE		6,656	
				154,894

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	305,979	
	UNEMPLOYMENT COMPENSATION	XIX D	46,270	
	WORKERS COMPENSATION INSURANCE	XIX D	93,782	
	HOSPITALIZATION INSURANCE	XIX D	66,492	
	EMPLOYEE BENEFITS - OTHER	XIX D	27,321	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				539,844
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		30,141	
				30,141
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G		
				0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		5,223	
				5,223
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		239,200	
				239,200
27	**OTHER**			
	BAD DEBTS	VI 24	513,864	
				513,864

GRAND TOTAL COLUMN 3 OTHER **2,465,716**

Facility Name & ID Number BRIA OF CAHOKIA #0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			62,197	62,197		62,197	134,093	196,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,228	3,228		3,228	233,057	236,285			32
33	Real Estate Taxes							56,430	56,430			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(540,000)				34
35	Rent-Equipment & Vehicles			35,482	35,482		35,482	9,030	44,512			35
36	Other (specify):* STORAGE			720	720		720	40,992	41,712			36
37	**TOTAL Ownership**			641,627	641,627		641,627	(66,398)	575,229			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,914	596,402	669,316		669,316		669,316			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			310,009	310,009		310,009		310,009			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		72,914	906,411	979,325		979,325		979,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,043,435	800,969	4,013,754	8,858,158		8,858,158	(770,900)	8,087,258			45

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	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	565	30		9
10	Interest and Other Investment Income	(2,162)	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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(11,277)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(513,864)	27		24
25	Fund Raising, Advertising and Promotional	(3,470)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(64,077)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (594,285)		$	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)	(176,615)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (176,615)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (770,900)		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

BRIA OF CAHOKIA

ID# 0048645

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (60,274)	21	1
2				2
3	AUTO LEASE-MARKETING	(3,803)	35	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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**	(64,077)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	742	0	0	0	0	0	0	0	742	6
7	Other (specify):*	0	0	0	150	0	0	0	0	0	0	0	150	7
8	**TOTAL General Services**	0	0	0	892	0	0	0	0	0	0	0	892	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	59,801	0	0	0	0	0	0	0	59,801	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	59,801	0	0	0	0	0	0	0	59,801	16
	C. General Administration													
17	Administrative	0	0	(163,864)	5,500	0	0	0	0	0	0	0	(158,364)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,700	2,399	(235,383)	0	0	0	0	0	0	0	(220,284)	19
20	Fees, Subscriptions & Promotions	(14,747)	0	131	4,233	0	0	0	0	0	0	0	(10,383)	20
21	Clerical & General Office Expenses	(60,274)	0	31,805	96,728	0	0	0	0	0	0	0	68,259	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	231	0	0	0	0	0	0	0	231	23
24	Travel and Seminar	0	0	341	2,345	0	0	0	0	0	0	0	2,686	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	19,990	2,279	3,504	0	0	0	0	0	0	0	25,773	26
27	Other (specify):*	(513,864)	0	17,690	23,061	0	0	0	0	0	0	0	(473,113)	27
28	**TOTAL General Administration**	(588,885)	32,690	(109,219)	(99,781)	0	0	0	0	0	0	0	(765,195)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(588,885)	32,690	(109,219)	(39,088)	0	0	0	0	0	0	0	(704,502)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	565	129,116	886	3,526	0	0	0	0	0	0	0	134,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,162)	216,177	0	19,042	0	0	0	0	0	0	0	233,057	32
33	Real Estate Taxes	0	56,430	0	0	0	0	0	0	0	0	0	56,430	33
34	Rent-Facility & Grounds	0	(540,000)	0	0	0	0	0	0	0	0	0	(540,000)	34
35	Rent-Equipment & Vehicles	(3,803)	0	10,596	2,237	0	0	0	0	0	0	0	9,030	35
36	Other (specify):*	0	40,992	0	0	0	0	0	0	0	0	0	40,992	36
37	TOTAL Ownership	(5,400)	(97,285)	11,482	24,805	0	0	0	0	0	0	0	(66,398)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(594,285)	(64,595)	(97,737)	(14,283)	0	0	0	0	0	0	0	(770,900)	45

