

		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: 3000237

Facility Name: Aliya of Palatine

Address: 24 S Plum Grove Road Palatine 60067

County: Cook

Telephone Number: (847)358-0311 Fax #: (847)358-8875

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

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

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Palatine # 3000237 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>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</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>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						2,625	407	3,032	8
9	SNF/PED									9
10	ICF	5,306	11,389	1,888		1,599			20,182	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,306	11,389	1,888		1,599	2,625	407	23,214	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.17%

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 11/1/24

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 69

Medicare Intermediary National Government Services

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	296,129	16,431	6,304	318,864		318,864	25,976	344,840			1
2	Food Purchase		179,074		179,074		179,074		179,074			2
3	Housekeeping	185,852	19,022		204,874		204,874		204,874			3
4	Laundry	49,997	17,151	86,854	154,002		154,002		154,002			4
5	Heat and Other Utilities			63,375	63,375		63,375	370	63,745			5
6	Maintenance	61,537	20,576	86,845	168,958		168,958	22,043	191,001			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			16,873	16,873		16,873	3,645	20,518			7
8	TOTAL General Services	593,515	252,254	260,251	1,106,020		1,106,020	52,034	1,158,054			8
	B. Health Care and Programs											
9	Medical Director			14,594	14,594		14,594		14,594			9
10	Nursing and Medical Records	2,285,407	154,945	21,529	2,461,881		2,461,881	60,109	2,521,990			10
10a	Therapy											10a
11	Activities	124,964	4,378		129,342		129,342		129,342			11
12	Social Services	66,560		680	67,240		67,240	2,443	69,683			12
13	CNA Training											13
14	Program Transportation			10,770	10,770		10,770		10,770			14
15	Other (specify):* Mgmt Alloc of Benefits							8,049	8,049			15
16	TOTAL Health Care and Programs	2,476,931	159,323	47,573	2,683,827		2,683,827	70,601	2,754,428			16
	C. General Administration											
17	Administrative	125,346		716,387	841,733		841,733	(686,276)	155,457			17
18	Directors Fees											18
19	Professional Services			281,048	281,048		281,048	(115,910)	165,138			19
20	Dues, Fees, Subscriptions & Promotions			50,524	50,524		50,524	(2,651)	47,873			20
21	Clerical & General Office Expenses	63,376	4,757	31,334	99,467		99,467	190,337	289,804			21
22	Employee Benefits & Payroll Taxes			456,042	456,042		456,042	16,669	472,711			22
23	Inservice Training & Education											23
24	Travel and Seminar			869	869		869	256	1,125			24
25	Other Admin. Staff Transportation			1,693	1,693		1,693	6,519	8,212			25
26	Insurance-Prop.Liab.Malpractice			177,947	177,947		177,947	2,518	180,465			26
27	Other (specify):* Mgmt Alloc of Benefits							30,389	30,389			27
28	TOTAL General Administration	188,722	4,757	1,715,844	1,909,323		1,909,323	(558,149)	1,351,174			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,259,168	416,334	2,023,668	5,699,170		5,699,170	(435,514)	5,263,656			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,646	15,646		15,646	(5,196)	10,450			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,350	61,350		61,350	5,740	67,090			32
33	Real Estate Taxes			545,725	545,725		545,725		545,725			33
34	Rent-Facility & Grounds			552,746	552,746		552,746	5,105	557,851			34
35	Rent-Equipment & Vehicles			6,906	6,906		6,906	1,197	8,103			35
36	Other (specify):* Loan Fees			9,787	9,787		9,787		9,787			36
37	TOTAL Ownership			1,192,160	1,192,160		1,192,160	6,846	1,199,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,946	440,229	504,175		504,175	3,374	507,549			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			416,708	416,708		416,708		416,708			42
43	Other (specify):* Disallowed Costs		13,037	183,642	196,679		196,679	(196,679)				43
44	TOTAL Special Cost Centers		76,983	1,040,579	1,117,562		1,117,562	(193,305)	924,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,259,168	493,317	4,256,407	8,008,892		8,008,892	(621,973)	7,386,919			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	(10,528)	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	(5,196)	30		9
10	Interest and Other Investment Income	(5,609)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(172,814)	43		24
25	Fund Raising, Advertising and Promotional	(13,337)	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	14,343			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (193,141)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(428,832)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (428,832)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (621,973)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (5,676)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable	(3,325)	17	4
5	Expense Minor Fixed Assets below \$2,500	1,712	1	5
6	Expense Minor Fixed Assets below \$2,500	18,361	6	6
7	Expense Minor Fixed Assets below \$2,500	2,197	10	7
8	Expense Minor Fixed Assets below \$2,500	5,066	21	8
9	Offset Vendor Rebates	(128)	21	9
10	Out of State Travel (Allocated from Home Office)	(1,886)	24	10
11	Out of State Seminar (Allocated from Home Office)	(1,978)	25	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	14,343		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Ownership Listing-1		See Page 6 Supplemental		See Page 6 Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$	Aliya Healthcare Consulting LLC		\$ 370	\$ 370	1
2	V	6	Maintenance		Aliya Healthcare Consulting LLC		617	617	2
3	V	17	Administrative	432,034	Aliya Healthcare Consulting LLC		33,436	(398,598)	3
4	V	19	Professional Services		Aliya Healthcare Consulting LLC		6,364	6,364	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		3,023	3,023	5
6	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		7,631	7,631	6
7	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		16,669	16,669	7
8	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		2,074	2,074	8
9	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		4,307	4,307	9
10	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		2,499	2,499	10
11	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		6,785	6,785	11
12	V	32	Interest		Aliya Healthcare Consulting LLC		11,349	11,349	12
13	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		5,105	5,105	13
14	Total			\$ 432,034			\$ 100,229	\$ * (331,805)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent-Equipment & Vehicles	\$	Aliya Healthcare Consulting LLC		\$ 1,044	\$ 1,044	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			\$			\$ 1,044	\$ * 1,044	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		\$ 24,264	\$ 24,264	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		3,065	3,065	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		3,645	3,645	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		57,912	57,912	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		2,443	2,443	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		8,049	8,049	20
21	V	17	Administrative	284,353	Alyze Healthcare Consulting LLC		0	(284,353)	21
22	V	19	Professional Services	122,693	Alyze Healthcare Consulting LLC		419	(122,274)	22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		2	2	23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		177,768	177,768	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		68	68	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		4,190	4,190	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		19	19	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		23,604	23,604	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		153	153	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		2,977	2,977	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		397	397	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 407,046			\$ 308,975	\$ * (98,071)	39

