

		FOR BHF USE					

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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: 0058636

Facility Name: Aliya of Highwood

Address: 50 Pleasant AvenueHighwood60040

County: Lake

Telephone Number: (847) 432-9142Fax #: (847) 432-4740

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)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(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 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 Highwood # 0058636 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>104</u>	Skilled (SNF)	<u>104</u>	<u>37,960</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>104</u>	TOTALS	<u>104</u>	<u>37,960</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						3,370	1,034	4,404	8
9	SNF/PED									9
10	ICF	7,154	19,483	2,048		2,649			31,334	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,154	19,483	2,048		2,649	3,370	1,034	35,738	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.15%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 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 104

Medicare Intermediary National Government Services

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	469,600	23,789	1,592	494,981		494,981	37,655	532,636			1
2	Food Purchase		293,371		293,371		293,371		293,371			2
3	Housekeeping	244,525	30,794		275,319		275,319		275,319			3
4	Laundry	64,197	23,144	38,490	125,831		125,831		125,831			4
5	Heat and Other Utilities			143,109	143,109		143,109	558	143,667			5
6	Maintenance	121,768	19,875	100,825	242,468		242,468	21,456	263,924			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			14,051	14,051		14,051	5,494	19,545			7
8	TOTAL General Services	900,090	390,973	298,067	1,589,130		1,589,130	65,163	1,654,293			8
	B. Health Care and Programs											
9	Medical Director			57,600	57,600		57,600		57,600			9
10	Nursing and Medical Records	3,623,472	270,770	20,382	3,914,624		3,914,624	87,287	4,001,911			10
10a	Therapy											10a
11	Activities	238,457	5,163	1,278	244,898		244,898		244,898			11
12	Social Services	103,802		6,580	110,382		110,382	3,682	114,064			12
13	CNA Training											13
14	Program Transportation			26,185	26,185		26,185		26,185			14
15	Other (specify):* Mgmt Alloc of Benefits							12,132	12,132			15
16	TOTAL Health Care and Programs	3,965,731	275,933	112,025	4,353,689		4,353,689	103,101	4,456,790			16
	C. General Administration											
17	Administrative	126,488		1,056,624	1,183,112		1,183,112	(1,011,240)	171,872			17
18	Directors Fees											18
19	Professional Services			338,098	338,098		338,098	(122,449)	215,649			19
20	Dues, Fees, Subscriptions & Promotions			72,186	72,186		72,186	(4,489)	67,697			20
21	Clerical & General Office Expenses	232,259	12,120	40,744	285,123		285,123	287,507	572,630			21
22	Employee Benefits & Payroll Taxes			711,293	711,293		711,293	25,124	736,417			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			1,305	1,305		1,305	388	1,693			24
25	Other Admin. Staff Transportation			5,089	5,089		5,089	9,827	14,916			25
26	Insurance-Prop.Liab.Malpractice			255,599	255,599		255,599	3,795	259,394			26
27	Other (specify):* Mgmt Alloc of Benefits							45,802	45,802			27
28	TOTAL General Administration	358,747	12,120	2,483,379	2,854,246		2,854,246	(765,735)	2,088,511			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,224,568	679,026	2,893,471	8,797,065		8,797,065	(597,471)	8,199,594			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			51,389	51,389		51,389	19,155	70,544			30
31	Amortization of Pre-Op. & Org.			528	528		528		528			31
32	Interest			23,492	23,492		23,492	47,347	70,839			32
33	Real Estate Taxes			196,800	196,800		196,800		196,800			33
34	Rent-Facility & Grounds			937,829	937,829		937,829	(58,888)	878,941			34
35	Rent-Equipment & Vehicles			39,347	39,347		39,347	1,805	41,152			35
36	Other (specify):*											36
37	TOTAL Ownership			1,249,385	1,249,385		1,249,385	9,419	1,258,804			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,830	583,352	693,182		693,182	5,085	698,267			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			665,819	665,819		665,819		665,819			42
43	Other (specify):* Disallowed Costs		32,869	254,213	287,082		287,082	(287,082)				43
44	TOTAL Special Cost Centers		142,699	1,503,384	1,646,083		1,646,083	(281,997)	1,364,086			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,224,568	821,725	5,646,240	11,692,533		11,692,533	(870,049)	10,822,484			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	(8,801)	30		9
10	Interest and Other Investment Income	(2,403)	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	(251,213)	43		24
25	Fund Raising, Advertising and Promotional	(34,869)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(43)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	4,215			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (293,117)		\$	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)	(576,932)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (576,932)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (870,049)		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			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (9,048)	20
2	Other Expenses Related to Lobbying Activities		
3			
4	Adjust Owner Wages to Allowable	(5,013)	17
5	Expense Minor Fixed Assets below \$2,500	1,083	1
6	Expense Minor Fixed Assets below \$2,500	15,906	6
7	Expense Minor Fixed Assets below \$2,500	8,065	21
8	Collection Agency Fees	(2,898)	43
9	Disallow Cable TV Accrual Reversal	1,944	43
10	Out of State Travel (Allocated from Home Office)	(2,842)	24
11	Out of State Seminar (Allocated from Home Office)	(2,982)	25
12			
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48			
49	Total	4,215	

