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: 0057893

Facility Name: Aliya of Oak Lawn

Address: 6300 W 95th Street (Number) Oak Lawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: (708) 559-8800 **Fax #** (708) 559-8820

HFS ID Number:

Date of Initial License for Current Owners: 2/1/23

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,080	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	192	TOTALS	192	70,080	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF						6,589	4,826	11,415	8
9	SNF/PED									9
10	ICF	11,480	24,144	5,287		611			41,522	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	11,480	24,144	5,287		611	6,589	4,826	52,937	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 75.54%

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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/23

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/23 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 192

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/25 Fiscal Year: 12/31/25

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	521,798	30,208	6,037	558,043		558,043	72,231	630,274			1
2	Food Purchase		385,636		385,636		385,636		385,636			2
3	Housekeeping	386,565	43,501		430,066		430,066		430,066			3
4	Laundry	136,885	38,455	3,230	178,570		178,570		178,570			4
5	Heat and Other Utilities			296,012	296,012		296,012	1,030	297,042			5
6	Maintenance	181,529	38,902	150,006	370,437		370,437	25,101	395,538			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			36,780	36,780		36,780	10,141	46,921			7
8	TOTAL General Services	1,226,777	536,702	492,065	2,255,544		2,255,544	108,503	2,364,047			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	6,203,454	386,326	29,116	6,618,896		6,618,896	171,364	6,790,260			10
10a	Therapy											10a
11	Activities	147,651	18,794	1,733	168,178		168,178		168,178			11
12	Social Services	223,733		3,973	227,706		227,706	6,797	234,503			12
13	CNA Training											13
14	Program Transportation			48,808	48,808		48,808		48,808			14
15	Other (specify):* Mgmt Alloc of Benefits							22,398	22,398			15
16	TOTAL Health Care and Programs	6,574,838	405,120	86,130	7,066,088		7,066,088	200,559	7,266,647			16
	C. General Administration											
17	Administrative	148,028		1,860,078	2,008,106		2,008,106	(1,776,292)	231,814			17
18	Directors Fees											18
19	Professional Services			538,208	538,208		538,208	(173,863)	364,345			19
20	Dues, Fees, Subscriptions & Promotions			90,679	90,679		90,679	(8,287)	82,392			20
21	Clerical & General Office Expenses	458,883	23,840	106,604	589,327		589,327	523,988	1,113,315			21
22	Employee Benefits & Payroll Taxes			1,530,886	1,530,886		1,530,886	46,383	1,577,269			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			4,971	4,971		4,971	713	5,684			24
25	Other Admin. Staff Transportation			10,182	10,182		10,182	18,143	28,325			25
26	Insurance-Prop.Liab.Malpractice			852,696	852,696		852,696	7,006	859,702			26
27	Other (specify):* Mgmt Alloc of Benefits							84,560	84,560			27
28	TOTAL General Administration	606,911	23,840	4,996,745	5,627,496		5,627,496	(1,277,649)	4,349,847			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,408,526	965,662	5,574,940	14,949,128		14,949,128	(968,587)	13,980,541			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.

Facility Name & ID Number Aliya of Oak Lawn #0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			66,637	66,637		66,637	(21,218)	45,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			138,925	138,925		138,925	14,745	153,670			32
33	Real Estate Taxes			981,570	981,570		981,570		981,570			33
34	Rent-Facility & Grounds			1,332,648	1,332,648		1,332,648	14,205	1,346,853			34
35	Rent-Equipment & Vehicles			50,243	50,243		50,243	3,332	53,575			35
36	Other (specify):* Loan Fees			2,027	2,027		2,027		2,027			36
37	**TOTAL Ownership**			2,572,050	2,572,050		2,572,050	11,064	2,583,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		367,635	1,363,623	1,731,258		1,731,258	9,388	1,740,646			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			894,789	894,789		894,789		894,789			42
43	Other (specify):* Disallowed Costs	58,145	27,260	615,096	700,501		700,501	(700,501)				43
44	**TOTAL Special Cost Centers**	58,145	394,895	2,873,508	3,326,548		3,326,548	(691,113)	2,635,435			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,466,671	1,360,557	11,020,498	20,847,726		20,847,726	(1,648,636)	19,199,090			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

