

		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: 0057950

Facility Name: BRIA OF ELMWOOD PARK

Address: 7733 WEST GRAND AVE ELMWOOD PARK 60707
Number City Zip Code

County: COOK

Telephone Number: (708) 452-9200 Fax # (708) 452-7913

HFS ID Number:

Date of Initial License for Current Owners: 05/01/23

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) 675-3585 Fax # (847) 675-3585

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 ELMWOOD PARK # 0057950 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	245	Skilled (SNF)	245	89,425	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	245	TOTALS	245	89,425	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				65		3,314	2,608	5,987	8
9	SNF/PED									9
10	ICF	8,511	34,290	4,174		1,094		2,476	50,545	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	8,511	34,290	4,174	65	1,094	3,314	5,084	56,532	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 63.22%

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 05/01/23

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 05/01/23 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 245

Medicare Intermediary CGS

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 ELMWOOD PARK** # **0057950** 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	572,970	32,935	307,748	913,653		913,653		913,653			1
2	Food Purchase		419,932		419,932		419,932		419,932			2
3	Housekeeping	500,474	45,906	33,946	580,326		580,326		580,326			3
4	Laundry	173,929	30,995	96,991	301,915		301,915		301,915			4
5	Heat and Other Utilities			310,979	310,979		310,979	1,566	312,545			5
6	Maintenance	111,662	144,074	45,618	301,354		301,354	17,145	318,499			6
7	Other (specify):* Scavenger			35,877	35,877		35,877	301	36,178			7
8	TOTAL General Services	1,359,035	673,842	831,159	2,864,036		2,864,036	19,012	2,883,048			8
	B. Health Care and Programs											
9	Medical Director			68,334	68,334		68,334		68,334			9
10	Nursing and Medical Records	8,081,819	800,577	684,703	9,567,099		9,567,099	99,472	9,666,571			10
10a	Therapy	1,141,122		23,071	1,164,193		1,164,193		1,164,193			10a
11	Activities	203,651	2,201	1,330	207,182		207,182		207,182			11
12	Social Services	174,593	305	2,462	177,360		177,360		177,360			12
13	CNA Training											13
14	Program Transportation			1,487	1,487		1,487		1,487			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,601,185	803,083	781,387	11,185,655		11,185,655	99,472	11,285,127			16
	C. General Administration											
17	Administrative	247,333		376,118	623,451		623,451	(338,603)	284,848			17
18	Directors Fees											18
19	Professional Services			448,869	448,869		448,869	(217,664)	231,205			19
20	Dues, Fees, Subscriptions & Promotions			78,882	78,882		78,882	(27,043)	51,839			20
21	Clerical & General Office Expenses	624,549	18,279	345,863	988,691		988,691	(116,737)	871,954			21
22	Employee Benefits & Payroll Taxes			1,568,478	1,568,478		1,568,478		1,568,478			22
23	Inservice Training & Education			31,442	31,442		31,442	137	31,579			23
24	Travel and Seminar							4,365	4,365			24
25	Other Admin. Staff Transportation			16,129	16,129		16,129	(4,436)	11,693			25
26	Insurance-Prop.Liab.Malpractice			452,696	452,696		452,696	1,916	454,612			26
27	Other (specify):*			364,039	364,039		364,039	(319,592)	44,447			27
28	TOTAL General Administration	871,882	18,279	3,682,516	4,572,677		4,572,677	(1,017,657)	3,555,020			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,832,102	1,495,204	5,295,062	18,622,368		18,622,368	(899,173)	17,723,195			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	38,526		CONTRACT NURSING	XVIII C 53-2	632,734
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		8,211
	CONTRACTED DIETARY SERVICES		269,222		PURCHASED SERVICES		
			307,748		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		33,946		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			33,946		PHARMACY CONSULTANT	XVIII B 39-2	11,468
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		96,991		PSYCHIATRIC	XVIII B __-2	12,000
			96,991		RN CONSULTANT	XVIII B 38-2	20,290
5	HEAT & OTHER UTILITIES						
	GAS HEAT		66,747				
	ELECTRICITY		113,079				
	WATER		121,822				684,703
	CABLE TV - LOBBY		9,331				
6			310,979	11	THERAPY		
	MAINTENANCE				PHYSICAL THERAPY SERVICES		
	GROUND MAINTENANCE		31,862		SPEECH THERAPY SERVICES		
	PAINTING & DECORATING				OCCUPATIONAL THERAPY SERVICES		
	BUILDING REPAIRS				REHABILITATION CONSULTANT	XVIII B __-2	
	MAINTENANCE TRAVEL				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	4,156
	EQUIPMENT MAINTENANCE & REPAIR		1,845		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	4,960
	ELEVATOR MAINTENANCE & REPAIR				RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	13,500
	OUTSIDE LABOR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	455
	EXTERMINATING SERVICE						
	FIRE SERVICE		11,911				23,071
				12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,330
7			45,618	13			1,330
	OTHER				SOCIAL SERVICES		
	SCAVENGER		35,877		SOCIAL REHABILITATION SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	2,462
					SOCIAL WORKER	XVIII B 45-2	
9			35,877	13			2,462
	MEDICAL DIRECTOR				NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		68,334		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL	LINE
14	PROGRAM TRANSPORTATION			22
	PATIENT TRANSPORTATION		1,487	
			1,487	
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	376,118	
	DIRECTORS FEES			
18	DIRECTORS FEES		0	
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	47,042	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	139,327	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		262,500	
			448,869	
20	FEES,SUBSCRIPTIONS,PROMOTIONS			23
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,609	
	EMPLOYEE WANT ADS	XIX F	7,000	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	21,281	
	LICENSES & PERMITS	XIX F	6,863	
	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	17,767	
	HEALTH CARE WORKER BACKGROUND CHE	XIX F	8,362	
	PATIENT BACKGROUND CHECKS	XIX F		
			78,882	
21	CLERICAL & GENERAL OFFICE EXPENSES			24
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,341	
	EQUIPMENT REPAIR & MAINTENANCE		186,005	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18	137,121	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		19,094	
	MESSENGER SERVICE		1,302	
			345,863	

