

		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: 3000288

Facility Name: Aliya of Crestwood

Address: 13259 S Central Ave Crestwood 60418

County: Cook

Telephone Number: (708) 597-1000 Fax #: (708) 389-9990

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2024

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: Larry Templin Telephone Number: (630) 361-2868

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 1/1/2025 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)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Crestwood # 3000288 Report Period Beginning: 1/1/2025 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>145</u>	Skilled (SNF)	<u>145</u>	<u>52,925</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>48</u>	Intermediate (ICF)	<u>48</u>	<u>17,520</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>193</u>	TOTALS	<u>193</u>	<u>70,445</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						3,265	1,832	5,097	8
9	SNF/PED									9
10	ICF	13,091	21,948	5,761		3,644			44,444	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	13,091	21,948	5,761		3,644	3,265	1,832	49,541	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 70.33%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? None (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 12/1/24

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/1/24 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 145

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25
* All facilities other than governmental must report on the accrual basis.

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	463,626	33,792	6,840	504,258		504,258	67,869	572,127			1
2	Food Purchase		354,268		354,268		354,268		354,268			2
3	Housekeeping	344,285	43,080		387,365		387,365		387,365			3
4	Laundry	149,610	31,239	1,127	181,976		181,976	2,070	184,046			4
5	Heat and Other Utilities			319,215	319,215		319,215	1,036	320,251			5
6	Maintenance	104,304	37,597	149,893	291,794		291,794	13,373	305,167			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			31,995	31,995		31,995	10,195	42,190			7
8	TOTAL General Services	1,061,825	499,976	509,070	2,070,871		2,070,871	94,543	2,165,414			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	5,464,150	368,250	22,387	5,854,787		5,854,787	161,985	6,016,772			10
10a	Therapy											10a
11	Activities	140,848	12,834	3,748	157,430		157,430		157,430			11
12	Social Services	108,592		333	108,925		108,925	6,833	115,758			12
13	CNA Training											13
14	Program Transportation			11,143	11,143		11,143		11,143			14
15	Other (specify):* Mgmt Alloc of Benefits							22,514	22,514			15
16	TOTAL Health Care and Programs	5,713,590	381,084	61,611	6,156,285		6,156,285	191,332	6,347,617			16
	C. General Administration											
17	Administrative	161,009		1,654,367	1,815,376		1,815,376	(1,574,661)	240,715			17
18	Directors Fees											18
19	Professional Services			438,409	438,409		438,409	(150,541)	287,868			19
20	Dues, Fees, Subscriptions & Promotions			71,553	71,553		71,553	(602)	70,951			20
21	Clerical & General Office Expenses	282,905	24,325	47,392	354,622		354,622	527,366	881,988			21
22	Employee Benefits & Payroll Taxes			1,138,485	1,138,485		1,138,485	46,624	1,185,109			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,227	2,227		2,227	717	2,944			24
25	Other Admin. Staff Transportation			5,229	5,229		5,229	18,238	23,467			25
26	Insurance-Prop.Liab.Malpractice			476,680	476,680		476,680	7,042	483,722			26
27	Other (specify):* Mgmt Alloc of Benefits							85,000	85,000			27
28	TOTAL General Administration	443,914	24,325	3,834,342	4,302,581		4,302,581	(1,040,817)	3,261,764			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,219,329	905,385	4,405,023	12,529,737		12,529,737	(754,942)	11,774,795			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
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 (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			25,179	25,179		25,179	(6,884)	18,295			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,593	53,593		53,593	10,859	64,452			32
33	Real Estate Taxes			946,490	946,490		946,490		946,490			33
34	Rent-Facility & Grounds			820,000	820,000		820,000	14,279	834,279			34
35	Rent-Equipment & Vehicles			62,967	62,967		62,967	3,349	66,316			35
36	Other (specify):*											36
37	TOTAL Ownership			1,908,229	1,908,229		1,908,229	21,603	1,929,832			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,907	574,211	718,118		718,118	9,437	727,555			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			877,049	877,049		877,049		877,049			42
43	Other (specify):* Disallowed Costs		28,596	385,535	414,131		414,131	(414,131)				43
44	TOTAL Special Cost Centers		172,503	1,836,795	2,009,298		2,009,298	(404,694)	1,604,604			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,219,329	1,077,888	8,150,047	16,447,264		16,447,264	(1,138,033)	15,309,231			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(19,122)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,884)	30		9
10	Interest and Other Investment Income	(20,884)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				17
18	Fines and Penalties	(22,685)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(343,601)	43		24
25	Fund Raising, Advertising and Promotional	(28,723)	43		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	(19,761)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (461,660)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(676,373)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (676,373)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,138,033)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (9,063)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable	(13,818)	17	4
5	Expense Minor Fixed Assets below \$2,500	2,070	4	5
6	Expense Minor Fixed Assets below \$2,500	14,496	6	6
7	Expense Minor Fixed Assets below \$2,500	8,784	21	7
8	Capitalize Large Repairs	(11,422)	6	8
9	Out of State Travel (Allocated from Home Office)	(5,275)	24	9
10	Out of State Seminar (Allocated from Home Office)	(5,533)	25	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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22				22
23				23
24				24
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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	(19,761)		49

