

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0058032

Facility Name: Aliya on 87th

Address: 2940 W 87th Street Chicago 60652
Number City Zip Code

County: Cook

Telephone Number: (773) 434-8787 Fax # (773) 434-8717

HFS ID Number:

Date of Initial License for Current Owners: 6/1/23

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ 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) (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 on 87th # 0058032 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	210	Skilled (SNF)	210	76,650	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	210	TOTALS	210	76,650	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						3,948	3,649	7,597	8
9	SNF/PED									9
10	ICF	18,052	37,909	4,373		2,327			62,661	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	18,052	37,909	4,373		2,327	3,948	3,649	70,258	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.66%

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 6/1/23

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 6/1/23 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 210

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	595,983	61,270	7,131	664,384		664,384	79,892	744,276			1
2	Food Purchase		485,098		485,098		485,098		485,098			2
3	Housekeeping	444,499	64,720		509,219		509,219		509,219			3
4	Laundry	162,055	37,679	4,896	204,630		204,630		204,630			4
5	Heat and Other Utilities			318,736	318,736		318,736	1,127	319,863			5
6	Maintenance	126,525	57,242	320,363	504,130		504,130	29,735	533,865			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			26,107	26,107		26,107	11,093	37,200			7
8	TOTAL General Services	1,329,062	706,009	677,233	2,712,304		2,712,304	121,847	2,834,151			8
	B. Health Care and Programs											
9	Medical Director			14,667	14,667		14,667		14,667			9
10	Nursing and Medical Records	7,055,610	441,935	32,857	7,530,402		7,530,402	179,890	7,710,292			10
10a	Therapy											10a
11	Activities	336,901	10,557	1,978	349,436		349,436		349,436			11
12	Social Services	210,095		1,785	211,880		211,880	7,435	219,315			12
13	CNA Training			4,125	4,125		4,125		4,125			13
14	Program Transportation			29,675	29,675		29,675		29,675			14
15	Other (specify):* Mgmt Alloc of Benefits							24,498	24,498			15
16	TOTAL Health Care and Programs	7,602,606	452,492	85,087	8,140,185		8,140,185	211,823	8,352,008			16
	C. General Administration											
17	Administrative	137,431		2,084,715	2,222,146		2,222,146	(1,993,072)	229,074			17
18	Directors Fees											18
19	Professional Services			581,670	581,670		581,670	(207,357)	374,313			19
20	Dues, Fees, Subscriptions & Promotions			89,948	89,948		89,948	(9,063)	80,885			20
21	Clerical & General Office Expenses	381,036	31,804	124,408	537,248		537,248	570,927	1,108,175			21
22	Employee Benefits & Payroll Taxes			1,357,782	1,357,782		1,357,782	50,731	1,408,513			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			1,804	1,804		1,804	781	2,585			24
25	Other Admin. Staff Transportation			6,667	6,667		6,667	19,658	26,325			25
26	Insurance-Prop.Liab.Malpractice			502,459	502,459		502,459	7,662	510,121			26
27	Other (specify):* Mgmt Alloc of Benefits							92,487	92,487			27
28	TOTAL General Administration	518,467	31,804	4,751,894	5,302,165		5,302,165	(1,467,246)	3,834,919			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,450,135	1,190,305	5,514,214	16,154,654		16,154,654	(1,133,576)	15,021,078			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			73,614	73,614		73,614	659,547	733,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,845	113,845		113,845	1,667,053	1,780,898			32
33	Real Estate Taxes			1,013,350	1,013,350		1,013,350		1,013,350			33
34	Rent-Facility & Grounds			1,801,277	1,801,277		1,801,277	(1,785,740)	15,537			34
35	Rent-Equipment & Vehicles			15,653	15,653		15,653	3,644	19,297			35
36	Other (specify):* Loan Costs			3,333	3,333		3,333		3,333			36
37	TOTAL Ownership			3,021,072	3,021,072		3,021,072	544,504	3,565,576			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,205	1,007,094	1,214,299		1,214,299	10,268	1,224,567			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,145,586	1,145,586		1,145,586		1,145,586			42
43	Other (specify):* Disallowed Costs	64,968	20,451	554,321	639,740		639,740	(639,740)				43
44	TOTAL Special Cost Centers	64,968	227,656	2,707,001	2,999,625		2,999,625	(629,472)	2,370,153			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,515,103	1,417,961	11,242,287	22,175,351		22,175,351	(1,218,544)	20,956,807			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	(18,093)	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	659,547	30		9
10	Interest and Other Investment Income	(33,608)	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	(2,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(487,717)	43		24
25	Fund Raising, Advertising and Promotional	(20,551)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(33,368)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(83,467)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,257)		\$	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)	(1,199,287)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,199,287)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,218,544)		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	\$ (18,270)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Offset Miscellaneous Income Against Expense	(125)	21	4
5	Adjust Owners Wages to Allowable Amount	(10,119)	17	5
6	Expense Minor Fixed Assets Below \$2,500	6,045	1	6
7	Expense Minor Fixed Assets Below \$2,500	18,529	6	7
8	Expense Minor Fixed Assets Below \$2,500	3,637	10	8
9	Expense Minor Fixed Assets Below \$2,500	6,792	21	9
10	Marketing Director Wages	(64,968)	43	10
11	Collection Agency Fees	(46,193)	43	11
12	Disallow Penalty Adjustments	33,150	43	12
13	Disallow Marketing Travel Expenses	(185)	25	13
14	Out of State Travel (Allocated from Home Office)	(5,739)	24	14
15	Out of State Seminar (Allocated from Home Office)	(6,021)	25	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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29				29
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(83,467)		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	32	Interest	\$	Wrightwood 87th SNF Property LLC		\$ 1,392,712	\$ 1,392,712	1
2	V	32	Amortization of Loan Costs		Wrightwood 87th SNF Property LLC		273,410	273,410	2
3	V	34	Rent-Facility & Grounds	1,801,277	Wrightwood 87th SNF Property LLC			(1,801,277)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,801,277			\$ 1,666,122	\$ * (135,155)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	\$	Aliya Healthcare Consulting LLC		\$ 1,127	\$ 1,127	15
16	V	6	Maintenance		Aliya Healthcare Consulting LLC		1,877	1,877	16
17	V	17	Administrative	1,219,292	Aliya Healthcare Consulting LLC		101,762	(1,117,530)	17
18	V	19	Professional Services		Aliya Healthcare Consulting LLC		19,369	19,369	18
19	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		9,200	9,200	19
20	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		23,226	23,226	20
21	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		50,731	50,731	21
22	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		6,312	6,312	22
23	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		13,111	13,111	23
24	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		7,606	7,606	24
25	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		20,649	20,649	25
26	V	32	Interest		Aliya Healthcare Consulting LLC		34,539	34,539	26
27	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		15,537	15,537	27
28	V	35	Rent-Equipment & Vehicles		Aliya Healthcare Consulting LLC		3,178	3,178	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			\$ 1,219,292			\$ 308,224	\$ * (911,068)	39

