

		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: 0058644

Facility Name: Aliya of Evanston

Address: 1300 Oak AvenueEvanston60201

County: Cook

Telephone Number: (847) 869-1300Fax #: (847) 869-1378

HFS ID Number:

Date of Initial License for Current Owners: 3/1/24

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 TemplinTelephone 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)

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Date)

Paid Preparer

(Print Name and Title) Larry TemplinPartner

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

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

MAIL TO: BUREAU OF HEALTH FINANCEILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES2200 Churchill Rd.Springfield, IL 62702-3406Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Evanston # 0058644 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 _____

	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>57</u>	Skilled (SNF)	<u>57</u>	<u>20,805</u>	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	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</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						2,004	720	2,724	8
9	SNF/PED									9
10	ICF	3,664	10,143	2,973		99			16,879	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,664	10,143	2,973		99	2,004	720	19,603	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.22%

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 3/1/24

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 3/1/24 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 57

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL ☒ 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	231,415	11,726	2,434	245,575		245,575	20,044	265,619			1
2	Food Purchase		129,615		129,615		129,615		129,615			2
3	Housekeeping	140,322	13,481		153,803		153,803		153,803			3
4	Laundry	620	140	96,813	97,573		97,573		97,573			4
5	Heat and Other Utilities			43,260	43,260		43,260	306	43,566			5
6	Maintenance	51,782	5,747	42,851	100,380		100,380	7,542	107,922			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			7,857	7,857		7,857	3,011	10,868			7
8	TOTAL General Services	424,139	160,709	193,215	778,063		778,063	30,903	808,966			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	2,007,875	129,268	18,996	2,156,139		2,156,139	54,458	2,210,597			10
10a	Therapy											10a
11	Activities	120,584	3,774	1,610	125,968		125,968		125,968			11
12	Social Services	60,300		4,515	64,815		64,815	2,018	66,833			12
13	CNA Training											13
14	Program Transportation			43,079	43,079		43,079		43,079			14
15	Other (specify):* Mgmt Alloc of Benefits							6,649	6,649			15
16	TOTAL Health Care and Programs	2,188,759	133,042	84,200	2,406,001		2,406,001	63,125	2,469,126			16
	C. General Administration											
17	Administrative	91,059		584,170	675,229		675,229	(559,298)	115,931			17
18	Directors Fees											18
19	Professional Services			262,802	262,802		262,802	(94,309)	168,493			19
20	Dues, Fees, Subscriptions & Promotions			54,802	54,802		54,802	(2,460)	52,342			20
21	Clerical & General Office Expenses	94,075	9,041	29,340	132,456		132,456	153,488	285,944			21
22	Employee Benefits & Payroll Taxes			385,546	385,546		385,546	13,770	399,316			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			1,232	1,232		1,232	211	1,443			24
25	Other Admin. Staff Transportation			4,561	4,561		4,561	5,387	9,948			25
26	Insurance-Prop.Liab.Malpractice			139,981	139,981		139,981	2,080	142,061			26
27	Other (specify):* Mgmt Alloc of Benefits							25,104	25,104			27
28	TOTAL General Administration	185,134	9,041	1,464,875	1,659,050		1,659,050	(456,027)	1,203,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,798,032	302,792	1,742,290	4,843,114		4,843,114	(361,999)	4,481,115			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			15,302	15,302		15,302	14,757	30,059			30
31	Amortization of Pre-Op. & Org.			528	528		528		528			31
32	Interest			23,561	23,561		23,561	34,728	58,289			32
33	Real Estate Taxes			292,130	292,130		292,130		292,130			33
34	Rent-Facility & Grounds			570,457	570,457		570,457	(35,286)	535,171			34
35	Rent-Equipment & Vehicles			7,748	7,748		7,748	988	8,736			35
36	Other (specify):* Loan Fees			3,889	3,889		3,889		3,889			36
37	TOTAL Ownership			913,615	913,615		913,615	15,187	928,802			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,590	333,641	395,231		395,231	2,787	398,018			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			262,510	262,510		262,510		262,510			42
43	Other (specify):* Disallowed Costs		12,092	141,461	153,553		153,553	(153,553)				43
44	TOTAL Special Cost Centers		73,682	737,612	811,294		811,294	(150,766)	660,528			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,798,032	376,474	3,393,517	6,568,023		6,568,023	(497,578)	6,070,445			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,773	30		9
10	Interest and Other Investment Income	(7,293)	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				18
19	Entertainment				19
20	Contributions	(3)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(139,708)	43		24
25	Fund Raising, Advertising and Promotional	(12,092)	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	(1,200)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (158,523)		\$	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)	(339,055)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (339,055)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (497,578)		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	\$ (4,959)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable	(2,748)	17	4
5	Expense Minor Fixed Assets below \$2,500	4,500	6	5
6	Expense Minor Fixed Assets below \$2,500	6,618	10	6
7	Expense Minor Fixed Assets below \$2,500	343	21	7
8	Collection Agency Fees	(1,750)	43	8
9	Offset Miscellaneous Income	(12)	21	9
10	Out of State Travel (Allocated from Home Office)	(1,558)	24	10
11	Out of State Seminar (Allocated from Home Office)	(1,634)	25	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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34				34
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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	(1,200)		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	30	Depreciation	\$	Evanston SNF Property LLC		\$ 12,984	\$ 12,984	1
2	V	32	Interest		Evanston SNF Property LLC		32,500	32,500	2
3	V	32	Amortization of Loan Costs		Evanston SNF Property LLC		146	146	3
4	V	34	Rent-Facility & Grounds	39,503	Evanston SNF Property LLC			(39,503)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 39,503			\$ 45,630	\$ * 6,127	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	5	Heat and Other Utilities	\$	Aliya Healthcare Consulting LLC		\$ 306	\$ 306	15
16	V	6	Maintenance		Aliya Healthcare Consulting LLC		510	510	16
17	V	17	Administrative	349,269	Aliya Healthcare Consulting LLC		27,620	(321,649)	17
18	V	19	Professional Services		Aliya Healthcare Consulting LLC		5,257	5,257	18
19	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		2,497	2,497	19
20	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		6,304	6,304	20
21	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		13,770	13,770	21
22	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		1,713	1,713	22
23	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		3,559	3,559	23
24	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		2,065	2,065	24
25	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		5,605	5,605	25
26	V	32	Interest		Aliya Healthcare Consulting LLC		9,375	9,375	26
27	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		4,217	4,217	27
28	V	35	Rent-Equipment & Vehicles		Aliya Healthcare Consulting LLC		862	862	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			\$ 349,269			\$ 83,660	\$ * (265,609)	39