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	\$	Highwood SNF Property LLC		\$ 27,956	\$ 27,956	1
2	V	32	Interest		Highwood SNF Property LLC		32,500	32,500	2
3	V	32	Amortization of Loan Costs		Highwood SNF Property LLC		146	146	3
4	V	34	Rent-Facility & Grounds	66,583	Highwood SNF Property LLC			(66,583)	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			\$ 66,583			\$ 60,602	\$ * (5,981)	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		\$ 558	\$ 558	15
16	V	6	Maintenance		Aliya Healthcare Consulting LLC		930	930	16
17	V	17	Administrative	628,033	Aliya Healthcare Consulting LLC		50,397	(577,636)	17
18	V	19	Professional Services		Aliya Healthcare Consulting LLC		9,592	9,592	18
19	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		4,556	4,556	19
20	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		11,502	11,502	20
21	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		25,124	25,124	21
22	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		3,127	3,127	22
23	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		6,493	6,493	23
24	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		3,767	3,767	24
25	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		10,225	10,225	25
26	V	32	Interest		Aliya Healthcare Consulting LLC		17,104	17,104	26
27	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		7,695	7,695	27
28	V	35	Rent-Equipment & Vehicles	\$	Aliya Healthcare Consulting LLC		1,574	1,574	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			\$ 628,033			\$ 152,644	\$ * (475,389)	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.

☒ 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		\$ 36,572	\$	36,572 15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		4,620		4,620 16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		5,494		5,494 17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		87,287		87,287 18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		3,682		3,682 19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		12,132		12,132 20
21	V	17	Administrative	428,591	Alyze Healthcare Consulting LLC		0		(428,591) 21
22	V	19	Professional Services	132,672	Alyze Healthcare Consulting LLC		631		(132,041) 22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		3		3 23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		0 24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		267,940		267,940 25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		103		103 26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		6,316		6,316 27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		28		28 28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		35,577		35,577 29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		0 30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		231		231 31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		4,487		4,487 32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		598		598 33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 561,263			\$ 465,701	\$ *	(95,562) 39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Evanston	Evanston, IL			Consulting LLC	Skokie, IL	Management Co	2
3	Aliya of Glenwood	Glenwood, 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					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	1.88	4.70	Salary	\$ 10,838	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	1.88	4.70	Salary	10,838	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	\$ 21,676		13

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

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

Facility Name & ID Number Aliya of Highwood # 0058636 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Aliya Healthcare Consulting, LLC
Street Address 8140 N McCormick Blvd, Suite 138
City / State / Zip Code Skokie, IL 60076
Phone Number (224) 536-4204
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Heat and Other Utilities	Available Bed Days	805,555	13	\$ 11,842	\$	37,960	\$ 558	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		37,960	930	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	37,960	50,397	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		37,960	9,592	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		37,960	4,556	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	37,960	11,502	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		37,960	25,124	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		37,960	3,127	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		37,960	6,493	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		37,960	3,767	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		37,960	10,225	11
12	32	Interest	Available Bed Days	805,555	13	362,992		37,960	17,104	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		37,960	7,695	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		37,960	1,574	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,239,292	\$ 1,190,369		\$ 152,644	25