	SCHED REF	TOTAL	LINE
EMPLOYEE BENEFITS & PAYROLL TAXES			22
FICA TAXES	XIX D	897,421	
UNEMPLOYMENT COMPENSATION	XIX D	98,214	
WORKERS COMPENSATION INSURANCE	XIX D	194,517	
HOSPITALIZATION INSURANCE	XIX D	317,593	
EMPLOYEE BENEFITS - OTHER	XIX D	60,733	
EMPLOYEE PHYSICAL EXAMS	XIX D		
INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
PENSION/PROFIT SHARING PLANS	XIX D		
		1,568,478	
INSERVICE TRAINING & EDUCATION			23
EDUCATION & SEMINARS		31,442	
		31,442	
TRAVEL & SEMINARS			24
EDUCATION & SEMINARS	XIX G		
TRAVEL	XIX G		
		0	
ADMIN. STAFF TRANSPORTATION			25
TRANSPORTATION - STAFF		16,129	
		16,129	
INSURANCE - PROP. LIAB & MALPRACTICE			26
GENERAL INSURANCE		452,696	
		452,696	
OTHER			27
BAD DEBTS	VI 24	364,039	
		364,039	

GRAND TOTAL COLUMN 3 OTHER

5,295,062

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			16,296	16,296		16,296	(3,675)	12,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,190	17,190		17,190	42,442	59,632			32
33	Real Estate Taxes			255,281	255,281		255,281	6,168	261,449			33
34	Rent-Facility & Grounds			1,944,432	1,944,432		1,944,432		1,944,432			34
35	Rent-Equipment & Vehicles			148,119	148,119		148,119	1,137	149,256			35
36	Other (specify):*											36
37	TOTAL Ownership			2,381,318	2,381,318		2,381,318	46,072	2,427,390			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,073	76,481	255,554		255,554		255,554			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			944,619	944,619		944,619		944,619			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		179,073	1,021,100	1,200,173		1,200,173		1,200,173			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,832,102	1,674,277	8,697,480	22,203,859		22,203,859	(853,101)	21,350,758			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	(10,361)	30		9
10	Interest and Other Investment Income	(15,455)	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	(137,121)	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	(364,039)	27		24
25	Fund Raising, Advertising and Promotional	(17,609)	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	(150,731)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (695,316)		\$	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)	(157,785)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (157,785)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (853,101)		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	\$ (17,767)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING SALARIES	(128,528)	21	3
4	MARKETING TRAVEL	(4,436)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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	(150,731)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$	IME REALTY CORPORATION		\$	\$	1
2	V								2
3	V	5	UTILITIES				1,566	1,566	3
4	V	6	MAINTENANCE				759	759	4
5	V	19	PROFESSIONAL FEES				67	67	5
6	V	26	INSURANCE				309	309	6
7	V	30	DEPRECIATION				2,485	2,485	7
