

		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: 3000232

Facility Name: Aliya of Glenwood

Address: 19330 S Cottage GrvGlenwood60425
NumberCityZip Code

County: Cook

Telephone Number: (708) 758-6200Fax #: (708) 758-9563

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2024

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 TemplinTelephone Number: (630) 361-2868Email 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 TemplinPartner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868Fax # ()

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 Glenwood # 3000232 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

N/A

	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	184	Skilled (SNF)	184	67,160	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	184	TOTALS	184	67,160	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						2,214	1,251	3,465	8
9	SNF/PED									9
10	ICF	10,865	27,398	3,415		615		2,407	44,700	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	10,865	27,398	3,415		615	2,214	3,658	48,165	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 71.72%

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 11/1/24

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/1/24 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 184

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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	367,021	26,429	2,976	396,426		396,426	69,493	465,919			1
2	Food Purchase		336,324		336,324		336,324		336,324			2
3	Housekeeping	395,495	27,198	241	422,934		422,934		422,934			3
4	Laundry	99,140	19,867	3,892	122,899		122,899		122,899			4
5	Heat and Other Utilities			255,629	255,629		255,629	987	256,616			5
6	Maintenance	56,659	26,571	89,473	172,703		172,703	30,004	202,707			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			15,617	15,617		15,617	9,719	25,336			7
8	TOTAL General Services	918,315	436,389	367,828	1,722,532		1,722,532	110,203	1,832,735			8
	B. Health Care and Programs											
9	Medical Director			28,089	28,089		28,089		28,089			9
10	Nursing and Medical Records	4,337,285	281,949	24,841	4,644,075		4,644,075	156,737	4,800,812			10
10a	Therapy											10a
11	Activities	207,080	14,485	(645)	220,920		220,920		220,920			11
12	Social Services	141,287		2,958	144,245		144,245	6,514	150,759			12
13	CNA Training											13
14	Program Transportation			40,304	40,304		40,304		40,304			14
15	Other (specify):* Mgmt Alloc of Benefits							21,464	21,464			15
16	TOTAL Health Care and Programs	4,685,652	296,434	95,547	5,077,633		5,077,633	184,715	5,262,348			16
	C. General Administration											
17	Administrative	134,412		1,547,649	1,682,061		1,682,061	(1,467,356)	214,705			17
18	Directors Fees											18
19	Professional Services			425,550	425,550		425,550	(155,314)	270,236			19
20	Dues, Fees, Subscriptions & Promotions			74,101	74,101		74,101	(7,067)	67,034			20
21	Clerical & General Office Expenses	290,126	20,988	41,589	352,703		352,703	500,353	853,056			21
22	Employee Benefits & Payroll Taxes			829,368	829,368		829,368	44,450	873,818			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,539	4,539		4,539	684	5,223			24
25	Other Admin. Staff Transportation			2,421	2,421		2,421	17,387	19,808			25
26	Insurance-Prop.Liab.Malpractice			440,589	440,589		440,589	6,713	447,302			26
27	Other (specify):* Mgmt Alloc of Benefits							81,037	81,037			27
28	TOTAL General Administration	424,538	20,988	3,365,806	3,811,332		3,811,332	(979,113)	2,832,219			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,028,505	753,811	3,829,181	10,611,497		10,611,497	(684,195)	9,927,302			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			16,964	16,964		16,964	(3,450)	13,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,146	119,146		119,146	2,587	121,733			32
33	Real Estate Taxes			1,017,060	1,017,060		1,017,060		1,017,060			33
34	Rent-Facility & Grounds			1,349,718	1,349,718		1,349,718	13,613	1,363,331			34
35	Rent-Equipment & Vehicles			25,022	25,022		25,022	3,193	28,215			35
36	Other (specify):*											36
37	TOTAL Ownership			2,527,910	2,527,910		2,527,910	15,943	2,543,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		153,429	541,490	694,919		694,919	8,997	703,916			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			798,682	798,682		798,682		798,682			42
43	Other (specify):* Disallowed Costs	38,138	31,794	443,031	512,963		512,963	(512,963)				43
44	TOTAL Special Cost Centers	38,138	185,223	1,783,203	2,006,564		2,006,564	(503,966)	1,502,598			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,066,643	939,034	8,140,294	15,145,971		15,145,971	(1,172,218)	13,973,753			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,954)	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	(3,450)	30		9
10	Interest and Other Investment Income	(27,676)	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	(117,325)	43		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	(315,749)	43		24
25	Fund Raising, Advertising and Promotional	(38,138)	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	(32,866)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (545,161)		\$	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)	(627,057)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (627,057)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,172,218)		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	\$ (15,134)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable	(8,869)	17	4
5	Expense Minor Fixed Assets below \$2,500	4,789	1	5
6	Expense Minor Fixed Assets below \$2,500	20,185	6	6
7	Expense Minor Fixed Assets below \$2,500	2,306	10	7
8	Expense Minor Fixed Assets below \$2,500	5,960	21	8
9	Miscellaneous Income Offset	(5)	21	9
10	Disallow Marketing Director Wages	(31,794)	43	10
11	Out of State Travel (Allocated from Home Office)	(5,029)	24	11
12	Out of State Seminar (Allocated from Home Office)	(5,275)	25	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(32,866)		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		\$ 987	\$ 987	1
2	V	6	Maintenance		Aliya Healthcare Consulting LLC		1,645	1,645	2
3	V	17	Administrative	789,373	Aliya Healthcare Consulting LLC		89,162	(700,211)	3
4	V	19	Professional Services		Aliya Healthcare Consulting LLC		16,970	16,970	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		8,061	8,061	5
6	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		20,350	20,350	6
7	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		44,450	44,450	7
8	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		5,531	5,531	8
9	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		11,488	11,488	9
10	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		6,664	6,664	10
11	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		18,092	18,092	11
12	V	32	Interest		Aliya Healthcare Consulting LLC		30,263	30,263	12
13	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		13,613	13,613	13
14	Total			\$ 789,373			\$ 267,276	\$ * (522,097)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent-Equipment & Vehicles	\$	Aliya Healthcare Consulting LLC		\$ 2,785	\$ 2,785	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			\$			\$ 2,785	\$ * 2,785	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		\$ 64,704	\$ 64,704	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		8,174	8,174	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		9,719	9,719	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		154,431	154,431	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		6,514	6,514	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		21,464	21,464	20
21	V	17	Administrative	758,276	Alyze Healthcare Consulting LLC		0	(758,276)	21
22	V	19	Professional Services	173,400	Alyze Healthcare Consulting LLC		1,116	(172,284)	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		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		474,048	474,048	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		182	182	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		11,174	11,174	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		49	49	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		62,945	62,945	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		408	408	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		7,938	7,938	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,059	1,059	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 931,676			\$ 823,931	\$ * (107,745)	39