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 PAGE 6-SUPPLEMENTAL						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 540,000	JEROME LANE, LLC		$	$ (540,000)	1
2	V								2
3	V	30	DEPRECIATION				129,116	129,116	3
4	V	32	INTEREST EXPENSE				211,277	211,277	4
5	V	32	AMORT LOAN COST				4,900	4,900	5
6	V	33	REAL ESTATE TAXES				56,430	56,430	6
7	V	19	PROFESSIONAL FEES				12,700	12,700	7
8	V	36	INSURANCE-MIP				40,992	40,992	8
9	V	26	INSURANCE-HAZARD				19,990	19,990	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 540,000			$ 475,405	$ * (64,595)	14

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 210,000	WEISS MANAGEMENT GROUP		$	$ (210,000)	15
16	V								16
17	V								17
18	V	17	ADMINISTRATIVE SALARIES				46,136	46,136	18
19	V	19	PROFESSIONAL FEES				2,399	2,399	19
20	V	20	LICENSES & PERMITS				131	131	20
21	V	21	OFFICE EXPENSES				31,805	31,805	21
22	V	24	TRANSPORTATION				341	341	22
23	V	26	INSURANCE				2,279	2,279	23
24	V	27	EMPLOYEE BENEFITS				17,690	17,690	24
25	V	30	DEPRECIATION (SL)				886	886	25
26	V	35	AUTO LEASE				10,596	10,596	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			$ 210,000			$ 112,263	$ * (97,737)	39

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	BOOKKEEPING/ADM SERVICES	$ 239,400	BRIA HEALTH SERVICES, LLC		$	$ (239,400)	15
16	V								16
17	V	17	CFO SALARY-A.WEINFELD				5,500	5,500	17
18	V	10	SALARIES-MEDICARE/NURSING				29,174	29,174	18
19	V	10	SALARIES-REGIONAL DIR RELATED PARTIES				26,215	26,215	19
20	V	21	SALARIES-CLERICAL RELATED PARTIES				3,842	3,842	20
21	V	21	SALARIES-CLERICAL				76,280	76,280	21
22	V	6	MAINTENANCE				742	742	22
23	V	7	SCAVENGER				150	150	23
24	V	10	NURSING CONSULTANT & SUPPLIES				4,412	4,412	24
25	V	19	PROFESSIONAL FEES				4,017	4,017	25
26	V	20	DUES,FEES,SUBSCRIPTIONS				4,233	4,233	26
27	V	21	OFFICE EXPENSE				16,606	16,606	27
28	V	23	SEMINARS				231	231	28
29	V	24	TRAVEL				2,345	2,345	29
30	V	26	INSURANCE				3,504	3,504	30
31	V	27	EMPLOYEE BENEFITS				23,061	23,061	31
32	V	30	DEPRECIATION				3,526	3,526	32
33	V	32	INTEREST				19,042	19,042	33
34	V	35	AUTO LEASE				1,347	1,347	34
35	V	35	EQUIPMENT RENTAL				890	890	35
36	V								36
37	V								37
38	V								38
39	Total			$ 239,400			$ 225,117	$ * (14,283)	39

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MARTIN J. WEISS	30.00	BRIA OF BELLEVILLE	BELLEVILLE	WEISS MGMT		MANAGEMENT/	1
2	NATAN WEISS	30.00			GROUP, INC	SKOKIE	CLERICAL	2
3	DANIEL WEISS	30.00	BRIA OF GENEVA	GENEVA				3
4	GARY A. WEINTRAUB	10.00			BRIA HEALTH		MANAGEMENT	4
5			BRIA OF FOREST EDGE	CHICAGO	SERVICES, LLC	SKOKIE	SERVICES	5
6								6
7			LAKE PARK CENTER	WAUKEGAN	JEROME LANE,		REAL ESTATE	7
8					LLC	SKOKIE		8
9			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				9
10				HEIGHTS				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								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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIC	30.00	SEE	15	38.00	SALARY	22,500	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	30.00	SCHEDULE	4	10.00	SALARY	7,000	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	30.00		4	10.00	SALARY	14,500	17-7	6
7											7
8	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:										8
9	AVRUM WEINFELD	SHAREHOLDER	ADMINISTRATIC	30.00		2	5.00	SALARY	5,500	17-7	9
10											10
11	DANIEL WEISS	SHAREHOLDER	REGIONAL DIR	30.00		4	10.00	SALARY	6,640	17-7	11
12											12
13								TOTAL	$ 56,140		13