STATE OF ILLINOIS					Ownership Listing-1			
Aliya of Palatine								
ID#		3000237						
Report Period Beginning:		1/1/2025						
Ending:		12/31/2025			N/A			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management			
-Owners of companies must be listed instead of company names.					Co./Home Office			
-Names of trust beneficiaries must be listed.								
		Place of Residence		Operator/Licensee	Building Co.	Ownership		
First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage	
1	Dvorah	S	Weinfeld	Chicago	IL	41.31000		78.89750
2	Avrum	P	Weinfeld	Chicago	IL	12.15000		
3	Moshe	M	Erlich	Lincolnwood	IL	12.15000		15.67500
4	Jordan	E	Reifer	Lincolnwood	IL	8.10000		5.22500
5	Rebecca	R	Kohn	Lincolnwood	IL	4.05000		0.11138
6	Nesanel	B	Davis	Chicago	IL	1.62000		0.04500
7	Sam	NG	Wasserman	Chicago	IL	1.62000		0.04500
8	Eli	NG	Webster	Chicago	IL	2.99970		
9	Marshall	NG	Meyers	Chicago	IL	2.99970		
10	Shai	Y	Berdugo	Lincolnwood	IL	2.49980		
11	Aaron	NG	Kraft	Lincolnwood	IL	2.99970		
12	Avi	NG	Schechter	Surfside	FL	4.99950		
13	Ephraim	NG	Cohen	Lincolnwood	IL	2.49980		
14								
15								
16	Remaining Owners of Aliya Healthcare Consulting LLC							
17	Henry	NG	Kohn	Lincolnwood	IL			0.00063
18	Oliver	NG	Kohn	Lincolnwood	IL			0.00063
19	Lillian	NG	Kohn	Lincolnwood	IL			0.00063
20	George	NG	Kohn	Lincolnwood	IL			0.00063
21								
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VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Aliya of Evanston	Evanston, IL			Aliya Healthcare			1
2	Aliya of Glenwood	Glenwood, IL			Consulting LLC	Skokie, IL	Management Co	2
3	Aliya of Highwood	Highwood, IL			Alyze Healthcare			3
4	Aliya of Homewood	Homewood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	4
5	Aliya of Oak Lawn	Oak Lawn, IL			Aliya of Palos Park			5
6	Aliya of Crestwood	Crestwood, IL			ILF LLC	Palos Park, IL	Independent Living	6
7	Aliya of Palos Park	Palos Park, IL			Wrightwood 87th			7
8	Aliya on 87th	Chicago, IL			SNF Property LLC	Skokie, IL	Lessor	8
9	Ryze at Homewood	Homewood, IL			Avenue SNF			9
10	Ryze at the Ridge	Chicago, IL			Property LLC	Skokie, IL	Lessor	10
11	Ryze on the Avenue	Chicago, IL			West SNF			11
12	Ryze West	Chicago, IL			Property LLC	Skokie, IL	Lessor	12
13					Evanston SNF			13
14					Property LLC	Skokie, IL	Lessor	14
15					Highwood SNF			15
16					Property LLC	Skokie, IL	Lessor	16
17					Ridge SNF			17
18					Property LLC	Skokie, IL	Lessor	18
19					Palos SNF			19
20					Property LLC	Skokie, IL	Lessor	20
21					Illuminate Hospice LL	Oakbrook Terrace, IL	Hospice	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Efriam Weinfeld	COO	Administrative	0.00	See Att Sch P7A	1.25	3.13	Salary	\$ 7,191	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	1.25	3.13	Salary	7,191	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	\$ 14,382		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 Palatine # 3000237 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	\$	25,185	\$ 370	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		25,185	617	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	25,185	33,436	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		25,185	6,364	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		25,185	3,023	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	25,185	7,631	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		25,185	16,669	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		25,185	2,074	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		25,185	4,307	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		25,185	2,499	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		25,185	6,785	11
12	32	Interest	Available Bed Days	805,555	13	362,992		25,185	11,349	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		25,185	5,105	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		25,185	1,044	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		\$ 101,273	25