8	V	32	INTEREST				2,791	2,791	8
9	V	33	RE TAX				6,168	6,168	9
10	V	21	OFFICE EXPENSE				381	381	10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 14,526	\$ * 14,526	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	\$ 262,500	BRIA HEALTH SERVICES, LLC		\$	\$ (262,500)	15
16	V	17	MANAGEMENT FEES	376,118				(376,118)	16
17	V								17
18	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	18
19	V	17	SALARIES-CFO				28,527	28,527	19
20	V	6	SALARIES-MAINTENANCE				13,170	13,170	20
21	V	10	SALARIES-A/R				99,472	99,472	21
22	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	22
23	V	21	SALARIES-CLERICAL				130,360	130,360	23
24	V	6	MAINTENANCE				3,216	3,216	24
25	V	7	SCAVENGER				301	301	25
26	V	19	PROFESSIONAL FEES				44,769	44,769	26
27	V	20	DUES,FEES,SUBSCRIPTIONS				8,333	8,333	27
28	V	21	OFFICE EXPENSE				16,059	16,059	28
29	V	23	SEMINARS				137	137	29
30	V	24	TRAVEL				4,365	4,365	30
31	V	26	INSURANCE				1,607	1,607	31
32	V	27	EMPLOYEE BENEFITS				44,447	44,447	32
33	V	30	DEPRECIATION				4,201	4,201	33
34	V	32	INTEREST				55,106	55,106	34
35	V	35	AUTO LEASE				542	542	35
36	V	35	EQUIPMENT RENTAL				595	595	36
37	V								37
38	V								38
39	Total			\$ 638,618			\$ 466,307	\$ * (172,311)	39

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

STATE OF ILLINOIS				Ownership Listing-1					
BRIA OF ELMWOOD PARK									
ID#		0057950							
Report Period Beginning:		01/01/2025		BRIA HEALTH SERVICE					
Ending:		12/31/2025		N/A					
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Operator/Licensee		Building Co.		Management	
-Owners of companies must be listed instead of company names.								Co./Home Office	
-Names of trust beneficiaries must be listed.				Place of Residence		Ownership Percentage		Ownership Percentage	
First Name		M.I.	Last Name	City		State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	DANIEL	T	WEISS	SKOKIE	IL	16.67500		33.30000	1
2	AVRUM		WEINFELD	CHICAGO	IL	16.66500		33.30000	2
3	AARON		WEISS	MAALEH ADUN	ISRAEL	0.81600			3
4	SAMUEL		WEISS	MAALEH ADUN	ISRAEL	0.81600			4
5	ABBIGAIL		WEISS	MAALEH ADUN	ISRAEL	0.81600			5
6	MEIRA		WEISS	MAALEH ADUN	ISRAEL	0.81600			6
7	MAAYAN		WEISS	MAALEH ADUN	ISRAEL	0.81600			7
8	ELISHAMA		WEISS	MAALEH ADUN	ISRAEL	0.81600			8
9	DAHLIA		WEISS	MAALEH ADUN	ISRAEL	0.81600			9
10	NATAN	S	WEISS	MAALEH ADUN	ISRAEL	5.47400		33.40000	10
11	AMY		WEISS	MAALEH ADUN	ISRAEL	5.47400			11
12	JENNIFER		STERN	LINCOLNWOOD	IL	7.14280			12
13	JOEL		MERMELSTEIN	LINCOLNWOOD	IL	7.14290			13
14	JEFFREY		MERMELSTEIN	LINCOLNWOOD	IL	7.14290			14
15	JACOB		MERMELSTEIN	LINCOLNWOOD	IL	7.14290			15
16	JOSHUA		MERMELSTEIN	LINCOLNWOOD	IL	7.14290			16
17	DANIEL		MERMELSTEIN	LINCOLNWOOD	IL	7.14280			17
18	GABRIEL		MERMELSTEIN	LINCOLNWOOD	IL	7.14280			18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
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73									73
74									74
75									75