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐

 NO

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

1		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		\$ 20,044	\$ 20,044	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		2,532	2,532	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		3,011	3,011	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		47,840	47,840	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		2,018	2,018	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		6,649	6,649	20
21	V	17	Administrative	234,901	Alyze Healthcare Consulting LLC		0	(234,901)	21
22	V	19	Professional Services	99,912	Alyze Healthcare Consulting LLC		346	(99,566)	22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		2	2	23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		146,853	146,853	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		56	56	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		3,462	3,462	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		15	15	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		19,499	19,499	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		126	126	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		2,459	2,459	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		328	328	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 334,813			\$ 255,240	\$ * (79,573)	39

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

STATE OF ILLINOIS			Ownership Listing-1					
Aliya of Evanston								
ID#		0058644						
Report Period Beginning:		1/1/2025						
Ending:		12/31/2025						
			Aliya Healthcare Consu					
			Evanston SNF Property LLC					
-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.		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	Dvorah	S	Weinfeld	Chicago	IL	46.81395	46.81395	75.50000
2	Avrum	P	Weinfeld	Chicago	IL	12.15000	12.15000	
3	Moshe	M	Erllich	Lincolnwood	IL	13.24350	13.24350	15.00000
4	Jordan	E	Reifer	Lincolnwood	IL	8.46450	8.46450	5.00000
5	Rebecca	R	Kohn	Lincolnwood	IL	0.18043	0.18043	2.49975
6	Henry	NG	Kohn	Lincolnwood	IL	0.00046	0.00046	0.00063
7	Oliver	NG	Kohn	Lincolnwood	IL	0.00046	0.00046	0.00063
8	Lillian	NG	Kohn	Lincolnwood	IL	0.00046	0.00046	0.00063
9	George	NG	Kohn	Lincolnwood	IL	0.00046	0.00046	0.00063
10	Nesanel	B	Davis	Chicago	IL	0.07290	0.07290	1.00000
11	Sam	NG	Wasserman	Chicago	IL	0.07290	0.07290	1.00000
12	Ephraim	Y	Cohen	Lincolnwood	IL	2.50000	2.50000	
13	Aaron	D	Kraft	Lincolnwood	IL	1.00000	1.00000	
14	Carrie	A	Eckstein	Bergenfield	NJ	1.00000	1.00000	
15	Eileen	F	Kraft	Baltimore	MD	1.00000	1.00000	
16	Avi	NG	Schechter	Surfside	FL	5.00000	5.00000	
17	Eli	NG	Webster	Chicago	IL	3.00000	3.00000	
18	Marshall	NG	Meyers	Chicago	IL	3.00000	3.00000	
19	Shai	Y	Berdugo	Lincolnwood	IL	2.50000	2.50000	
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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 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	Aliya of Crestwood	Crestwood, IL			Aliya Healthcare			1
2	Aliya of Glenwood	Glenwood, IL			Consulting LLC	Skokie, IL	Management Co	2
3	Aliya of Highwood	Highwood, IL			Alyze Healthcare			3
4	Aliya of Homewood	Homewood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	4
5	Aliya of Oak Lawn	Oak Lawn, IL			Aliya of Palos Park			5
6	Aliya of Palatine	Palatine, IL			ILF LLC	Palos Park, IL	Independent Living	6
7	Aliya of Palos Park	Palos Park, IL			Wrightwood 87th			7
8	Aliya on 87th	Chicago, IL			SNF Property LLC	Skokie, IL	Lessor	8
9	Ryze at Homewood	Homewood, IL			Avenue SNF			9
10	Ryze at the Ridge	Chicago, IL			Property LLC	Skokie, IL	Lessor	10
11	Ryze on the Avenue	Chicago, IL			West SNF			11
12	Ryze West	Chicago, IL			Property LLC	Skokie, IL	Lessor	12
13					Evanston SNF			13
14					Property LLC	Skokie, IL	Lessor	14
15					Highwood SNF			15
16					Property LLC	Skokie, IL	Lessor	16
17					Ridge SNF			17
18					Property LLC	Skokie, IL	Lessor	18
19					Illuminate Hospice LL	Oakbrook Terrace, IL	Hospice	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	1.03	2.58	Salary	\$ 5,940	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	1.03	2.58	Salary	5,940	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	\$ 11,880		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