Facility Name & ID Number Aliya of Palatine # 3000237 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		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	1	Dietary	Licensed Beds	2,201	13	\$ 773,991	\$ 773,991	69	\$ 24,264	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	69	3,065	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		69	3,645	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	69	57,912	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	69	2,443	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		69	8,049	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		69	419	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		69	2	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	69	177,768	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		69	68	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		69	4,190	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		69	19	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		69	23,604	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		69	153	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	69	2,977	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		69	397	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,558,836	\$ 9,157,901		\$ 308,975	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Optimum		X	Working Capital		11/30/25	1,000,000		11/30/28	variable	22,621		6
7													7
8													8
9	TOTAL Facility Related						\$ 1,000,000	\$			\$ 22,621		9
	B. Non-Facility Related*												
10								Amortization of Loan Costs			38,729		10
11								Offset Interest Income			(5,609)		11
12								Allocated from Home Office			11,349		12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ 44,469		14
15	TOTALS (line 9+line14)						\$ 1,000,000	\$			\$ 67,090		15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	84,000	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		\$	64,231	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(19,769)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	565,494	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$		6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	545,725	7
Assessed Value from Real Estate Tax Bill:	2024	1,236,370	8			
Real Estate Tax Bill for Calendar Year:	2020	400,794	9			
	2021	431,392	10			
	2022	494,390	11			
	2023	392,259	12			
	2024	385,387	13			
Accrual based on prior year tax bill.						
Aliya of Palatine Paid \$64,231 for its Portion of the 2024 Taxes						

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

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aliya of Palatine COUNTY Cook

FACILITY IDPH LICENSE NUMBER 3000237

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. 02-22-205-006-0000	Long Term Care Property	\$ 7,480.97	\$ 7,480.97
2. 02-22-205-007-0000	Long Term Care Property	\$ 377,906.27	\$ 377,906.27
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 385,387.24	\$ 385,387.24

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: 23,500B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 2

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

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

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

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Install Door Closure and Magnetic Door Holder/Circuit Wiring		2024		6,250		15	417	417	625
10	Installation of New doors and Hardware		2025		5,834		15	194	194	194
11	Repair Elevator Door Operator		2025		45,310		15	1,510	1,510	1,510
12	Install Fireproof Window Curtains		2025		15,513		15	517	517	517
13	Recovered and Installed Canvas Awning		2025		4,452		15	148	148	148
14	Repaired Leak in Ceiling in Cable Room, Circulating Pump-Boiler Rm		2025		3,409		15	114	114	114
15	Install New Wander Guard System at the Front Entrance		2025		11,635		15	388	388	388
16	Replace Damaged Detection Line-Fire Alarm		2025		4,204		15	140	140	140
17	Install Cove Base		2025		15,350		15	512	512	512
18	Replace VFD on RTU-Second Floor		2025		3,685		15	123	123	123
19	Wire Garbage Disposal		2025		2,996		15	100	100	100
20	Patch Parking Lot Asphalt		2025		15,227		15	508	508	508
21	Replace Sprinkler Heads		2025		5,404		15	180	180	180
22	Replace Three Boilers		2025		16,000		15	533	533	533
23	Replace Voltage Terminal Block		2025		4,205		15	140	140	140
24	Relocate Kitchen RTU Unit and Reowork Ductwork		2025		7,893		15	263	263	263
25	Replace Maglock, Keypad and Power Supply-2nd Floor		2025		3,019		15	101	101	101
26	Replace Water Heater		2025		8,368		15	279	279	279
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35	Financial Statement Depreciation					7,549			(7,549)	
36										36