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

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 [X] NO [ ]

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

Name of Related Organization: WEISS MANAGEMENT GROUP
Street Address: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	74,492	2	$ 88,000	$ 88,000	39,054	$ 46,136	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	74,492	2	4,575		39,054	2,399	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	74,492	2	249		39,054	131	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	74,492	2	60,666	60,000	39,054	31,805	4
5	24	TRANSPORTATION	PATIENT CENSUS	74,492	2	650		39,054	341	5
6	26	INSURANCE	PATIENT CENSUS	74,492	2	4,347		39,054	2,279	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	74,492	2	33,743		39,054	17,690	7
8	30	DEPRECIATION (SL)	PATIENT CENSUS	74,492	2	1,690		39,054	886	8
9	35	AUTO LEASE	PATIENT CENSUS	74,492	2	20,210		39,054	10,596	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					$ 214,130	$ 148,000		$ 112,263	25

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 [X] 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) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	CFO SALARY-A.WEINFELD	wghtd avr hours		9	$ 99,000	$ 99,000		$ 5,500	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	476,457	9	355,924	355,924	39,054	29,174	2
3	10	SALARIES-REGIONAL DIR RELA	wghtd avr hours		9	235,935	235,935		26,215	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours		9	107,288	107,288		3,842	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	476,457	9	930,610	930,610	39,054	76,280	5
6	6	MAINTENANCE	CENSUS DAYS	476,457	9	9,053		39,054	742	6
7	7	SCAVENGER	CENSUS DAYS	476,457	9	1,836		39,054	150	7
8	10	NURSING CONSULTANT & SUPPI	CENSUS DAYS	476,457	9	53,827		39,054	4,412	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	476,457	9	49,003		39,054	4,017	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	476,457	9	51,648		39,054	4,233	10
11	21	OFFICE EXPENSE	CENSUS DAYS	476,457	9	202,594		39,054	16,606	11
12	23	SEMINARS	CENSUS DAYS	476,457	9	2,822		39,054	231	12
13	24	TRAVEL	CENSUS DAYS	476,457	9	28,614		39,054	2,345	13
14	26	INSURANCE	CENSUS DAYS	476,457	9	42,750		39,054	3,504	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	476,457	9	281,347		39,054	23,061	15
16	30	DEPRECIATION	CENSUS DAYS	476,457	9	43,023		39,054	3,526	16
17	32	INTEREST	CENSUS DAYS	476,457	9	232,306		39,054	19,042	17
18	35	AUTO LEASE	CENSUS DAYS	476,457	9	16,432		39,054	1,347	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	476,457	9	10,854		39,054	890	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,754,866	$ 1,728,757		$ 225,117	25

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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: JEROM LANE, LLC						$	$			$	1
2	CAMBRIDGE REALTY	X		MORTGAGE		11/01/16	6,705,000	6,254,227	10/01/51	3.3500	211,277	2
3	LOAN COSTS	X		AMORT OVER LIFE OF LOAN			171,492	151,075			4,900	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	05/08/11	2,000,000			PRIME+	3,228	6
7												7
8	RELATED PARTY ALLOCATION										19,042	8
9	TOTAL Facility Related						$ 8,876,492	$ 6,405,302			$ 238,447	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,876,492	$ 6,405,302			$ 238,447	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 40,992 Line # 36

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

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 56,450	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.)		$ 56,159	2
3. Under or (over) accrual (line 2 minus line 1).		$ (291)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,721	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.		$ 56,430	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	50,678	8
	2016	59,743	9
	2017	52,781	10
	2018	55,891	11
	2019	56,159	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF CAHOKIA COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0048645

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-12.0-206-016	NURSING HOME	$ 56,159.48	$ 56,159.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 56,159.48	$ 56,159.48