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 Ownership Listing-1		See Page 6 Supplemental		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.

☒ 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	5	Heat and Other Utilities	\$	Aliya Healthcare Consulting LLC		\$ 1,036	\$ 1,036	1
2	V	6	Maintenance		Aliya Healthcare Consulting LLC		1,725	1,725	2
3	V	17	Administrative	859,002	Aliya Healthcare Consulting LLC		93,524	(765,478)	3
4	V	19	Professional Services		Aliya Healthcare Consulting LLC		17,800	17,800	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		8,455	8,455	5
6	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		21,346	21,346	6
7	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		46,624	46,624	7
8	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		5,801	5,801	8
9	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		12,050	12,050	9
10	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		6,990	6,990	10
11	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		18,977	18,977	11
12	V	32	Interest		Aliya Healthcare Consulting LLC		31,743	31,743	12
13	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		14,279	14,279	13
14	Total			\$ 859,002			\$ 280,350	\$ * (578,652)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	35	Rent-Equipment & Vehicles	\$	Aliya Healthcare Consulting LLC		\$ 2,921	\$ 2,921	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 2,921	\$ * 2,921	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	1	Dietary	\$	Alyze Healthcare Consulting LLC		\$ 67,869	\$	67,869 15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		8,574		8,574 16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		10,195		10,195 17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		161,985		161,985 18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		6,833		6,833 19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		22,514		22,514 20
21	V	17	Administrative	795,365	Alyze Healthcare Consulting LLC		0		(795,365) 21
22	V	19	Professional Services	169,512	Alyze Healthcare Consulting LLC		1,171		(168,341) 22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		6		6 23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		0 24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		497,236		497,236 25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		191		191 26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		11,721		11,721 27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		52		52 28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		66,023		66,023 29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		0 30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		428		428 31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		8,327		8,327 32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,110		1,110 33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 964,877			\$ 864,235	\$ *	(100,642) 39