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

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49	Allocated from Aliya Healthcare Consulting LLC	2024	1,403		15	94	94	140	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	763		15	25	25	25	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)		\$180,920	\$7,549		\$6,286	\$(1,263)	\$6,540	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	\$12,167	\$2,476	\$2,265	\$(211)	5-10 Yrs	\$3,397	71
72	Current Year Purchases	37,970	5,621	1,899	(3,722)	10 Yrs	1,899	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$50,137	\$8,097	\$4,164	\$(3,933)		\$5,296	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	2	
	Reference	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)	\$231,057	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$15,646	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$10,450	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(5,196)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$11,836	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:PG 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	69	11/1/24	\$552,746	5	5	3
4	Additions							4
5								5
6		Allocated from Home Office			5,105			6
7	TOTAL		69		\$557,851			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the leaseN/A.
9. Option to Buy:☒ YES☐ NOTerms: Exercisable after initial term*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☒ YES☐ NO
16. Rental Amount for movable equipment: \$7,950Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18	Allocated from Home Office			153	18
19					19
20					20
21	TOTAL		\$	153	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name:Aliya of Palatine

IDPH License ID Number:3000237

Fiscal Year End:12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	2,350
Dietary Equipment	2,967
Office Equipment	1,589
Allocated from Home Office	1,044
Total - Line 16	7,950

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8				
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,284	\$ 160,857	\$	4,284	\$ 160,857	1		
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,120	53,671		1,120	53,671	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	39(3)	hrs		6,264	201,514		6,264	201,514	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				63,946		63,946	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
	Academic Education		hrs							11		
12	Other (specify): <u>Respiratory Therapy</u>	39(7)	71		2,977			71	2,977	12		
13	Other (specify): <u>See Attached Sch 16A</u>	39(3)				24,087			24,087	13		
14	TOTAL			\$	2,977	11,668	\$	63,946	11,739	\$	507,052	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 Palatine

IDPH License ID Number:

3000237

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	18,667
Radiology	5,420
Total - Line 16	24,087

12/31/2025

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 569,901	\$ 569,901	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	351,444	351,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,879	38,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)	565,494	565,494	32
33	Accrued Interest Payable	17,103	17,103	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	15,492	15,492	36
37	<u>Due to Related Party</u>	894,171	894,171	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,452,484	\$ 2,452,484	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,452,484	\$ 2,452,484	46
47	TOTAL EQUITY(page 18, line 24)	\$ 915,250	\$ 892,299	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,367,734	\$ 3,344,783	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (19,478)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (19,478)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	934,728	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)	\$ 934,728	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)	\$ 915,250	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya of Palatine

3000237

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	\$ 11,206,804	1
2	Discounts and Allowances for all Levels	(2,783,347)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,423,457	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	217,231	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 217,231	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,407	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)	\$ 1,407	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,609	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,609	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rebate Income	128	28
28a	C.N.A. Initiative/QIP Revenue	295,788	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 295,916	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,943,620	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,106,020	31
32	Health Care	2,683,827	32
33	General Administration	1,909,323	33
	B. Capital Expense		
34	Ownership	1,192,160	34
	C. Ancillary Expense		
35	Special Cost Centers	700,854	35
36	Provider Participation Fee	416,708	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,008,892	40
41	Income before Income Taxes (line 30 minus line 40)**	934,728	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 934,728	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,525,447	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,274,277	45
46	MMAI-Medicaid is the Primary Payer	542,790	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	665,173	48
49	Medicare Part A	2,089,959	49
50	Other-(specify) Medicare Replacement	257,767	50
51	Other-(specify) Insurance	68,044	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)	\$ 8,423,457	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	2,149	2,313	\$ 139,133	\$ 60.15	1
2	Assistant Director of Nursing	973	997	44,177	44.31	2
3	Registered Nurses	6,575	6,995	304,514	43.53	3
4	Licensed Practical Nurses	12,131	12,425	497,994	40.08	4
5	CNAs & Orderlies	45,328	48,980	1,209,344	24.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,856	2,072	49,520	23.90	9
10	Activity Assistants	3,973	4,216	75,444	17.89	10
11	Social Service Workers	1,896	2,080	66,560	32.00	11
12	Dietician					12
13	Food Service Supervisor	1,663	1,897	60,271	31.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,935	12,677	235,858	18.61	15
16	Dishwashers					16
17	Maintenance Workers	1,907	2,041	61,537	30.15	17
18	Housekeepers	9,123	10,154	185,852	18.30	18
19	Laundry	2,441	2,677	49,997	18.68	19
20	Administrator	1,984	2,080	125,346	60.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,152	2,239	63,376	28.31	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	1,898	2,666	90,245	33.85	33
34	TOTAL (lines 1 - 33)	107,984	116,509	\$ 3,259,168 *	\$ 27.97	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	71	14,594	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,374	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	100	L39, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	10	680	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	82	\$ 28,748		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	50	\$ 2,678	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	50	\$ 2,678		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Aliya of Palatine