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	(10,875)	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	(21,218)	30		9
10	Interest and Other Investment Income	(16,834)	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	(35,747)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,736)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(549,670)	43		24
25	Fund Raising, Advertising and Promotional	(27,260)	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	(75,779)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (741,119)		$	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)	(907,517)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (907,517)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,648,636)		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

Aliya of Oak Lawn

ID# 0057893

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (16,704)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable Amount	(9,254)	17	4
5	Expense Minor Fixed Assets Below $2,500	4,713	1	5
6	Expense Minor Fixed Assets Below $2,500	14,855	6	6
7	Expense Minor Fixed Assets Below $2,500	10,219	10	7
8	Expense Minor Fixed Assets Below $2,500	8,137	21	8
9	Marketing Director Wages	(58,145)	43	9
10	Collection Agency Fees	(18,804)	43	10
11	Offset Miscellaneous Income Against Expense	(44)	21	11
12	Out of State Travel (Allocated from Home Office)	(5,248)	24	12
13	Out of State Seminar (Allocated from Home Office)	(5,504)	25	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(75,779)		49

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Aliya Healthcare Consulting LLC		$ 1,030	$ 1,030	1
2	V	6	Maintenance		Aliya Healthcare Consulting LLC		1,716	1,716	2
3	V	17	Administrative	1,068,834	Aliya Healthcare Consulting LLC		93,040	(975,794)	3
4	V	19	Professional Services		Aliya Healthcare Consulting LLC		17,708	17,708	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		8,411	8,411	5
6	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		21,235	21,235	6
7	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		46,383	46,383	7
8	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		5,771	5,771	8
9	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		11,987	11,987	9
10	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		6,954	6,954	10
11	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		18,879	18,879	11
12	V	32	Interest		Aliya Healthcare Consulting LLC		31,579	31,579	12
13	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		14,205	14,205	13
14	Total			$ 1,068,834			$ 278,898	$ * (789,936)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent-Equipment & Vehicles	$	Aliya Healthcare Consulting LLC		$ 2,906	$ 2,906	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			$			$ 2,906	$ * 2,906	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Alyze Healthcare Consulting LLC		$ 67,518	$ 67,518	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		8,530	8,530	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		10,141	10,141	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		161,145	161,145	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		6,797	6,797	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		22,398	22,398	20
21	V	17	Administrative	791,244	Alyze Healthcare Consulting LLC		0	(791,244)	21
22	V	19	Professional Services	189,000	Alyze Healthcare Consulting LLC		1,165	(187,835)	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		494,660	494,660	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		190	190	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		11,660	11,660	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		52	52	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		65,681	65,681	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		426	426	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		8,283	8,283	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,105	1,105	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 980,244			$ 859,757	$ * (120,487)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS **Ownership Listing-1**

Aliya of Oak Lawn

ID# **0057893**

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)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Dvorah	S	Weinfeld	Chicago	IL	51.00000		75.50000	1
2	Avrum	P	Weinfeld	Chicago	IL	15.00000			2
3	Moshe	M	Erlich	Lincolnwood	IL	15.00000		15.00000	3
4	Jordan	E	Reifer	Lincolnwood	IL	10.00000		5.00000	4
5	Rebecca	R	Kohn	Lincolnwood	IL	4.95000		2.49975	5
6	Henry	NG	Kohn	Lincolnwood	IL	0.01250		0.00063	6
7	Oliver	NG	Kohn	Lincolnwood	IL	0.01250		0.00063	7
8	Lillian	NG	Kohn	Lincolnwood	IL	0.01250		0.00063	8
9	George	NG	Kohn	Lincolnwood	IL	0.01250		0.00063	9
10	Nesanel	B	Davis	Chicago	IL	2.00000		1.00000	10
11	Sam	NG	Wasserman	Chicago	IL	2.00000		1.00000	11
12									12
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47									47
48									48
49									49
50									50
51									51
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70									70
71									71
72									72
73									73
74									74
75									75

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	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 Highwood	Highwood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	4
5	Aliya of Homewood	Homewood, 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