Facility Name & ID Number

BRIA OF ELMWOOD PARK

0057950

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
Hours						Percent	Description	Amount			
1	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:								\$		1
2	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	16.67				SALARY	6,000	17-7	7
8	DANIEL WEISS	MEMBER	ADMINISTRATIV	16.68				SALARY	6,000	17-7	8
9											9
10	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										10
11	NATAN WEISS	MEMBER	FINANCE/MGMT	5.47				MGMT FEES	13,500	17-7	11
12	DANIEL WEISS	MEMBER	ADMINISTRATIV	16.68				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 ELMWOOD PARK # 0057950 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	\$	56,532	\$ 1,566	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		56,532	759	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		56,532	67	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		56,532	309	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		56,532	2,485	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		56,532	2,791	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		56,532	6,168	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		56,532	381	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	\$		\$ 14,526	25

Facility Name & ID Number BRIA OF ELMWOOD PARK # 0057950 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	56,532	28,527	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	56,532	13,170	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	56,532	99,472	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	56,532	130,360	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		56,532	3,216	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		56,532	301	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		56,532	44,769	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		56,532	8,333	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		56,532	16,059	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		56,532	137	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		56,532	4,365	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		56,532	1,607	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		56,532	44,447	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		56,532	4,201	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		56,532	55,106	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		56,532	542	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		56,532	595	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,996	\$ 4,030,510		\$ 466,307	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	PARKWAY BANK AND TRUS	X		LOC		1/3/2024	600,000				PRIME+	17,190	6
7													7
8	RELATED PARTY ALLOCATION											57,897	8
9	TOTAL Facility Related						\$ 600,000	\$				\$ 75,087	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	\$				\$ 75,087	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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	2,959,616	8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023	754,294	12		
	2024	922,719	13		
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>BRIA OF ELMWOOD PARK</u>	COUNTY	<u>COOK</u>
---------------	-----------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT MITCH KOHANANOO

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565 B. General Construction Type: Exterior BRICK Frame Number of Stories 4

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. 200
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number **BRIA OF ELMWOOD PARK**

0057950

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			96,868	2,484		2,484		7
8		RELATED PARTY -IMPR			65,449	1,661		1,661		8
	Improvement Type**									
9		INSTALL THE NEW PUMP TO THE EXISTING FLANGE WITH								9
10		THE NEW GASKET.	2023		3,552		27.5	75	75	333
11		PARKING LOT RESEAL/PATCH AND STRIPED, INSTALL 11 CONCRETE								11
12		PARKING LOT PARK STOPS, ADD HANDICAP LOGOS.	2023		5,500		15	214	214	948
13		SIGN: REPLACEMENT PANELS ON FLAT LEXAN VILYL WRAP	2023		5,207		27.5	110	110	488
14		REMOVE AND REPLACE IN FLOOR GREASE TRAP	2023		6,400		27.5	136	136	602
15		INSTALL A NEW WATER HEATER WITH NEW COOPER PIPING	2023		14,680		27.5	312	312	1,380
16		ROOMS 108,208,202,201,308,108,303:PRIME AND PAINT ROOMS,								16
17		PATCH BASEBOARD METAL FRAMING, INSTALLED LIGHTS,								17
18		WALL HUNG BRACKETS	2024		20,728		27.5	440	440	1,194
19		INSTALLATION OF (80) CAT5E CABLE FOR VOICE AND DATA								19
20		TERMINATED ON BOTH SIDES CM RATED	2024		18,218		27.5	386	386	1,048
21		BACK DOOR RAMP AND RALLINGS REPAIR: PATCH THR								21
22		CONCRETE, CUT AND WELD ON THE GUARD RAILING	2024		17,060		27.5	362	362	982
23		INSTALLED DELAYED EGRESS MAGNETIC LOCK ON REAR								23
24		RAMP EXIT DOOR	2024		3,665		15	142	142	386
25		OVERHAUL THE MIDDLE DRYER, TRUNION TUB SUPPORT	2024		3,587		15	139	139	378
26		HVAC LABOR AND MATERIAL	2024		12,786		15	497	497	1,349
27		OVEN WALL AND OFFICE: DEMOLITION AND REBUILD	2024		7,875		15	306	306	831
28		INSTALL NEW PARKING LOT LIGHTS	2024		4,182		15	163	163	442
29		THE B&G HOUSE PUMP:REPLACE THE MOTOR, SEALS, GASKETS,								29
30		AND BEARING ASSEMBLY	2024		11,862		15	461	461	1,252
31		REPLACE WATER HEATER	2024		12,700		15	494	494	1,341
32		REPAIR AC UNITS IN ROOMS:REPLACED BOARDS AND								32
33		CONTROLS	2024		2,776		5	324	324	879
34		REPLACR BOOSTER HEATER	2024		8,900		15	346	346	939
35		REPAIRS ON BOILER #1, #2, AND AHU: REPLACE THE LOW								35
36			2024		26,438	16,296	15	1,028	(15,268)	2,790