Facility Name & ID Number Aliya of Highwood # 0058636 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Alyze Healthcare Consulting, LLC
Street Address 8140 N McCormick Blvd, Suite 138
City / State / Zip Code Skokie, IL 60076
Phone Number (224) 536-4204
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Licensed Beds	2,201	13	\$ 773,991	\$ 773,991	104	\$ 36,572	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	104	4,620	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		104	5,494	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	104	87,287	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	104	3,682	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		104	12,132	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		104	631	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		104	3	9
10	21	Clerical & General Office	Direct Allocation	1	1	117,150	117,150			10
11	21	Clerical & General Office	Licensed Beds	2,201	13	5,670,551	5,645,701	104	267,940	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		104	103	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		104	6,316	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		104	28	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		104	35,577	15
16	27	Mgmt Allocation of Benefits	Direct Allocation	1	1	82,720				16
17	35	Rent-Equipment & Vehicles	Licensed Beds	2,201	13	4,883		104	231	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	104	4,487	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		104	598	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,558,836	\$ 9,157,901		\$ 465,701	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Monticello AM		X	Mortgage	Varies	12/17/25	\$ 11,180,000	\$ 11,180,000	12/17/27	0.0750	\$ 32,500	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Optimum		X	Working Capital		5/23/24			5/23/25	0.1050	7,775	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 11,180,000	\$ 11,180,000			\$ 40,275	9	
	B. Non-Facility Related*												
10								Amortization of Loan Costs			15,863	10	
11								Offset Interest Income			(2,403)	11	
12								Allocated from Home Office			17,104	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 30,564	14	
15	TOTALS (line 9+line14)						\$ 11,180,000	\$ 11,180,000			\$ 70,839	15	

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	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	\$	156,952	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(143,048)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	339,848	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	196,800	7
Assessed Value from Real Estate Tax Bill: 2024 2,307,552 8					
Real Estate Tax Bill for Calendar Year: 2020 156,986 9					
2021 160,725 10					
2022 173,475 11					
2023 176,237 12					
2024 187,727 13					
Accrual based on prior year tax bill.					
The Taxes Paid Above on Line 2 Consist of 1 Payment out of Escrow of \$156,952 for its Portion of the 2024 Taxes					

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aliya of Highwood COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0058636

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. 16-15-427-002	Long Term Care Property	\$ 187,727.30	\$ 187,727.30
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 187,727.30	\$ 187,727.30

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: 26,802B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 1

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

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization. (X)
(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: 2
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:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Nursing Home		2025	\$ 1,350,000	1
2					2
3	TOTALS			\$ 1,350,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Highwood

0058636

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	104		2025	1961	\$ 8,100,000	\$	25	\$ 27,000	\$ 27,000	\$ 27,000
5										
6										
7										
8										
	Improvement Type**									
9	Install Exterior Sign			2024	3,685		15	246	246	369
10	Remove/replace 15 ft of piping and re-install water meter			2024	8,755		15	584	584	876
11	Replace Water Heater			2024	19,055		15	1,270	1,270	1,905
12	Repair Elevator Panel/Buttons			2024	3,475		15	232	232	348
13	Install New Selector Upgrade for Elevator			2024	8,884		15	592	592	888
14	Dialysis Unit Build Out-Walls, Flooring, Electrical, Plumbing			2025	213,351		15	7,112	7,112	7,112
15	Cabinets and Sinks, Painting, Split AC System									
16	Installed 75 Gallon Water Heater			2025	4,998		15	167	167	167
17	Installed Camera System			2025	2,767		15	92	92	92
18	Replace West and North Fire Department Connections, Couplings and Pip			2025	4,872		15	162	162	162
19	Replace 21' of 2" Pipe, Couplings, Sprinkler Heads-Parking Area			2025	4,172		15	139	139	139
20	Installation of Magnetic Lock at Patio Exit Gate/Door Opener on Patio De			2025	12,012		15	400	400	400
21	Remove Fire Sprinkler Heads and Install Low Point Placards			2025	6,972		15	232	232	232
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35	Financial Statement Depreciation					20,664			(20,664)	
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	2,114		15	141	141	211	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	1,150		15	38	38	38	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)		\$ 8,396,262	\$ 20,664		\$ 38,407	\$ 17,743	\$ 39,939	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	\$42,850	\$17,315	\$4,285	\$(13,030)	10 Yrs	\$6,428	71
72	Current Year Purchases	2,804,411	13,410	27,852	14,442	5-10 Yrs	27,852	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,847,261	\$30,725	\$32,137	\$1,412		\$34,280	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)	\$12,593,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$51,389	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$70,544	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$19,155	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$74,219	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: Highland Park 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:	1961	104	3/1/24	\$871,246			3
4	Additions							4
5								5
6		Allocated from Home Office			7,695			6
7	TOTAL		104		\$878,941			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:
- ☒ X
- 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?
- ☒ X
- YES
- ☐
- NO
16. Rental Amount for movable equipment: \$21,978
- 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	Resident Transport	2024 Ram Promaster Van	\$1,553.98	\$18,943	17
18					18
19	Allocated from Home Office			231	19
20					20
21	TOTAL		\$1,553.98	\$19,174	21