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Efriam Weinfeld	COO	Administrative	0.00	See Att Sch P7A	3.48	8.70	Salary	$ 20,009	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	3.48	8.70	Salary	20,009	L17,C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 40,018		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 Oak Lawn # 0057893 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Available Bed Days	805,555	13	$ 11,842	$	70,080	$ 1,030	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		70,080	1,716	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	70,080	93,040	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		70,080	17,708	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		70,080	8,411	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	70,080	21,235	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		70,080	46,383	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		70,080	5,771	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		70,080	11,987	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		70,080	6,954	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		70,080	18,879	11
12	32	Interest	Available Bed Days	805,555	13	362,992		70,080	31,579	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		70,080	14,205	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		70,080	2,906	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		$ 281,804	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Licensed Beds	2,201	13	$ 773,991	$ 773,991	192	$ 67,518	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	192	8,530	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		192	10,141	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	192	161,145	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	192	6,797	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		192	22,398	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		192	1,165	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		192	6	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	192	494,660	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		192	190	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		192	11,660	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		192	52	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		192	65,681	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		192	426	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	192	8,283	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		192	1,105	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,558,836	$ 9,157,901		$ 859,757	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	eCapital		X	Working Capital							126,092	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 126,092	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			12,833	10
11								Offset Interest Income			(16,834)	11
12								Allocated from Home Office			31,579	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 27,578	14
15	TOTALS (line 9+line14)						$	$			$ 153,670	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.)

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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.**		$ 422,499	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	$ 1,265,273	2
3. Under or (over) accrual (line 2 minus line 1).		$ 842,774	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 138,796	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.		$ 981,570	7

Assessed Value from Real Estate Tax Bill:	2024	4,265,655	8
Real Estate Tax Bill for Calendar Year:	2020	809,305	9
	2021	890,235	10
	2022	710,127	11
	2023	1,026,261	12
	2024	1,265,273	13

Accrual based on prior year tax bill.

	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 Oak Lawn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0057893

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-005-0000	Long Term Care Property	$ 1,265,272.69	$ 1,265,272.69
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,265,272.69	$ 1,265,272.69

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 provide copies of their original **second installment** tax bill.