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

STATE OF ILLINOIS					Ownership Listing-1			
Aliya of Crestwood								
ID#		3000288						
Report Period Beginning:		1/1/2025			Aliya Healthcare Consu			
Ending:		12/31/2025			N/A			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)							Management	
-Owners of companies must be listed instead of company names.					Operator/Licensee		Building Co.	
-Names of trust beneficiaries must be listed.					Ownership Percentage		Ownership Percentage	
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	Dvorah	S	Weinfeld	Chicago	IL	45.01000		75.50000
2	Avrum	P	Weinfeld	Chicago	IL	13.23768		
3	Moshe	M	Erlich	Lincolnwood	IL	13.23768		15.00000
4	Jordan	E	Reifer	Lincolnwood	IL	8.83000		5.00000
5	Rebecca	R	Kohn	Lincolnwood	IL	4.41000		2.49975
6	Nesanel	B	Davis	Chicago	IL	1.76500		1.00000
7	Sam	NG	Wasserman	Chicago	IL	1.76500		1.00000
8	Avi	NG	Schechter	Surfside	FL	8.74910		
9	Aaron	NG	Kraft	Lincolnwood	IL	2.99970		
10								
11								
12	Remaining Owners of Aliya Healthcare Consulting LLC							
13	Henry	NG	Kohn	Lincolnwood	IL			0.00063
14	Oliver	NG	Kohn	Lincolnwood	IL			0.00063
15	Lillian	NG	Kohn	Lincolnwood	IL			0.00063
16	George	NG	Kohn	Lincolnwood	IL			0.00063
17								
18								
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VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Aliya of Evanston	Evanston, IL			Aliya Healthcare			
2	Aliya of Glenwood	Glenwood, IL			Consulting LLC	Skokie, IL	Management Co	
3	Aliya of Highwood	Highwood, IL			Alyze Healthcare			
4	Aliya of Homewood	Homewood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	
5	Aliya of Oak Lawn	Oak Lawn, IL			Aliya of Palos Park			
6	Aliya of Palatine	Palatine, IL			ILF LLC	Palos Park, IL	Independent Living	
7	Aliya of Palos Park	Palos Park, IL			Wrightwood 87th			
8	Aliya on 87th	Chicago, IL			SNF Property LLC	Skokie, IL	Lessor	
9	Ryze at Homewood	Homewood, IL			Avenue SNF			
10	Ryze at the Ridge	Chicago, IL			Property LLC	Skokie, IL	Lessor	
11	Ryze on the Avenue	Chicago, IL			West SNF			
12	Ryze West	Chicago, IL			Property LLC	Skokie, IL	Lessor	
13					Evanston SNF			
14					Property LLC	Skokie, IL	Lessor	
15					Highwood SNF			
16					Property LLC	Skokie, IL	Lessor	
17					Ridge SNF			
18					Property LLC	Skokie, IL	Lessor	
19					Palos SNF			
20					Property LLC	Skokie, IL	Lessor	
21					Illuminate Hospice LL	Oakbrook Terrace, IL	Hospice	
22								
23								
24								
25								
26								
27								
28								
29								
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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Efriam Weinfeld	COO	Administrative	0.00	See Att Sch P7A	3.50	8.75	Salary	\$ 20,113	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	3.50	8.75	Salary	20,113	L17,C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 40,226		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Crestwood # 3000288 Report Period Beginning: 1/1/2025 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 Aliya Healthcare Consulting, LLC
Street Address 8140 N McCormick Blvd, Suite 138
City / State / Zip Code Skokie, IL 60076
Phone Number (224) 536-4204
Fax Number ()

	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	Heat and Other Utilities	Available Bed Days	805,555	13	\$ 11,842	\$	70,445	\$ 1,036	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		70,445	1,725	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	70,445	93,524	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		70,445	17,800	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		70,445	8,455	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	70,445	21,346	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		70,445	46,624	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		70,445	5,801	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		70,445	12,050	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		70,445	6,990	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		70,445	18,977	11
12	32	Interest	Available Bed Days	805,555	13	362,992		70,445	31,743	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		70,445	14,279	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		70,445	2,921	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,239,292	\$ 1,190,369		\$ 283,271	25

Ending: 2/31/2025

()

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Optimum		X	Working Capital		3/13/25	3,000,000		3/13/28	variable	34,598		6
7													7
8													8
9	TOTAL Facility Related						\$ 3,000,000	\$			\$ 34,598		9
	B. Non-Facility Related*												
10								Amortization of Loan Costs			18,995		10
11								Offset Int Inc			(20,884)		11
12								Allocated from Home Office			31,743		12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ 29,854		14
15	TOTALS (line 9+line14)						\$ 3,000,000	\$			\$ 64,452		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	98,500	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.)		2024		\$	52,145	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(46,355)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	992,845	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$		6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	946,490	7
Assessed Value from Real Estate Tax Bill:	2024	2,153,503	8			
Real Estate Tax Bill for Calendar Year:	2020	1,091,219	9			
	2021	927,809	10			
	2022	1,232,013	11			
	2023	1,465,546	12			
	2024	624,741	13			
Accrual based on prior year tax bill.						
Aliya of Crestwood Paid \$52,145 for its Portion of the 2024 Taxes						