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 348,433	\$ 20,441		\$ 10,080	\$ (10,361)	\$ 17,562	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	\$ 150,588	\$	\$	\$	5-10	\$ 26,000	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		2,541	2,541				74
75	TOTALS	\$ 150,588	\$ 2,541	\$ 2,541	\$		\$ 26,000	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)	\$ 499,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,982	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,621	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,361)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 43,562	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:ELMWOOD CARE PROPERTY, 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:		245	02/2023	\$1,944,432	5		3
4	Additions							4
5								5
6								6
7	TOTAL		245		\$1,944,432			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:☐ YES☒ X NO Terms:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ X NO
16. Rental Amount for movable equipment: \$127,622 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	#####	20,497	18
19					19
20					20
21	TOTAL		\$#####	\$20,497	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:
Beginning02/01/2023
Ending02/01/2027

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

	Fiscal Year Ending	Annual Rent
12.	12/2026	\$981,837
13.	12/2027	\$984,848
14.		\$

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	\$		\$ 32,736	\$		\$ 32,736	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			900			900	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			42,845			42,845	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				124,997		124,997	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					39,784		39,784	13
	Other (specify): IV THERAPY, RENTAL	39-2					14,292		14,292	
14	TOTAL			\$		\$ 76,481	\$ 179,073		\$ 255,554	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	\$ 512,261	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 172,806)	5,045,146		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	304,490		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>ESCROWS</u>	35,729		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,897,626	\$	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	177,652		15
16	Equipment, at Historical Cost	150,589		16
17	Accumulated Depreciation (book methods)	(148,158)		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): <u>OPTION DEPOSIT</u>	368,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 548,083	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,445,709	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,920,157	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,000,000		29
30	Accrued Salaries Payable	856,332		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 PARTIES</u>	3,653,468		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,429,957	\$	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)	\$ 9,429,957	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,984,248)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,445,709	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,289,642)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,289,642)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(694,606)	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)	\$ (694,606)	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)	\$ (2,984,248)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF ELMWOOD PARK

0057950

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	\$ 20,580,089	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 20,580,089	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	340,970	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 340,970	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***	15,455	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,455	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	586,946	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 586,946	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,523,460	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,864,036	31
32	Health Care	11,185,655	32
33	General Administration	4,572,677	33
	B. Capital Expense		
34	Ownership	2,381,318	34
	C. Ancillary Expense		
35	Special Cost Centers	255,554	35
36	Provider Participation Fee	944,619	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,203,859	40
41	Income before Income Taxes (line 30 minus line 40)**	(680,399)	41
42	Income Taxes	(14,207)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (694,606)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,771,765.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	11,736,197.00	45
46	MMAI-Medicaid is the Primary Payer	1,229,452.00	46
47	MMAI-Medicare is the Primary Payer	52,733.00	47
48	Private Pay	355,265.00	48
49	Medicare Part A	2,557,739.00	49
50	Other-(specify) HOSPICE	729,000.00	50
51	Other-(specify) INSURANCE	1,147,938.00	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)	\$ 20,580,089	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	1,908	1,995	\$ 138,202	\$ 69.27	1
2	Assistant Director of Nursing			89,767		2
3	Registered Nurses	17,148	18,114	797,101	44.00	3
4	Licensed Practical Nurses	54,426	60,130	2,717,797	45.20	4
5	CNAs & Orderlies	119,656	135,883	4,102,232	30.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	32,251	34,750	1,141,122	32.84	8
9	Activity Director					9
10	Activity Assistants	9,168	10,331	203,651	19.71	10
11	Social Service Workers	5,628	6,036	174,593	28.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,710	25,796	572,970	22.21	15
16	Dishwashers					16
17	Maintenance Workers	3,402	4,019	111,662	27.78	17
18	Housekeepers	18,996	23,480	500,474	21.31	18
19	Laundry	6,298	7,876	173,929	22.08	19
20	Administrator	3,808	3,944	247,333	62.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,803	18,481	624,549	33.79	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	1,963	2,029	48,163	23.74	31
32	Other Health C: Care Plan Coord	4,354	4,578	188,557	41.19	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	318,519	357,442	\$ 11,832,102 *	\$ 33.10	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	\$ 38,526	1-3	35
36	Medical Director	O	68,334	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	11,468	10-3	39
40	Physical Therapy Consultant	L	4,156	10a-3	40
41	Occupational Therapy Consultant	Y	4,960	10a-3	41
42	Respiratory Therapy Consultant		13,500	10a-3	42
43	Speech Therapy Consultant	F	455	10a-3	43
44	Activity Consultant	E	1,330	11-3	44
45	Social Service Consultant	E	2,462	12-3	45
46	Other(specify) Psychiatric	S	12,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 157,191		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 337,638		50
51	Licensed Practical Nurses		248,083		51
52	Certified Nurse Assistants/Aides		47,013		52
53	TOTAL (lines 50 - 52)		\$ 632,734		53