Facility Name & ID Numb Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,339 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install Low Voltage Data Lines and 10 20 amp Receptacles-Dialysis Room			2023	16,449		15	1,097	1,097	2,742	9
10	Replaced Flooring-Main Areas, Hallways, Offices			2023	99,735		15	6,649	6,649	16,623	10
11	Repair Backflow Preventer			2023	3,060		15	204	204	510	11
12	Replaced Pressure Relief Valve-Sprinkler			2023	3,910		15	261	261	652	12
13	Replaced Hot Water Pipe-Storage Tanks to Hallway			2023	2,690		15	179	179	448	13
14	HVAC Repair-Replaced Combustion Damper Actuato			2023	3,365		15	224	224	560	14
15	Repair circulating pump			2024	5,855		15	390	390	585	15
16	Installed New Kitchen Floor Drain with a New P-Trap			2024	2,573		15	172	172	258	16
17	Relocate cabling/electric in 16 Resident Rooms			2024	7,413		15	494	494	741	17
18	Install New Storage Tank			2024	6,230		15	415	415	623	18
19	Replace Leaking Sprinkler Valve and Pendants-near Bistro, East of Hallw			2024	3,742		15	249	249	374	19
20	Excavate and install 36" storm sewer basin			2024	6,500		15	433	433	650	20
21	Repair concrete-courtyard			2024	6,000		15	400	400	600	21
22	Replaced York 5 Ton AC Unit			2024	14,655		15	977	977	1,466	22
23	Replaced check assembly on backflow			2024	3,860		15	257	257	386	23
24	Replaced 9 smoke detectors throughout building			2024	3,941		15	263	263	394	24
25	Removed ejector pit clog			2024	2,859		15	191	191	286	25
26	Removed clog from sewer line 60 ft			2024	6,161		15	411	411	616	26
27	Replaced garbage disposal/repaired outlet			2024	3,900		15	260	260	390	27
28	Relocate thermostat out of Ice Machine room			2024	3,607		15	240	240	360	28
29	Installed 2 Condensors-Office			2024	7,426		15	495	495	743	29
30	Replace wiring in 2 bathrooms-hand dryer			2025	2,849		15	95	95	95	30
31	Replace Motor for Kitchen Exhaust			2025	2,585		15	86	86	86	31
32	Replace Call Light System, Install New Call Lights in Rms 100-114			2025	44,428		15	1,481	1,481	1,481	32
33	Replaced hot surface ignitor,other parts-boiler room in the basemen			2025	3,808		15	127	127	127	33
34	Install Camera System			2025	19,523		15	651	651	651	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 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 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	Replace Gas Valve,Control Board, Repaired Leaking Pump-Hot W	2025	5,431	$	15	$ 181	$ 181	$ 181	37
38	Replace Door	2025	4,510		15	150	150	150	38
39	Replace Kitchen/Laundry Water Heater	2025	19,400		15	647	647	647	39
40	Pave Parking Lot	2025	88,870		15	2,962	2,962	2,962	40
41	Rebuild Backflow Preventer	2025	5,650		15	188	188	188	41
42	Replace Starter on Generator	2025	2,992		15	100	100	100	42
43	Replace Circulating Pump-Domestic Water Boiler	2025	3,565		15	119	119	119	43
44	Remodel of New Office (i.e. Family Meeting Room) next to Recept	2025	105,062		15	3,502	3,502	3,502	44
45	Framing, Drywall, Paint, Doors, Light Fixtures, Countertops								45
46	Replace Circulating Pump-Domestic Water Boiler	2025	2,951		15	98	98	98	46
47	Install Lockable/Emergency Shut Off Switches on 3 Boilers	2025	4,998		15	167	167	167	47
48	Repair 12 Feet of Leaking Galvanized Hot Water Pipe in Ceiling.	2025	7,352		15	245	245	245	48
49	Rework the Existing Sprinkler Piping,Heads in the 1st Floor Show	2025	10,620		15	354	354	354	49
50	Windows Treatments-Resident Rooms	2025	4,034		15	134	134	134	50
51	Replace Heat Pump-PTAC	2025	4,010		15	134	134	134	51
52	Replace Domestic Hot Water Tank-Basement Mechanical Rm	2025	34,220		15	1,141	1,141	1,141	52
53	Replace Existing Failed Shower Exhaust Fan	2025	3,894		15	130	130	130	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65	Financial Statement Depreciation			23,996			(23,996)		65
66									66
67	Allocated from Aliya Healthcare Consulting LLC	2024	3,904		15	260	260	390	67
68	Allocated from Aliya Healthcare Consulting LLC	2025	2,124		15	71	71	71	68
69									69
70	TOTAL (lines 4 thru 69)		$ 600,711	$ 23,996		$ 27,284	$ 3,288	$ 43,160	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	$ 114,963	$ 35,436	$ 11,496	$ (23,940)	10 Yrs	$ 22,570	71
72	Current Year Purchases	128,918	7,205	6,639	(566)	5-10 Yrs	6,639	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 243,881	$ 42,641	$ 18,135	$ (24,506)		$ 29,209	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)	$ 844,592	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,637	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,419	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (21,218)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 72,369	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.

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CCG Illinois Holdings 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. [X] 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:	1962	98	1/1/23	$ 1,332,648	20	None	3
4	Additions	1969	75					4
5		1987-9 & 1999-10	19					5
6		Allocated from Home Office			14,205			6
7	TOTAL		192		$ 1,346,853 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: Varies *

10. Effective dates of current rental agreement:
Beginning 1/1/23
Ending 12/31/42

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2026	$ 1,481,500
13.	12/31/2027	$ 1,522,241
14.	12/31/2028	$ 1,564,103

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: $ 19,851 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	2023 Ford Star Transport	$ 1,799.00	$ 21,588	17
18	Maintenance	2022 Ford F150	975.82	11,710	18
19	Allocated from Home Office			426	19
20					20
21	TOTAL		$ 2,774.82	$ 33,724	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Aliya of Oak Lawn**
IDPH License ID Number: **0057893**
Fiscal Year End: **12/31/2025**

Schedule 14A

XII. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	12,124
Office Equipment	4,821
Allocated from Home Office	2,906
Total - Line 16	**19,851**

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	18,940	$ 435,783	$	18,940	$ 435,783	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,919	74,071		1,919	74,071	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		21,462	574,198	589	21,462	574,787	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				367,046		367,046	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(7)	198	8,283				198	8,283	12
13	Other (specify): See Attached Sch\ 16A	39(3)				272,979			272,979	13
14	TOTAL			$ 8,283	42,321	$ 1,357,031	$ 367,635	42,519	$ 1,732,949	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 Oak Lawn**
IDPH License ID Number: **0057893**
Fiscal Year End: **12/31/2025**