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 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. 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		2014	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	133		2014		$ 2,668,552	$ 97,038	27.5	$ 97,038	$	$ 650,652	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				59,282	1,579		1,579			8
	Improvement Type**										
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2006	30,000	1,091	27.5	1,091		15,474	9
10	AIR CONDITIONS			2006	947		5			947	10
11	INSTALLATION OF EXAUST SYSTEM			2007	3,340	121	27.5	121		1,689	11
12	AIR CONDITIONS			2007	11,065		5			11,065	12
13	INSTALLATION OF ROOFTOP UNIT			2007	4,140	151	27.5	151		2,057	13
14	CALLCARE STATION REPLACEMENT			2007	3,122	114	27.5	114		1,544	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIO			2007	6,870	458	15	458		5,992	15
16	INSTALLATION OF DOORS-FRONT ENTRANCE,VESTIBULE			2007	11,640	423	27.5	423		5,552	16
17	PAINTING			2007	7,587		5			7,587	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS			2007	14,027		5			14,027	18
19	BUILDING RENOVATION AND REMODELING:			2007	228,253	8,300	27.5	8,300		108,246	19
20	A,B,C,D-WINGS CORRIDOR,RISIDENT ROOMS, THERAPY										20
21	ROOM,LOBBY, RECEPTION,ACTIVITY ROOM, HALL-LIGHT										21
22	FIXTURES,FLOORING,CEILING GRID & TILE,HANDRAILS,										22
23	CORNER GUARDS,NURSES STATION B-WING CORRIDOR										23
24	D-WING RESIDENT ROOM-FLOORING			2008	34,382	1,250	27.5	1,250		15,990	24
25	SHOWER-VARIOUS DIFFERENT AREAS			2008	16,266	591	27.5	591		7,511	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2008	26,400	960	27.5	960		12,040	26
27	INSTALLED NEW OFFICE, SIDEWALK TO THE OFFICE			2008	29,175	1,061	27.5	1,061		13,307	27
28	INSTALLATION OF ALARM SYSTEM			2008	42,875	1,559	27.5	1,559		19,423	28
29	INSTALLATION OF DOORS-OXYGEN ROOM, COURTYARD			2008	6,147	224	27.5	224		2,809	29
30	AIR CONDITIONS, WATER HEATER			2008	5,513		5			5,513	30
31	REPLACE EXISTING SPRINKLER PIPING			2008	9,498	345	27.5	345		4,183	31
32	SEALING PARKING LOT			2008	2,500	167	15	167		2,060	32
33	WALL AIR CONDITIONS			2009	6,308		5			6,308	33
34	WANDERGUARD E. STANDARD, BUMPER GUARD			2009	10,612	386	27.5	386		4,326	34
35	LOUNGE,RESIDENT & ACTIVITY ROOMS-FLOORING			2010	16,410	597	27.5	597		6,542	35
36	WALL AIR CONDITIONS			2010	6,712		5			6,712	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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
37	INSTALL DOORS AND HARDWARE	2010	$ 2,966	$ 108	27.5	$ 108	$	$ 1,130	37
38	INSTALL ACCELERATOR, REPLACE DRY PENDENT	2010	3,218	117	27.5	117		1,224	38
39	RANCH STYLE GARAGE	2010	15,515	564	27.5	564		5,852	39
40	NEW LAUNDRY ROOM-INSTALL DOORS,CONCRETE SLAI	2010	28,249	1,027	27.5	1,027		10,313	40
41	FOOTING FOR PERMIT,ELECTRICAL,WIRING,WINDOW,TILE								41
42	WALL AIR CONDITIONS	2011	6,639		5			6,639	42
43	SEAL COATING PARKING LOT	2011	20,931	1,395	15	1,395		13,718	43
44	INSTALLED QUARTER BARREL STYLE AWNINGS	2011	2,955	107	27.5	107		1,039	44
45	RESIDENT ROOMS-CUSTOM BUILT-IN WARDROBES	2011	18,278	665	27.5	665		6,456	45
46	INSTALL RTU & DUST RUN FROM ATTIC INTO ADM OFFI	2011	12,989	472	27.5	472		4,425	46
47	SHOWER ROOM: FOUR PIESE FIBERGLASS SHOWER;	2011	12,163	442	27.5	442		4,070	47
48	FULL PLYWOOD BACKING ON ALL WALLS; POLYESTER								48
49	GELCOAT FINISH								49
50	WALL AIR CONDITIONS	2012	12,123		5			12,123	50
51	INSTALLED 35 GALLON GREASE TRAP IN THE FLOOR	2012	13,900	505	27.5	505		4,314	51
52	REPLACED PIPE IN ATTIC , INSTALLED COMPRESSOR	2012	12,100	440	27.5	440		3,685	52
53	WALL AIR CONDITIONS	2013	6,903		5			6,903	53
54	SPRINKLERS	2013	91,610	3,331	27.5	3,331		25,399	54
55	CARPET FOR COFFICES AND LOBBY INSET; WALK-OFF								55
56	CARPET; WALL BASE	2013	5,794		5			5,794	56
57	PLASTER CEILING-INSTALL 2 EXPANSION JOINTS; ATTIC								57
58	SPACE-RE-INSULATE WITH 6" BLOWN	2013	10,338	376	27.5	376		2,648	58
59	WALL AIR CONDITIONS	2014	10,764		5	2,463	2,463	10,764	59
60	INSTALL REDUCED PRESSURE BACKFLOW PREVENTER								60
61	ON FIRE SPRINKLER SERVICE	2014	8,815	321	27.5	321		2,100	61
62	POUR AND FINISH PAD AND WALKWAY	2015	18,283	665	27.5	665		3,796	62
63	INSTALLED A NEW DURO-LAST ROOFING SYSTEM	2015	18,397	669	27.5	669		3,373	63
64	INSTALLSUBPANELS AND FEED PTAC UNITS	2015	21,640	787	27.5	787		3,968	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,616,193	$ 128,406		$ 130,869	$ 2,463	$ 1,071,289	70