Ending: 2/31/2025

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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	Monticello AM		X	Mortgage	Varies	12/17/25	\$ 5,190,000	\$ 5,190,000	12/17/27	0.0750	\$ 32,500	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Optimum		X	Working Capital	5/3/2024				5/23/25	0.1050	7,844	6	
7												7	
8												8	
9	TOTAL Facility Related				\$45,415.00		\$ 5,190,000	\$ 5,190,000			\$ 40,344	9	
	B. Non-Facility Related*												
10								Amortization of Loan Costs			15,863	10	
11								Offset Interest Income			(7,293)	11	
12								Allocated from Home Office			9,375	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 17,945	14	
15	TOTALS (line 9+line14)						\$ 5,190,000	\$ 5,190,000			\$ 58,289	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.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.		\$	300,000	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		\$	232,650	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(67,350)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	359,480	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.				\$	292,130	7
Assessed Value from Real Estate Tax Bill:	2024	1,113,232	8			
Real Estate Tax Bill for Calendar Year:	2020	194,809	9			
	2021	205,301	10			
	2022	258,590	11			
	2023	269,500	12			
	2024	278,268	13			
Accrual based on prior year tax bill.						
The Taxes Paid Above on Line 2 Consist of 2 Payment out of Escrow of \$123,926 and \$108,724 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 Evanston COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0058644

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. 11-18-326-011-0000	Long Term Care Property	\$ 278,268.15	\$ 278,268.15
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 278,268.15	\$ 278,268.15

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: 19,800B. General Construction Type: Exterior BrickFrameNumber of Stories 2

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? X YES NO
If so, please complete the following:

1. Total Amount Incurred: 1,0562. Number of Years Over Which it is Being Amortized: 1
3. Current Period Amortization: 5284. Dates Incurred: 2024

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	Nursing Home		2025	\$ 627,000	1
2					2
3	TOTALS			\$ 627,000	3

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	57		2025	1961	\$ 3,762,000	\$	25	\$ 12,540	\$ 12,540	\$ 12,540
5										
6										
7										
8										
	Improvement Type**									
9	Install New Call Light System			2024	53,638		15	3,576	3,576	5,364
10	Exterior Building Sign			2024	5,377		15	358	358	537
11	Repair AC Unit ECM Motor			2024	3,374		15	225	225	337
12	Install Flooring-Lobby			2025	7,250		15	242	242	242
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32	Financial Statement Depreciation					7,010			(7,010)	
33										
34										
35										
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	1,159		15	77	77	116	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	630		15	21	21	21	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)		\$ 3,833,428	\$ 7,010		\$ 17,039	\$ 10,029	\$ 19,157	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	\$18,640	\$6,554	\$1,864	\$(4,690)	10 Yrs	\$2,796	71
72	Current Year Purchases	1,263,599	1,738	11,156	9,418	5-10 Yrs	11,156	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,282,239	\$8,292	\$13,020	\$4,728		\$13,952	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)	\$5,742,667	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$15,302	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$30,059	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$14,757	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$33,109	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: Evanston NRC Realty 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:	<u>1961</u>	<u>57</u>	<u>3/1/24</u>	\$ <u>530,954</u>			3
4	Additions							4
5								5
6		<u>Allocated from Home Office</u>			<u>4,217</u>			6
7	TOTAL		<u>57</u>		\$ <u>535,171</u>			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 N/A .
N/A
9. Option to Buy: ☒ YES ☐ NO Terms: Purchased Facility in Dec 2025 *