STATE OF ILLINOIS					Ownership Listing-1					
Aliya of Glenwood										
ID#		3000232								
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			
Place of Residence										
First Name	M.I.	Last Name	City	State	Ownership Percentage	Building Co. Ownership Percentage	Co./Home Office Ownership Percentage			
1	Dvorah	S Weinfeld	Chicago	IL	41.31000		75.50000	1		
2	Avrum	P Weinfeld	Chicago	IL	12.15000			2		
3	Moshe	M Erlich	Lincolnwood	IL	12.15000		15.00000	3		
4	Jordan	E Reifer	Lincolnwood	IL	8.10000		5.00000	4		
5	Rebecca	R Kohn	Lincolnwood	IL	4.05000		2.49975	5		
6	Nesanel	B Davis	Chicago	IL	1.62000		1.00000	6		
7	Sam	NG Wasserman	Chicago	IL	1.62000		1.00000	7		
8	Eli	NG Webster	Chicago	IL	2.99970			8		
9	Marshall	NG Meyers	Chicago	IL	2.99970			9		
10	Shai	Y Berdugo	Lincolnwood	IL	2.49980			10		
11	Aaron	NG Kraft	Lincolnwood	IL	2.99970			11		
12	Avi	NG Schechter	Surfside	FL	4.99950			12		
13	Ephraim	NG Cohen	Lincolnwood	IL	2.49980			13		
14								14		
15								15		
16	Remaining Owners of Aliya Healthcare Consulting LLC								16	
17	Henry	NG Kohn	Lincolnwood	IL			0.00063	17		
18	Oliver	NG Kohn	Lincolnwood	IL			0.00063	18		
19	Lillian	NG Kohn	Lincolnwood	IL			0.00063	19		
20	George	NG Kohn	Lincolnwood	IL			0.00063	20		
21								21		
22								22		
23								23		
24								24		
25								25		
26								26		
27								27		
28								28		
29								29		
30								30		
31								31		
32								32		
33								33		
34								34		
35								35		
36								36		
37								37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70								70		
71								71		
72								72		
73								73		
74								74		
75								75		