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
15	PLUS APPEAL COST FROM LINE 5 \$	15
16	LESS REFUND FROM LINE 6 \$	16
17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aliya of Crestwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 3000288

CONTACT PERSON REGARDING THIS REPORT Victor Vidal

TELEPHONE (847) 287-5991 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 24-33-300-004-0000	Long Term Care Property	\$ 624,741.38	\$ 624,741.38
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 624,741.38	\$ 624,741.38

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
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. N/A
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.
N/A

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	N/A			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Crestwood

3000288

Report Period Beginning:

1/1/2025

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										7
8										8
	Improvement Type**									
9	Repair Roof-Seal Open Seams and Termination Bar			2025	3,950		15	132	132	132
10	Replaced Heat Exchanger-Front Dining/Nurse Station RTU			2025	5,520		15	184	184	184
11	Installed Magnetic Locks for Stairwell Doors			2025	17,852		15	595	595	595
12	Replaced Dimmable Ultra Slim Ceiling Lights			2025	3,459		15	115	115	115
13	Replaced Flat Panel Dimmable Fixtures/Lights			2025	12,428		15	414	414	414
14	Elevator Upgrades-New Hydraulic Packing, Muffler, Shut Off Valve			2025	5,800		15	193	193	193
15	Install Flooring-Lobby, Dining Room (left) and Dining Room (right)			2025	12,112		15	404	404	404
16	Replace 4 Roof Drains, Membrane, Sealant			2025	3,974		15	132	132	132
17	Rebuild Kitchen Suppression System-Hoses, O Ring, Pull Station			2025	6,416		15	214	214	214
18	Replaced Garbage Disposal			2025	5,800		15	193	193	193
19	Replaced Boiler Ignitor			2025	5,216		15	174	174	174
20	Replaced Pressure Guages on Boiler			2025	2,705		15	90	90	90
21	Replaced Displays, Worn Parts and PM Kits on Boiler			2025	5,770		15	192	192	192
22	Replace Relay Wiring for Alarm of Doors			2025	2,947		15	98	98	98
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32	Financial Statement Depreciation					3,192			(3,192)	
33										33
34										34
35										35
36										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

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	Allocated from Aliya Healthcare Consulting LLC	2024	3,924		15	262	262	392	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	2,135		15	71	71	71	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)		\$100,008	\$3,192		\$3,463	\$271	\$3,593	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 51,718	\$ 11,264	\$ 10,344	\$ (920)	5 Yrs	\$ 15,516	71
72	Current Year Purchases	77,350	10,723	4,488	(6,235)	5-10 Yrs	4,488	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 129,068	\$ 21,987	\$ 14,832	\$ (7,155)		\$ 20,004	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	N/A									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)	\$ 229,076	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,179	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,295	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,884)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 23,597	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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:Freeport 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:	1960	193	12/1/2024	\$820,000	10	10	3
4	Additions							4
5								5
6		Allocated from Home Office			14,279			6
7	TOTAL		193		\$834,279			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 leaseN/A.
9. Option to Buy:☒ YES☐ NOTerms: Exercisable after initial term*

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: \$65,888Description: See Attached Schedule 14A
(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	Allocated from Home Office			428	18
19					19
20					20
21	TOTAL		\$	\$428	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:

Aliya of Crestwood

IDPH License ID Number:

3000288

Fiscal Year End:

12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	57,328
Office Equipment	5,639
Allocated from Home Office	2,921
Total - Line 16	65,888