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

** See instructions.

BRIA OF ELMWOOD PARK
LEGAL EXPENSES
1/1/2025-12/31/2025

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/3/2025	BRIAN A STINES PC	COLLECTIONS	3,197
2/1/2025	BRIAN A. STINES, P.C.	GUARDIANSHIP	3,500
3/1/2025	BRIAN A. STINES, P.C.	GUARDIANSHIP	2,347
3/30/2025	BRIAN A. STINES, P.C.	GUARDIANSHIP	2,614
5/2/2025	BRIAN A. STINES, P.C.	GUARDIANSHIP	1,419
6/1/2025	BRIAN A. STINES, P.C.	GUARDIANSHIP	2,490
6/29/2025	BRIAN A. STINES, P.C.	GUARDIANSHIP	1,060
	BRIAN A. STINES, P.C.	GUARDIANSHIP	179
1/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	639
2/28/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	140
3/31/2025	HINSHAW & CULBERTSON	DEVELOP SETTLEMENT RECOMMENDATION	420
5/1/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF TYPE A VIOLATION	1,194
5/31/2025	HINSHAW & CULBERTSON	REVIEW & ANALYSIS OF IDPH PREHEARING NOTICE	785
6/23/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	560
6/1/2025	CHUHAK & TECSON	REVIEW OF FILED PETITION FOR TEMPORARY GUARDIAN	1,582
6/24/2025	MARY RALEIGH	GUARDIAN AND ESTATE	4,908
1/2/2025	GARY WEINTRAUB	LOAN MODIFICATION AND LINE OF CREDIT	2,300
1/24/2025	SKIDELSKY & ASSOCIATES	2023 SPECIFIC OBJECTIONS	400
3/26/2025	SKIDELSKY & ASSOCIATES	2024 TRIENNIAL REAL ESTATE ASSESMENT	2,500
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
4/1/2025	MIDWEST CARE MANAGEMENT	GUARDIAN OF ESTATE	2,121
4/14/2025	MIDWEST CARE MANAGEMENT	GUARDIAN OF ESTATE	1,370
6/17/2025	MIDWEST CARE MANAGEMENT	GUARDIAN OF ESTATE	1,497
	MIDWEST CARE MANAGEMENT	GUARDIAN OF ESTATE	2,640
5/19/2025	ERICH PAVEL III	GUARDIAN OF AD LITEM FEES	2,308
3/1/2025	FMS LAW GROUP	GUARDIAN OF AD LITEM FEES	2,730
4/22/2025	MONAHAN LAW GROUP	REVIEW OF STATUS OF TRUST DOCUMENTS	3,581
TOTAL			53,381

XX. GENERAL INFORMATION:

- (1)

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

YES
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	21,090
	21,090 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	17,767
	17,767 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	38,857
	38,857 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.

\$

944,619

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

Has any meal income been offset against related costs?

Indicate the amount.

\$
- (12)

Travel and Transportation

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

NO

If YES, attach a complete explanation.

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

NO

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

\$

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

5%

d. Have vehicle usage logs been maintained?

NO

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

NO

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

YES

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

NO

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

\$

N/A
- (13)

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

NO

Firm Name:
- (14)

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

YES
- (15)

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

YES

See page 39 of the instructions for details.

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