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,616,193	$ 128,406		$ 130,869	$ 2,463	$ 1,071,289	1
2	RELATED RARTY: JEROM LANE, LLC								2
3	INSTALLED A NEW DURO-LAST ROOFING SYSTEM	2016	66,725	2,426	27.5	2,426		4,852	3
4	A AND C WING CORRIDOR-INSTALLATION OF TILE	2018	17,043	620	27.5	620		1,240	4
5	INSTALL DIRECT ACCESS/AIPHONE AND DOOR LOCKS	2018	16,704	607	27.5	607		1,214	5
6	COMPLETE & FURNISH MUD WORK & REPAINT	2018	18,255	3,651	5	3,651		7,302	6
7	23 RESIDENT ROOMS-INSTALLATION OF VINAL TILE AND								7
8	ACRYLIC CEMENT FLOOR	2018	27,152	987	27.5	987		1,974	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	TOTAL (lines 1 thru 33)		$ 3,762,072	$ 136,697		$ 139,160	$ 2,463	$ 1,087,871	34

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

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 269,630	$ 2,739	$ 29,115	$ 26,376	5-10	$ 157,007	71
72	Current Year Purchases	27,894	27,894	1,395	(26,499)	10	1,395	72
73	Fully Depreciated Assets	108,529					108,529	73
74	RELATED PARTY		26,620	26,620				74
75	TOTALS	$ 406,053	$ 57,253	$ 57,130	$ (123)		$ 266,931	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2008 FORD WAGON	2008	$ 37,400	$ 1,775	$	$ (1,775)	5	$ 37,400	76
77										77
78	ADMINISTRATIVE	2007 LAND ROVER/RANGE	2010	33,484					33,484	78
79										79
80	TOTALS			$ 70,884	$ 1,775	$	$ (1,775)		$ 70,884	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)	$ 4,589,009	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 195,725	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 196,290	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 565	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,425,686	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.

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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: $ 31,679 Description: SEE SCHEDULE ATTACHED
(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	MARKETING	2017 FORD ESCAPE	$ 458.79	$ 3,803	17
18					18
19					19
20					20
21	TOTAL		$ 458.79	$ 3,803	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.