Schedule 16A

XIV. Special Services
Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	75,001
Radiology	13,773
Dialysis	184,205
Total - Line 16	**272,979**

STATE OF ILLINOIS

Facility Name & ID Number Aliya of Oak Lawn # 0057893 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	$ (319,306)	$ (319,306)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 989,378)	4,438,503	4,438,503	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,992	30,992	6
7	Other Prepaid Expenses	159,102	159,102	7
8	Accounts Receivable (owners or related parties)	26,051,066	26,051,066	8
9	Other(specify): Deposit	35,000	35,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 30,395,357	$ 30,395,357	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	569,748	600,711	15
16	Equipment, at Historical Cost	404,041	243,881	16
17	Accumulated Depreciation (book methods)	(118,163)	(72,369)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	365,558	365,558	21
22	Other Long-Term Assets (spe Loan Costs	18,680	18,680	22
23	Other(specify): Deposits	1,066,279	1,066,279	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,306,143	$ 2,222,740	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 32,701,500	$ 32,618,097	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,060,838	$ 1,060,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	342,899	342,899	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,806	28,806	31
32	Accrued Real Estate Taxes(Sch.IX-B)	138,796	138,796	32
33	Accrued Interest Payable	5,847	5,847	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	1,020,525	1,020,525	36
37	Due to Related Party	25,581,047	25,581,047	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 28,178,758	$ 28,178,758	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	Net LT Lease Liability	1,865,731	1,865,731	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,865,731	$ 1,865,731	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 30,044,489	$ 30,044,489	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,657,011	$ 2,573,608	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 32,701,500	$ 32,618,097	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (262,866)	1
2	Restatements (describe):		2
3	Rent Expense	(678,464)	3
4	Depreciation Expense	(40,632)	4
5	Miscellaneous	(1,390)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (983,352)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,049,422	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) Contributed Capital	2,590,941	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,640,363	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,657,011	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 37,128,834	1
2	Discounts and Allowances for all Levels	(16,065,380)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,063,454	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	324,562	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 324,562	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	180	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	844	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	313	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)**	$ 1,337	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,834	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,834	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income/Med Records Income**	15	28
28a	**C.N.A. Initiative/QIP Revenue**	490,946	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 490,961	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 21,897,148	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,255,544	31
32	Health Care	7,066,088	32
33	General Administration	5,627,496	33
	B. Capital Expense		
34	Ownership	2,572,050	34
	C. Ancillary Expense		
35	Special Cost Centers	2,431,759	35
36	Provider Participation Fee	894,789	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,847,726	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,049,422	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,049,422	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 3,461,493	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,279,991	45
46	MMAI-Medicaid is the Primary Payer	1,594,156	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	307,075	48
49	Medicare Part A	5,195,331	49
50	Other-(specify) **Medicare Replacement**	2,786,868	50
51	Other-(specify) **Insurance**	438,540	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)	$ 21,063,454	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,759	1,807	$ 116,193	$ 64.30	1
2	Assistant Director of Nursing	2,016	2,104	126,762	60.25	2
3	Registered Nurses	36,449	39,377	1,785,917	45.35	3
4	Licensed Practical Nurses	25,217	26,042	1,048,072	40.25	4
5	CNAs & Orderlies	96,423	102,869	2,541,766	24.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,864	1,981	55,233	27.88	9
10	Activity Assistants	4,054	4,338	92,418	21.30	10
11	Social Service Workers	5,032	5,570	204,918	36.79	11
12	Dietician	72	80	3,269	40.86	12
13	Food Service Supervisor	2,085	2,141	69,220	32.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,302	19,989	449,309	22.48	15
16	Dishwashers					16
17	Maintenance Workers	5,906	6,279	181,529	28.91	17
18	Housekeepers	17,536	19,079	386,565	20.26	18
19	Laundry	6,502	6,919	136,885	19.78	19
20	Administrator	1,816	1,879	148,028	78.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,844	11,584	374,363	32.32	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	3,665	4,197	103,340	24.62	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	15,841	16,851	642,884	38.15	33
34	TOTAL (lines 1 - 33)	255,383	273,086	$ 8,466,671 *	$ 31.00	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	2,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	24,336	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	91	6,592	L39, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,733	L11, C3	44
45	Social Service Consultant	57	3,973	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	$ 39,134		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2	103	L10, C3	51
52	Certified Nurse Assistants/Aides	18	453	L10, C3	52
53	TOTAL (lines 50 - 52)	20	$ 556		53