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	1,066	1,114	51,761	46.46
Central Supply Clerk	832	1,552	38,484	24.80
TOTAL	1,898	2,666	90,245	

Facility Name & ID Number		Aliya of Palatine		STATE OF ILLINOIS		Page 21		
				# 3000237		Report Period Beginning: 1/1/2025		
						Ending: 12/31/2025		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Morgan Arens	Administrator	0	\$ 125,346	Workers' Compensation Insurance	\$ 63,033	IDPH License Fee	\$ 4,070	
				Unemployment Compensation Insurance	29,831	Advertising: Employee Recruitment	22,354	
				FICA Taxes	244,841	Health Care Worker Background Check		
				Employee Health Insurance	81,221	(Indicate # of checks performed 14)	789	
				Employee Meals		Patient Background Checks 195	2,140	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	11,351	
				401k Expense	7,435	Telemedicine Solutions	3,405	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Meals/Food/Activities	13,353	Various Licenses & Fees	6,415	
(List each licensed administrator separately.)			\$ 125,346	Uniforms	4,020			
B. Administrative - Other				Other Employee Benefits	12,308	Allocated from Home Office	3,025	
						Less: Public Relations Expense (		
Description			Amount	Allocated from Home Office	16,669	PAC and Lobbying payments	(5,676)	
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			\$ 432,034			All non-allowable advertising (		
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			284,353					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 716,387	TOTAL (agree to Schedule V, line 22, col.8)	\$ 472,711	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 47,873	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Alyze Healthcare Consulting	Bookkeeping		\$ 122,696				Out-of-State Travel	\$
Roth & Company	Accounting		996	N/A				
Templin Healthcare accounting	Accounting		2,425					
NYX Health, LLC	Accounting		923				In-State Travel	
Waystar	Data Processing		3,861					
Point Click Care	Data Processing		33,257					
Paylocity	Payroll Processing		15,496					
Personnel Planners, Inc	Unemployment Consulting		395				Seminar Expense	869
Nancy Given	PBJ Preparation		4,500					
See Legal Attachment	Legal Services		13,388				Allocated from Home Office	256
See Attached Schedule 21A			83,111				Entertainment Expense (	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 281,048				TOTAL	\$ 1,125

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Aliya of Palatine
IDPH License ID Number: 3000237
Fiscal Year End: 12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
AcctZen, LLC	Accounting Services	411
ADDA Infusion	HR Consulting	886
Adelpo	Data Processing	1,920
Allegro Data Solutions	Data Processing	294
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	1,500
Certisurv LLC	State Survey Consulting	300
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	12,638
CTI III, LLC	Business Consultant	667
DiningRD	EHR Integration	440
Direct Supply	Data Processing	1,600
Guided Care	Data Processing	15,850
Inovalon Provider, Inc.	Data Processing	762
Mega Data Health Systems	Data Processing	6,009
Midwest Care Management Services	Guardianship Consultant	140
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	3,599
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	4,188
Reside Admissions	Data Processing	2,894
Sage Intacct, Inc	Data Processing	2,981
Wellsky	Data Processing	11,201
Prior Year Accrual Reversals		(6,000)
Total		83,111

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name

Amount

HEALTH CARE COUNCIL OF IL (HCCI)

5,675

5,675

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)

5,676

5,676

Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

11,351

11,351

Total
- (5)

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

\$ 20,077

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.

\$ 416,708

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.

\$

No

Has any meal income been offset against related costs?

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.