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: \$ 8,610 Description: 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	<u>Allocated from Home Office</u>			<u>126</u>	18
19					19
20					20
21	TOTAL		\$	\$ 126	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 Evanston

IDPH License ID Number:

0058644

Fiscal Year End:

12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	5,144
Dietary Equipment	440
Office Equipment	2,164
Allocated from Home Office	862
Total - Line 16	8,610

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$	3,214	\$ 118,157	\$	3,214	\$ 118,157	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,046	59,718		1,046	59,718	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,954	138,697		2,954	138,697	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				61,590		61,590	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(7)	59	2,459				59	2,459	12
13	Other (specify): <u>See Attached Sch 16A</u>	39(3)				16,919			16,919	13
14	TOTAL			\$ 2,459	7,214	\$ 333,491	\$ 61,590	7,273	\$ 397,540	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 Evanston

IDPH License ID Number:

0058644

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	13,767
Radiology	3,152
Total - Line 16	16,919

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,364	\$ 11,364	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 233,621)	1,182,353	1,182,353	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,136	58,136	6
7	Other Prepaid Expenses	25,023	25,023	7
8	Accounts Receivable (owners or related parties)	10,649,279	10,649,279	8
9	Other(specify): Deposit	35,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 11,961,155	\$ 11,926,155	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		627,000	13
14	Buildings, at Historical Cost		3,762,000	14
15	Leasehold Improvements, at Historical Cost	84,964	71,428	15
16	Equipment, at Historical Cost	53,529	1,282,239	16
17	Accumulated Depreciation (book methods)	(19,314)	(33,109)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds	306,806	525,517	21
22	Other Long-Term Assets (specify) Loan Costs/Goodwill		838,138	22
23	Other(specify): Deposits	100,000	100,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 525,985	\$ 7,173,213	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,487,140	\$ 19,099,368	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 172,482	\$ 172,482	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,601	298,601	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	30,242	30,242	31
32	Accrued Real Estate Taxes(Sch.IX-B)	359,480	359,480	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	78,176	38,673	36
37	Due to Related Party	11,144,168	11,144,168	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,083,149	\$ 12,043,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,190,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Long Term Lease Liability	63,188	63,188	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 63,188	\$ 5,253,188	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,146,337	\$ 17,296,834	46
47	TOTAL EQUITY(page 18, line 24)	\$ 340,803	\$ 1,802,534	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,487,140	\$ 19,099,368	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (263,175)	1
2	Restatements (describe):		2
3	Rent Expense	(63,188)	3
4	Depreciation Expense	(4,012)	4
5	Rounding	(1)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (330,376)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	671,179	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)	\$ 671,179	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)	\$ 340,803	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Evanston