10. Effective dates of current rental agreement:
- Beginning 3/1/24
- Ending 2/28/29

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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 Highwood

IDPH License ID Number:0058636

Fiscal Year End:12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	15,473
Dietary Equipment	557
Office Equipment	4,374
Allocated from Home Office	1,574
Total - Line 16	21,978

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)	\$			

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	\$	4,900	\$ 188,691	\$	4,900	\$ 188,691	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,130	60,550		1,130	60,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,298	254,767		6,298	254,767	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				109,830		109,830	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)	107	4,487				107	4,487	12
13	Other (specify): <u>See Attached Sch 16A</u>	39(3)				74,935			74,935	13
14	TOTAL			\$ 4,487	12,328	\$ 578,943	\$ 109,830	12,435	\$ 693,260	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 Highwood

IDPH License ID Number:

0058636

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	38,626
Radiology	10,195
Dialysis	26,114
Total - Line 16	74,935

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	\$ 41,891	\$ 41,891	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 413,674)	1,452,516	1,452,516	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,542	104,542	6
7	Other Prepaid Expenses	13,521	13,521	7
8	Accounts Receivable (owners or related parties)	5,911,640	5,911,640	8
9	Other(specify): Deposit	35,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,559,110	\$ 7,524,110	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,350,000	13
14	Buildings, at Historical Cost		8,100,000	14
15	Leasehold Improvements, at Historical Cost	312,020	296,262	15
16	Equipment, at Historical Cost	185,114	2,847,261	16
17	Accumulated Depreciation (book methods)	(59,739)	(74,219)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds	245,361	366,039	21
22	Other Long-Term Assets (specify) Loan Costs/Goodwill		1,561,138	22
23	Other(specify): Deposits	100,000	100,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 782,756	\$ 14,546,481	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,341,866	\$ 22,070,591	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 376,963	\$ 376,963	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	807,410	807,410	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	79,862	79,862	31
32	Accrued Real Estate Taxes(Sch.IX-B)	339,848	339,848	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	99,410	32,827	36
37	Due to Related Party	5,210,667	5,210,667	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,914,160	\$ 6,847,577	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,180,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Net Long Term Lease Liability	103,695	103,695	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 103,695	\$ 11,283,695	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,017,855	\$ 18,131,272	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,324,011	\$ 3,939,319	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,341,866	\$ 22,070,591	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 173,506	1
2	Restatements (describe):		2
3	Rent Expense	(103,755)	3
4	Depreciation Expense	(8,351)	4
5	Miscellaneous	60	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 61,460	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,262,551	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)	\$ 1,262,551	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)	\$ 1,324,011	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Highwood

0058636

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	\$ 17,490,715	1
2	Discounts and Allowances for all Levels	(5,127,455)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,363,260	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	197,400	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 197,400	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	267	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	1,463	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)	\$ 1,750	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,403	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,403	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	C.N.A. Initiative/QIP Revenue	390,271	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 390,271	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,955,084	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,589,130	31
32	Health Care	4,353,689	32
33	General Administration	2,854,246	33
	B. Capital Expense		
34	Ownership	1,249,385	34
	C. Ancillary Expense		
35	Special Cost Centers	980,264	35
36	Provider Participation Fee	665,819	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,692,533	40
41	Income before Income Taxes (line 30 minus line 40)**	1,262,551	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,262,551	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,986,938	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,411,171	45
46	MMAI-Medicaid is the Primary Payer	568,808	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,163,251	48
49	Medicare Part A	2,684,213	49
50	Other-(specify) Medicare Replacement	355,657	50
51	Other-(specify) Insurance	193,222	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)	\$ 12,363,260	56