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 231,832	$		$ 231,832	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			132,622			132,622	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			231,948			231,948	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				53,969		53,969	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY	39-2					7,339		7,339	
	Other (specify): IV THERAPY, RENTAL						11,606		11,606	13
14	TOTAL			$		$ 596,402	$ 72,914		$ 669,316	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.

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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	$ 946,745	$ 1,067,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 286,000)	3,322,313	3,322,313	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	363,926	407,537	6
7	Other Prepaid Expenses	58,258	103,258	7
8	Accounts Receivable (owners or related parties)	150,000	214,910	8
9	Other(specify): ESCROWS		347,401	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,841,242	$ 5,462,537	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		2,668,552	14
15	Leasehold Improvements, at Historical Cost	888,359	1,034,238	15
16	Equipment, at Historical Cost	476,938	762,438	16
17	Accumulated Depreciation (book methods)	(891,059)	(1,856,788)	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): LOAN COSTS		151,075	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 474,238	$ 3,109,515	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,315,480	$ 8,572,052	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 870,393	$ 870,393	26
27	Officer's Accounts Payable	373,993	376,993	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	64,910	182,771	29
30	Accrued Salaries Payable	57,669	57,669	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,751	66,471	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		17,460	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PA LOAN	727,900	727,900	36
37	PPP LOAN	719,200	719,200	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,823,816	$ 3,018,857	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,136,366	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)**	$	$ 6,136,366	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,823,816	$ 9,155,223	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,491,664	$ (583,171)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,315,480	$ 8,572,052	48

***(See instructions.)**

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,110,099	1
2	Restatements (describe):		2
3	PRIOR	(256)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,109,843	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	381,821	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)**	$ 381,821	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)**	$ 2,491,664	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,306,381	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,306,381	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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***	2,162	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,162	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	931,436	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 931,436	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,239,979	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,315,973	31
32	Health Care	3,471,617	32
33	General Administration	2,449,616	33
	B. Capital Expense		
34	Ownership	641,627	34
	C. Ancillary Expense		
35	Special Cost Centers	669,316	35
36	Provider Participation Fee	310,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,858,158	40
41	**Income before Income Taxes (line 30 minus line 40)****	381,821	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 381,821	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,124,077	44
45	Private Pay - Net Inpatient Revenue	72,510	45
46	Medicare - Net Inpatient Revenue	1,697,028	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	158,096	47
48	Other-(specify) MANAGED CARE	254,670	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,306,381	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	2,236	$ 109,599	$ 49.02	1
2	Assistant Director of Nursing	2,112	2,570	82,651	32.16	2
3	Registered Nurses	7,037	7,658	283,861	37.07	3
4	Licensed Practical Nurses	26,299	29,948	795,740	26.57	4
5	CNAs & Orderlies	87,292	95,454	1,192,340	12.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,430	11,459	130,725	11.41	10
11	Social Service Workers	11,031	12,091	188,958	15.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,489	19,762	225,951	11.43	15
16	Dishwashers					16
17	Maintenance Workers	3,872	4,139	90,137	21.78	17
18	Housekeepers	29,225	31,239	331,679	10.62	18
19	Laundry	3,511	3,942	43,218	10.96	19
20	Administrator	2,088	2,384	112,256	47.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,332	12,307	193,525	15.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,767	5,426	80,336	14.81	31
32	Other Health C: Care Plan Coord	5,991	7,119	182,459	25.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	225,364	247,734	$ 4,043,435 *	$ 16.32	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 18,782	1-3	35
36	Medical Director	O	6,817	9-3	36
37	Medical Records Consultant	N	360	10-3	37
38	Nurse Consultant	T	13,050	10-3	38
39	Pharmacist Consultant	H	8,398	10-3	39
40	Physical Therapy Consultant	L	21,867	10a-3	40
41	Occupational Therapy Consultant	Y	17,915	10a-3	41
42	Respiratory Therapy Consultant		2,880	10a-3	42
43	Speech Therapy Consultant	F	6,684	10a-3	43
44	Activity Consultant	E	2,341	11-3	44
45	Social Service Consultant	E	2,446	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 101,540		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses	49	2,908	10-3	51
52	Certified Nurse Assistants/Aides	1,699	57,474	10-3	52
53	TOTAL (lines 50 - 52)	1,748	$ 60,382		53