0058644

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	\$ 8,962,251	1
2	Discounts and Allowances for all Levels	(2,088,559)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,873,692	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,687	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 111,687	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	20	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	300	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	181	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)	\$ 501	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,293	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,293	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records Income	12	28
28a	C.N.A. Initiative/QIP Revenue	246,017	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 246,029	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,239,202	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	778,063	31
32	Health Care	2,406,001	32
33	General Administration	1,659,050	33
	B. Capital Expense		
34	Ownership	913,615	34
	C. Ancillary Expense		
35	Special Cost Centers	548,784	35
36	Provider Participation Fee	262,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,568,023	40
41	Income before Income Taxes (line 30 minus line 40)**	671,179	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 671,179	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,046,048	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,895,760	45
46	MMAI-Medicaid is the Primary Payer	848,772	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	34,611	48
49	Medicare Part A	1,582,363	49
50	Other-(specify) Medicare Replacement	313,996	50
51	Other-(specify) Insurance	152,142	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)	\$ 6,873,692	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	1,508	1,660	\$ 97,797	\$ 58.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,021	13,991	601,692	43.01	3
4	Licensed Practical Nurses	7,073	7,364	299,319	40.65	4
5	CNAs & Orderlies	32,416	35,015	865,649	24.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	51,440	24.73	9
10	Activity Assistants	3,461	3,683	69,144	18.77	10
11	Social Service Workers	1,974	2,062	57,260	27.77	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,080	64,896	31.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,070	8,404	166,519	19.81	15
16	Dishwashers					16
17	Maintenance Workers	1,824	2,080	51,782	24.90	17
18	Housekeepers	6,360	6,847	140,322	20.49	18
19	Laundry	27	27	620	22.96	19
20	Administrator	1,920	2,015	91,059	45.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,206	2,439	43,166	17.70	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	2,059	2,115	53,392	25.24	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	3,048	3,356	143,975	42.90	33
34	TOTAL (lines 1 - 33)	88,935	95,218	\$ 2,798,032 *	\$ 29.39	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	16,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,007	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	150	L39, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,610	L11, C3	44
45	Social Service Consultant	65	4,515	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	90	\$ 34,282		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	27	\$ 1,592	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	27	\$ 1,592		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Aliya of Evanston

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	1,496	1,647	86,246	52.37
Admissions Coordinator	1,360	1,517	50,909	33.56
Transportation	120	120	3,040	25.33
Staffing Coordinator	72	72	3,780	52.50
TOTAL	3,048	3,356	143,975	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Felipe Martinez	Administrator	0	\$ 19,732
Brittany Ward	Administrator	0	71,327
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,059
B. Administrative - Other			
Description			Amount
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7		\$	349,269
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			234,901
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 584,170
C. Professional Services			
Vendor/Payee	Type		Amount
Alyze Healthcare Consulting	Bookkeeping	\$	99,912
Roth & Company	Accounting		15,996
Templin Healthcare Accounting	Accounting		5,926
NYX Health LLC	Accounting		923
Waystar	Data Processing		3,861
Point Click Care	Data Processing		28,731
Paylocity	Payroll Processing		14,001
Personnel Planners, Inc	Unemployment Consulting		1,785
Nancy Given	PBJ Preparation		4,900
See Legal Attachment	Legal Services		10,713
See Attached Schedule 21A			76,054
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 262,802
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	(3,395)
Unemployment Compensation Insurance			11,535
FICA Taxes			209,274
Employee Health Insurance			106,159
Employee Meals			11,230
Illinois Municipal Retirement Fund (IMRF)*			
Pension/401k Expense			17,136
Employee Meals/Food/Activities			19,685
Uniforms			2,329
Other Employee Benefits			11,593
Allocated from Home Office			13,770
TOTAL (agree to Schedule V, line 22, col.8)			\$ 399,316
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,658
Advertising: Employee Recruitment			26,959
Health Care Worker Background Check (Indicate # of checks performed 19)			1,061
Patient Background Checks 297			3,269
Association Dues (total from pg 22, #4)			9,918
Telemedicine Solutions			4,055
Various Licenses & Fees			7,882
Allocated from Home Office			2,499
Less: Public Relations Expense	(		)
PAC and Lobbying payments			(4,959)
All non-allowable advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 52,342
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			1,232
Allocated from Home Office			211
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	1,443

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

****See instructions.**

Facility Name: Aliya of Evanston
IDPH License ID Number: 0058644
Fiscal Year End: 12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
2401 Incorporated of Illinois	Architecture	5,800
AcctZen, LLC	Accounting Services	711
ADDA Infusion	HR Consulting	531
Adelpo	Data Processing	1,920
Allegro Data Solutions	Data Processing	515
AR Proactive, Inc.	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,600
Certisurv LLC	State Survey Consulting	900
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	15,386
CTI III, LLC	Business Consultant	667
DiningRD	EHR Integration	835
Direct Supply	Data Processing	1,600
Guided Care	Data Processing	19,768
Inovalon Provider, Inc.	Data Processing	762
Life Safety Resources, LLC	Life Safety Consultant	4,200
Mega Data Health Systems	Data Processing	6,361
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	4,542
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	3,588
Reside Admissions	Data Processing	2,981
Sage Intacct, Inc	Data Processing	2,924
Wellsky	Data Processing	7,632
Prior Year Accrual Reversal		(30,000)
Total		76,054

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 |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>4,959</u> |
| | |
| | |
| | <u>4,959</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>4,959</u> |
| | |
| | |
| | |
| | <u>4,959</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>9,918</u> |
| | |
| | |
| | |
| | <u>9,918</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 15,687 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. \$ 262,510
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. \$ 11,230 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.