SEE ACCOUNTANTS' PREPARATION REPORT

Aliya of Oak Lawn

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	3,304	3,512	171,930	48.96
Admissions Coordinator	2,064	2,208	84,520	38.28
Infection Preventist	2,111	2,207	94,059	42.62
Resident Assessment Coordinator	1,658	1,930	91,851	47.59
Central Supply	1,870	1,972	49,103	24.90
Transportation	894	902	18,815	20.86
Staffing Coordinator	2,024	2,080	64,804	31.16
Transitional Care Liaison	144	160	9,657	60.36
Customer Experience Director	1,772	1,880	58,145	30.93
TOTAL	15,841	16,851	642,884	

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Landra Cupil Jones	Administrator	0	$ 53,154
Priscilla Osei	Administrator	0	94,874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,028

B. Administrative - Other

Description	Amount
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7	$ 1,068,834
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7	791,244
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,860,078
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alyze Healthcare Consulting	Bookkeeping	$ 189,000
Templin Healthcare Accounting	Accounting	5,926
Roth & Company	Accounting	23,542
NYX Health, LLC	Accounting	923
The Wright Group Consulting	Financial Consulting	11,500
Waystar	Data Processing	3,861
Point Click Care	Data Processing	89,795
Paylocity	Payroll Processing	35,074
Personnel Planners, Inc	Unemployment Consulting	2,100
Nancy Given	PBJ Preparation	4,800
See Legal Attachment	Legal Services	33,656
See Attached Schedule 21A		138,031
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 538,208

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 337,284
Unemployment Compensation Insurance	131,259
FICA Taxes	639,658
Employee Health Insurance	284,302
Employee Meals	6,818
Illinois Municipal Retirement Fund (IMRF)*	
Pension/401k Expense	71,791
Employee Meals/Food/Activities	31,877
Uniforms	9,510
Other Employee Benefits	18,387
Allocated from Home Office	46,383
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,577,269

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,628
Advertising: Employee Recruitment	29,133
Health Care Worker Background Check	
(Indicate # of checks performed 42)	2,140
Patient Background Checks 883	9,714
Association Dues (total from pg 22, #4)	33,408
Telemedicine Solutions	4,055
The Joint Commission	2,920
Various Dues & Subscriptions, Licenses	7,681
Allocated from Home Office	8,417
Less: Public Relations Expense	( )
PAC and Lobbying payments	(16,704)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,392

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	187
Seminar Expense	4,784
Allocated from Home Office	713
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,684

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Aliya of Oak Lawn**
IDPH License ID Number: **0057893**
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	531
Adelpo	Data Processing	1,920
Allegro Data Solutions	Data Processing	2,867
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,600
Certisurv LLC	State Survey Consulting	1,975
Compliagent	Data Processing	171
Complihealth Corp	Data Processing	5,272
Creative Technology Solutions, LLC	Data Processing	36,262
CTI III, LLC	Business Consultant	668
DiningRD	EHR Integration	850
Direct Supply	Data Processing	1,600
Guided Care	Data Processing	750
Inovalon Provider, Inc.	Data Processing	762
MedaSync Inc.	Data Processing	1,500
Medicaid Done Right LLC	Billing Consultant	2,250
Mega Data Health Systems	Data Processing	6,361
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	109
Onyx Procurement Solutions	Procurement Services	8,800
Pax8	Data Processing	10,774
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	5,988
Real Estate Valuation Group LLC	Appraisal	4,500
Reside Admissions	Data Processing	4,448
Sage Intacct, Inc	Data Processing	2,981
Stout Risius Ross, LLC	Appraisal	6,289
Third Eye Health Inc.	Data Processing	9,000
Wellsky	Data Processing	6,142
Total		**138,031**

Facility Name & ID Number Aliya of Oak Lawn # 0057893 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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)	16,704
	16,704 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)	16,704
	16,704 Total

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

HEALTH CARE COUNCIL OF IL (HCCI)	33,408
	33,408 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 58,715 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. $ 894,789
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. $ 6,818 Has any meal income been offset against related costs? No Indicate the amount. $ N/A

(12) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14

d. Have vehicle usage logs been maintained? Yes

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

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

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(14) Have all costs which do not relate to the provision of long term care been adjusted out 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.