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 Evanston	Evanston, IL			Aliya Healthcare			1
2	Aliya of Palatine	Palatine, 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 Crestwood	Crestwood, 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					Palos SNF			19
20					Property LLC	Skokie, IL	Lessor	20
21					Illuminate Hospice LL	Oakbrook Terrace, IL	Hospice	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 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	3.33	8.33	Salary	\$ 19,175	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	3.33	8.33	Salary	19,175	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	\$ 38,350		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

()

SEE ACCOUNTANTS' PREPARATION REPORT

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		11/30/24	2,500,000		11/30/28	variable	65,426		6
7													7
8													8
9	TOTAL Facility Related						\$ 2,500,000	\$			\$ 65,426		9
	B. Non-Facility Related*												
10								Amortization of Loan Costs			53,720		10
11								Offset Interest Income			(27,676)		11
12								Allocated from Home Office			30,263		12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ 56,307		14
15	TOTALS (line 9+line14)						\$ 2,500,000	\$			\$ 121,733		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.		\$	156,000	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		\$	166,562	2
3. Under or (over) accrual (line 2 minus line 1).				\$	10,562	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	1,006,498	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.				\$	1,017,060	7
Assessed Value from Real Estate Tax Bill:	2024	2,339,079	8			
Real Estate Tax Bill for Calendar Year:	2020	598,293	9			
	2021	642,653	10			
	2022	775,536	11			
	2023	1,005,904	12			
	2024	1,016,028	13			
Accrual based on prior year tax bill.						
Aliya of Glenwood Paid \$166,562 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 Glenwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 3000232

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. 32-10-201-006-0000	Long Term Care Property	\$ 7,758.27	\$ 7,758.27
2. 32-10-201-009-0000	Long Term Care Property	\$ 1,008,269.42	\$ 1,008,269.42
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,016,027.69	\$ 1,016,027.69

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: 98,010B. General Construction Type: Exterior BrickFrameNumber of Stories

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:

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 Glenwood

3000232

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	Install Tile/Cove Base-TY Area and Hall			2025	15,750		15	525	525	525	9	
10	Install Outlets-3 in Wall, 1 in Ceiling			2025	6,526		15	218	218	218	10	
11	Replace Capsule Pak-Walk In Freezer			2025	14,143		15	471	471	471	11	
12	Replace Pump, Mixing Valves-Water Heater			2025	6,636		15	221	221	221	12	
13	Replace Push Button Locks on 2 Breakroom Doors and 5 Other Doors			2025	7,787		15	260	260	260	13	
14	Repair Compressor in Fornt Office AC			2025	3,404		15	113	113	113	14	
15	Install Egressable Mag Lock and Employee Armature Plate/Magnetic Lock			2025	2,705		15	90	90	90	15	
16	Install New Pipe-Hot Water Tank			2025	2,849		15	95	95	95	16	
17	Replace Receptacles-Resident Rooms/Common Areas, Flush Mount Data			2025	17,218		15	574	574	574	17	
18	Replace Exhaust Fan Motor			2025	3,149		15	105	105	105	18	
19	Replace Dry Pendant-Sprinkler System			2025	4,188		15	140	140	140	19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35	Financial Statement Depreciation					4,746			(4,746)		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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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	3,741		15	249	249	374	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	2,035		15	68	68	68	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)		\$ 90,131	\$ 4,746		\$ 3,129	\$ (1,617)	\$ 3,254	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	\$31,870	\$6,379	\$5,897	\$ (482)	5-10 Yrs	\$8,845	71
72	Current Year Purchases	70,255	5,839	4,488	(1,351)	5-10 Yrs	4,488	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$102,125	\$12,218	\$10,385	\$ (1,833)		\$13,333	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)	\$192,256	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$16,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$13,514	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,450)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$16,587	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:19330 S. Cottage Grove, 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:		184	11/1/24	\$1,349,718	5	5	3
4	Additions							4
5								5
6		Allocated from Home Office			13,613			6
7	TOTAL		184		\$1,363,331			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.
- N/A

9. Option to Buy:☒ YES☐ NO
- Terms: 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: \$27,807Description: 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			408	18
19					19
20					20
21	TOTAL		\$	\$408	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 Glenwood

IDPH License ID Number:

3000232

Fiscal Year End:

12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	14,153
Dietary Equipment	3,028
Office Equipment	7,841
Allocated from Home Office	2,785
Total - Line 16	27,807

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

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	\$	3,626	\$ 151,113	\$	3,626	\$ 151,113	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		461	30,592		461	30,592	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		4,305	207,159	176	4,305	207,335	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				153,253		153,253	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)	190	7,938				190	7,938	12
13	Other (specify): <u>See Attached Sch 16A</u>	39(3)				152,626			152,626	13
14	TOTAL			\$ 7,938	8,392	\$ 541,490	\$ 153,429	8,582	\$ 702,857	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 Glenwood

IDPH License ID Number:

3000232

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	19,132
Radiology	2,791
Dialysis	130,703
Total - Line 16	152,626

Facility Name & ID Number	Aliya of Glenwood
--------------------------------------	--------------------------

3000232

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	\$ (69,491)	\$ (69,491)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 365,697)	2,806,693	2,806,693	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	200,437	200,437	6
7	Other Prepaid Expenses	136,546	136,546	7
8	Accounts Receivable (owners or related parties)	772,949	772,949	8
9	Other(specify): <u>Option Deposit</u>	100,000	100,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,947,134	\$ 3,947,134	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	93,943	90,131	15
16	Equipment, at Historical Cost	129,293	102,125	16
17	Accumulated Depreciation (book methods)	(16,964)	(16,587)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,487,435	1,487,435	21
22	Other Long-Term Assets (specify <u>Loan Costs</u>)	70,521	70,521	22
23	Other(specify): <u>Security Deposits</u>	15,570	15,570	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,779,798	\$ 1,749,195	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,726,932	\$ 5,696,329	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 763,462	\$ 763,462	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	539,543	539,543	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,854	64,854	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,006,498	1,006,498	32
33	Accrued Interest Payable	42,789	42,789	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	188,256	188,256	36
37	<u>Due to Related Party</u>	1,921,713	1,921,713	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,527,115	\$ 4,527,115	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)	\$ 4,527,115	\$ 4,527,115	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,199,817	\$ 1,169,214	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,726,932	\$ 5,696,329	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 83,902	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 83,902	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,115,915	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)	\$ 1,115,915	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)	\$ 1,199,817	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Glenwood