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AMBER MCGINNIS	ADMINISTRATOR	0	$ 112,256
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,256

B. Administrative - Other

Description		Amount
WEISS MGMT GROUP, INC	MANAGEMENT FEES	$ 210,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 210,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 127
NATIONAL DATACARE	DATA PROCESSING	2,601
PARAGON	DATA PROCESSING	10,171
KBKB, LTD	ACCOUNTING FEES	16,250
RICHARD PEELO & ASSOCIAT	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	UC CONSULTANT	6,213
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN	239,400
RESOLUTE HEALTHCARE	LTC MEDICAID PROCESS	2,452
SOLUTIONS	CONSULTING	
SEE LEGAL SCHEDULE ATTACHED		93,489
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 375,203

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,782
Unemployment Compensation Insurance	46,270
FICA Taxes	305,979
Employee Health Insurance	66,492
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	27,321
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 539,844

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	$ 1,990
Advertising: Employee Recruitment	22,290
Health Care Worker Background Check	975
(Indicate # of checks performed 24)	
Patient Background Checks 268	3,801
TRUST/FRANCHISE/CONTRIB/ETC	11,277
MARKETING/ADV/PROMO	3,470
LICENSES/DUES/SUBSCRIPTIONS	14,580
MGMT CO ALLOC	4,364
TRUST/FRANCHISE/CONTRIB/ETC	(11,277)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,470)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,000

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	2,686
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,686

* Attach copy of IMRF notifications

**See instructions.

BRIA OF CAHOKIA
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/31/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,787.50
2/29/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,690.00
3/31/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,495.00
4/30/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,430.00
5/31/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,657.50
6/30/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,495.00
8/3/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,560.00
8/31/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,722.50
9/30/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,462.50
10/31/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,722.50
11/30/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,820.00
12/31/2020	GARY A. WEINTRAUB P.C.	CONSULTATIONS REGARDING COMPLIANCE OF OBRA	1,722.50
3/26/2020	GREGORY SKINNER	COURT CASE	425.00
12/11/2020	JACKSON LEWIS	FLAT FEE - SENSITIVITY TRAINING	1,000.00
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500.00
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	1,500.00
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
6/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
7/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION	2,300.00
6/1/2020	MICHAEL KLUPCHAK	UNION ISSUES ABOUT SAFETY WITH COVID	962.50
1/7/2020	SANDBERG PHOENIX	COURT CASE	437.28
2/11/2020	SANDBERG PHOENIX	COURT CASE	96.12
2/11/2020	SANDBERG PHOENIX	COURT CASE	1,081.29
7/6/2020	SANDBERG PHOENIX	COURT CASE	696.83
8/7/2020	SANDBERG PHOENIX	COURT CASE	120.14
9/8/2020	SANDBERG PHOENIX	COURT CASE	48.06
12/11/2020	SANDBERG PHOENIX	COURT CASE	768.92
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
1/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
2/29/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
3/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
4/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
5/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
6/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
7/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
8/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
9/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
10/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
11/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
12/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
5/19/2020	US LEGAL	COURT REPORTING FEES	600.40
7/1/2020	US LEGAL	COURT REPORTING FEES	291.90
7/1/2020	US LEGAL	COURT REPORTING FEES	1,515.83
3/10/2020	FLUHR & MOORE LLC	LEGAL SETTLEMENT	31,565.69
4/1/2020	CENTERS FOR MEDICARE & MEDICAID SERVICES	LEGAL SETTLEMENT	3,434.31
10/15/2020	GOLDENBERG HELLER & ANTOGNOLI P.C.	LEGAL SETTLEMENT	2,713.04
	TOTAL		**93,488.98**

Facility Name & ID Number BRIA OF CAHOKIA # 0048645 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE $ 13,099

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
RIVER BLUFFS OF CAHOKIA NURSING & REHAB CENTER #0042713; 05/01/2000

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 310,009
This amount is to be recorded on line 42 of Schedule V.

(12) 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.

(13) 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

(14) 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.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) 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?
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

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name:

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

(19) 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.