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	5,310	\$ 233,255	\$	5,310	\$ 233,255	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		670	41,656		670	41,656	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,303	266,692		5,303	266,692	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				143,907		143,907	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(7)	199	8,327				199	8,327	12
13	Other (specify): See Attached Sch 16A	39(3)				32,608			32,608	13
14	TOTAL			\$ 8,327	11,283	\$ 574,211	\$ 143,907	11,482	\$ 726,445	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Aliya of Crestwood

IDPH License ID Number:

3000288

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	26,057
Radiology	6,551
Total - Line 16	32,608

Facility Name & ID Number **Aliya of Crestwood**

3000288

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2025**

(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	\$ (352,839)	\$ (352,839)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 368,006)	2,568,481	2,568,481	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	230,259	230,259	6
7	Other Prepaid Expenses	229,585	229,585	7
8	Accounts Receivable (owners or related parties)	641,534	641,534	8
9	Other(specify): <u>Option Deposit</u>	400,000	400,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,717,020	\$ 3,717,020	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	85,872	100,008	15
16	Equipment, at Historical Cost	152,595	129,068	16
17	Accumulated Depreciation (book methods)	(25,179)	(23,597)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	948,855	948,855	21
22	Other Long-Term Assets (specify <u>Loan Costs</u>)	54,875	54,875	22
23	Other(specify): <u>Security Deposits</u>	51,245	51,245	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,268,263	\$ 1,260,454	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,985,283	\$ 4,977,474	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 510,459	\$ 510,459	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,156	280,156	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,797	37,797	31
32	Accrued Real Estate Taxes(Sch.IX-B)	992,845	992,845	32
33	Accrued Interest Payable	40,000	40,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	55,751	55,751	36
37	<u>Due to Related Party</u>	2,052,246	2,052,246	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,969,254	\$ 3,969,254	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)	\$ 3,969,254	\$ 3,969,254	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,016,029	\$ 1,008,220	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,985,283	\$ 4,977,474	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (44,157)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (44,157)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,060,186	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)	\$ 1,060,186	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,016,029	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Crestwood

3000288

Report Period Beginning: 1/1/2025

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	\$ 19,635,988	1
2	Discounts and Allowances for all Levels	(2,617,392)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,018,596	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	161,449	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 161,449	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	225	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)	\$ 225	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,884	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,884	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	C.N.A. Initiative/QIP Revenue	306,296	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 306,296	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,507,450	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,070,871	31
32	Health Care	6,156,285	32
33	General Administration	4,302,581	33
	B. Capital Expense		
34	Ownership	1,908,229	34
	C. Ancillary Expense		
35	Special Cost Centers	1,132,249	35
36	Provider Participation Fee	877,049	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,447,264	40
41	Income before Income Taxes (line 30 minus line 40)**	1,060,186	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,060,186	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 3,865,695	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,481,115	45
46	MMAI-Medicaid is the Primary Payer	1,701,189	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,267,766	48
49	Medicare Part A	2,481,031	49
50	Other-(specify) Medicare Replacement	1,180,089	50
51	Other-(specify) Insurance	41,711	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 17,018,596	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,382	2,466	\$ 169,839	\$ 68.87	1
2	Assistant Director of Nursing	2,213	2,307	121,268	52.57	2
3	Registered Nurses	24,199	25,462	1,174,372	46.12	3
4	Licensed Practical Nurses	33,043	34,692	1,462,551	42.16	4
5	CNAs & Orderlies	80,976	86,129	2,225,530	25.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,813	1,869	46,669	24.97	9
10	Activity Assistants	4,391	4,939	94,179	19.07	10
11	Social Service Workers	3,848	4,056	108,592	26.77	11
12	Dietician					12
13	Food Service Supervisor	1,742	1,828	59,778	32.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,378	20,537	403,848	19.66	15
16	Dishwashers					16
17	Maintenance Workers	3,796	4,028	104,304	25.89	17
18	Housekeepers	15,749	17,128	344,285	20.10	18
19	Laundry	6,744	7,428	149,610	20.14	19
20	Administrator	2,024	2,080	161,009	77.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,218	8,669	212,822	24.55	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	2,603	2,742	58,141	21.20	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	8,267	8,932	322,532	36.11	33
34	TOTAL (lines 1 - 33)	221,386	235,292	\$ 7,219,329 *	\$ 30.68	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		\$		35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	20,513	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	3,748	L11, C3	44
45	Social Service Consultant	5	333	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	59	\$ 48,594		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Aliya of Crestwood