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,620	2,763	\$ 177,064	\$ 64.08	1
2	Assistant Director of Nursing	2,221	2,312	119,706	51.78	2
3	Registered Nurses	18,957	20,384	906,713	44.48	3
4	Licensed Practical Nurses	14,312	14,871	577,802	38.85	4
5	CNAs & Orderlies	60,893	67,047	1,676,196	25.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,800	2,755	76,976	27.94	9
10	Activity Assistants	6,785	7,411	161,481	21.79	10
11	Social Service Workers	3,345	3,761	103,802	27.60	11
12	Dietician	72	80	3,346	41.83	12
13	Food Service Supervisor	1,744	1,805	60,321	33.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,136	17,910	405,933	22.67	15
16	Dishwashers					16
17	Maintenance Workers	3,752	4,176	121,768	29.16	17
18	Housekeepers	10,860	12,126	244,525	20.17	18
19	Laundry	3,253	3,445	64,197	18.63	19
20	Administrator	1,992	2,080	126,488	60.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,779	8,433	204,634	24.27	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	2,024	2,080	53,477	25.71	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	3,444	3,595	140,139	38.98	33
34	TOTAL (lines 1 - 33)	161,989	177,034	\$ 5,224,568 *	\$ 29.51	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	96	57,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	17,261	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	61	4,409	L39,C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,278	L11, C3	44
45	Social Service Consultant	94	6,580	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	269	\$ 87,128		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 Highwood

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	2,164	2,268	103,874	45.80
Admissions Coordinator	976	1,007	27,625	27.43
Staffing Coordinator	304	320	8,640	27.00
TOTAL	3,444	3,595	140,139	

Facility Name & ID Number		Aliya of Highwood		STATE OF ILLINOIS		Page 21		
				# 0058636		Report Period Beginning: 1/1/2025		
						Ending: 12/31/2025		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Strange	Administrator	0	\$ 126,488	Workers' Compensation Insurance	\$ 47,956	IDPH License Fee	\$ 1,658	
				Unemployment Compensation Insurance	24,875	Advertising: Employee Recruitment	25,848	
				FICA Taxes	393,701	Health Care Worker Background Check		
				Employee Health Insurance	174,083	(Indicate # of checks performed 15)	671	
				Employee Meals	4,727	Patient Background Checks 210	2,312	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	18,096	
				401k Expense	34,420	The Joint Commission	7,671	
				Employee Meals/Food/Activities	14,512	Telemedicine Solutions	4,055	
				Uniforms	2,812	Various Licenses & Fees	11,875	
				Other Employee Benefits	14,207	Allocated from Home Office	4,559	
						Less: Public Relations Expense (		
				Allocated from Home Office	25,124	PAC and Lobbying payments	(9,048)	
						All non-allowable advertising (		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 126,488	\$ 736,417		\$ 67,697		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			\$ 628,033				Out-of-State Travel	\$
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			428,591	N/A				
							In-State Travel	
							Seminar Expense	1,305
							Allocated from Home Office	388
							Entertainment Expense (	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL		(agree to Sch. V, line 24, col. 8)		
(Attach a copy of any management service agreement)			\$ 1,056,624	\$		TOTAL		\$ 1,693
C. Professional Services								
Vendor/Payee	Type		Amount					
Alyze Healthcare Consulting	Bookkeeping		\$ 132,672					
Roth & Company	Accounting		15,996					
Templin Healthcare Accounting	Accounting		5,926					
NYX Health, LLC	Accounting		923					
Waystar	Data Processing		3,561					
Point Click Care	Data Processing		46,553					
Paylocity	Payroll Processing		19,804					
Personnel Planners, Inc	Unemployment Consulting		1,056					
Nancy Given	PBJ Preparation		4,150					
See Legal Attachment	Legal Services		11,263					
See Attached Schedule 21A			96,194					
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)			\$ 338,098					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Aliya of Highwood
IDPH License ID Number: 0058636
Fiscal Year End: 12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
AcctZen, LLC	Accounting Services	711
ADDA Infusion	HR Consulting	1,217
Adelpo	Data Processing	1,760
Allegro Data Solutions	Data Processing	882
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,300
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	24,995
Curis Services LLC	Bookkeeping Services	17,500
CTI III, LLC	Business Consultant	667
DiningRD	EHR Integration	850
Direct Supply	Data Processing	1,473
Guided Care	Data Processing	20,936
Inovalon Provider, Inc.	Data Processing	762
Medicaid Done Right LLC	Billing Consultant	1,200
Mega Data Health Systems	Data Processing	5,911
Netsmart Technologies	Data Processing	3,397
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	7,086
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	3,588
Reside Admissions	Data Processing	4,082
Sage Intacct, Inc	Data Processing	2,981
Wellsky	Data Processing	5,832
Prior Year Accrual Reversals		(30,071)
Total		96,194

XX. GENERAL INFORMATION:

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

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	9,048
	9,048 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	9,048
	9,048 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	18,096
	18,096 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	43,928	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.

\$	665,819
----	---------

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.

\$	4,727	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.