3000232

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	\$ 19,799,500	1
2	Discounts and Allowances for all Levels	(4,131,237)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,668,263	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,195	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 119,195	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	754	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)	\$ 754	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,676	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,676	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5	28
28a	C.N.A. Initiative/QIP Revenue	445,993	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 445,998	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,261,886	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,722,532	31
32	Health Care	5,077,633	32
33	General Administration	3,811,332	33
	B. Capital Expense		
34	Ownership	2,527,910	34
	C. Ancillary Expense		
35	Special Cost Centers	1,207,882	35
36	Provider Participation Fee	798,682	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,145,971	40
41	Income before Income Taxes (line 30 minus line 40)**	1,115,915	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,115,915	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,095,172	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,805,017	45
46	MMAI-Medicaid is the Primary Payer	972,850	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	222,531	48
49	Medicare Part A	1,860,162	49
50	Other-(specify) Medicare Replacement	718,829	50
51	Other-(specify) Insurance	113,044	51
52	Other-(specify) Veterans	880,658	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)	\$ 15,668,263	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	1,430	1,545	\$ 99,295	\$ 64.27	1
2	Assistant Director of Nursing	1,816	1,919	98,418	51.29	2
3	Registered Nurses	16,152	16,903	747,500	44.22	3
4	Licensed Practical Nurses	27,684	28,999	1,140,362	39.32	4
5	CNAs & Orderlies	74,641	80,496	1,950,673	24.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,154	54,253	25.19	9
10	Activity Assistants	7,746	8,504	152,827	17.97	10
11	Social Service Workers	3,681	3,913	109,601	28.01	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	68,432	32.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,205	16,449	298,589	18.15	15
16	Dishwashers					16
17	Maintenance Workers	1,952	2,080	56,659	27.24	17
18	Housekeepers	18,481	20,329	395,495	19.45	18
19	Laundry	4,768	5,319	99,140	18.64	19
20	Administrator	1,816	2,021	134,412	66.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,506	9,194	221,582	24.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,904	2,080	43,888	21.10	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	10,398	10,997	395,517	35.97	33
34	TOTAL (lines 1 - 33)	200,100	214,982	\$ 6,066,643 *	\$ 28.22	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	169	28,089	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	20,998	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	7	455	L11, C3	44
45	Social Service Consultant	42	2,958	L12, C3	45
46	Other(specify)				46
47	Accrual Reversal		(1,100)	L11, C3	47
48					48
49	TOTAL (lines 35 - 48)	218	\$ 51,400		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 Glenwood

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	1,992	2,080	95,061	45.70
Admissions Coordinator	1,744	1,840	68,544	37.25
Infection Preventist	2,142	2,238	99,622	44.51
Transportation	1,365	1,365	31,686	23.21
Customer Experience Director	1,128	1,306	38,138	29.20
Staffing Coordinator	2,027	2,168	62,466	28.81
TOTAL	10,398	10,997	395,517	

Facility Name:

Aliya of Glenwood

IDPH License ID Number:

3000232

Fiscal Year End:

12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
AcctZen, LLC	Accounting	411
ADDA Infusion	HR Consulting	886
Adelpo	Data Processing	1,920
Allegro Data Solutions	Data Processing	882
AR Proactive, Inc.	Data Processing	4,764
Bill.com LLC	Data Processing	640
Careflow CRM	Data Processing	3,300
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	26,777
CTI III, LLC	Business Consultant	668
DiningRD	EHR Integration	850
Direct Supply	Data Processing	1,600
Guided Care	Data Processing	18,650
Inovalon Provider, Inc.	Data Processing	762
Mega Data Health Systems	Data Processing	6,254
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	7,878
Pendulum, LLC	Risk Management	4,250
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	4,188
Reside Admissions	Data Processing	2,894
Sage Intacct, Inc	Data Processing	2,981
Wellsky	Data Processing	11,201
Prior Year Accrual Reversal		(6,000)
Total		111,183

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	15,134
	15,134 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)	15,134
	15,134 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	30,268
	30,268 Total
- (5)

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

\$ 43,079 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.

\$ 798,682

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?

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

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