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	2,016	2,194	103,733	47.28
Admissions Coordinator	1,904	2,080	70,083	33.69
Infection Preventist	1,074	1,161	51,398	44.27
Central Supply	1,279	1,367	34,163	24.99
Staffing Coordinator	1,994	2,130	63,155	29.65
TOTAL	8,267	8,932	322,532	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description	Amount		
Arleen Batorek	Administrator	0	\$ 161,009	Workers' Compensation Insurance	\$	130,079	IDPH License Fee	\$ 1,884		
				Unemployment Compensation Insurance		57,809	Advertising: Employee Recruitment	31,037		
				FICA Taxes		546,559	Health Care Worker Background Check			
				Employee Health Insurance		286,688	(Indicate # of checks performed 63)	3,542		
				Employee Meals			Patient Background Checks 534	5,875		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	18,125		
				Pension/401k Expense		53,591	Telemedicine Solutions	4,655		
				Employee Meals/Food/Activities		26,215	Various Licenses & Fees	6,435		
				Uniforms		19,759				
				Other Employee Benefits		17,785	Allocated from Home Office	8,461		
							Less: Public Relations Expense (			
				Allocated from Home Office		46,624	PAC and Lobbying payments	(9,063)		
							All non-allowable advertising (			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 161,009	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,185,109	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 70,951
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			\$ 859,002	N/A			Out-of-State Travel	\$		
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			795,365							
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,654,367							
C. Professional Services										
Vendor/Payee	Type		Amount							
Alyze Healthcare Consulting	Bookkeeping		\$ 169,512							
Roth & Company	Accounting		996							
NYX Health, LLC	Accounting		923							
Waystar	Data Processing		3,861							
Point Click Care	Data Processing		89,858							
Paylocity	Payroll Processing		25,439							
Personnel Planners, Inc	Unemployment Consulting		1,980							
Nancy Given	PBJ Preparation		4,800				Seminar Expense	2,227		
See Legal Attachment	Legal Services		16,572							
							Allocated from Home Office	717		
See Attached Schedule 21A			124,468				Entertainment Expense (			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 438,409	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 2,944

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name: Aliya of Crestwood
IDPH License ID Number: 3000288
Fiscal Year End: 12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
AcctZen, LLC	Financial Consulting	370
ADDA Infusion	HR Consulting	886
Adelpo	Data Processing	1,920
Allegro Data Solutions	Data Processing	1,470
AR Proactive, Inc.	Data Processing	4,764
Bill.com LLC	Data Processing	640
Careflow CRM	Data Processing	3,300
Certisurv LLC	State Survey Consulting	250
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	37,251
CTI III, LLC	Business Consultant	668
DiningRD	EHR Integration	1,941
Direct Supply	Data Processing	1,334
Guided Care	Data Processing	15,350
Inovalon Provider, Inc.	Data Processing	762
MedaSync Inc.	Data Processing	1,000
Mega Data Health Systems	Data Processing	5,417
Netsmart Technologies	Data Processing	3,588
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	109
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	10,290
ProviNet Solutions	Data Processing	337
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	3,839
Reside Admissions	Data Processing	4,772
Sage Intacct, Inc	Data Processing	2,981
Status Solutions	Data Processing	9,000
Wellsky	Data Processing	3,608
Prior Year Accrual Reversal		(3,000)
Total		124,468

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)	9,062
	9,062 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)	9,063
	9,063 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	18,125
	18,125 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	65,116	Line	10
----	--------	------	----
- (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.

\$	877,049
----	---------

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.

\$	None	Has any meal income been offset against related costs?	No	Indicate the amount.	\$ N/A
----	------	--	----	----------------------	--------
- (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.

\$ N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

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