VII. RELATED PARTIES (continued)

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

☒ 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		\$ 73,847	\$ 73,847	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		9,329	9,329	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		11,093	11,093	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		176,253	176,253	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		7,435	7,435	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		24,498	24,498	20
21	V	17	Administrative	865,423	Alyze Healthcare Consulting LLC		0	(865,423)	21
22	V	19	Professional Services	228,000	Alyze Healthcare Consulting LLC		1,274	(226,726)	22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		7	7	23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		541,034	541,034	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		208	208	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		12,753	12,753	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		56	56	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		71,838	71,838	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		466	466	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		9,060	9,060	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,208	1,208	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,093,423			\$ 940,359	\$ * (153,064)	39

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 Oak Lawn	Oak Lawn, IL			ILF LLC	Palos Park, IL	Independent Living	6
7	Aliya of Palatine	Palatine, IL			Wrightwood 87th			7
8	Aliya of Palos Park	Palos Park, IL			SNF Property LLC	Skokie, IL	Lessor	8
9	Ryze at Homewood	Homewood, IL			Avenue SNF			9
10	Ryze at the Ridge	Chicago, IL			Property LLC	Skokie, IL	Lessor	10
11	Ryze on the Avenue	Chicago, IL			West SNF			11
12	Ryze West	Chicago, IL			Property LLC	Skokie, IL	Lessor	12
13					Evanston SNF			13
14					Property LLC	Skokie, IL	Lessor	14
15					Highwood SNF			15
16					Property LLC	Skokie, IL	Lessor	16
17					Ridge SNF			17
18					Property LLC	Skokie, IL	Lessor	18
19					Palos SNF			19
20					Property LLC	Skokie, IL	Lessor	20
21					Illuminate Hospice LL	Oakbrook Terrace, IL	Hospice	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Efriam Weinfeld	COO	Administrative	0.00	See Att Sch P7A	3.83	9.54	Salary	\$ 21,886	L17,C7	1
2	Moshe Erlich	CIO	Administrative	14.3250	See Att Sch P7A	3.83	9.54	Salary	21,886	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	\$ 43,772		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 on 87th # 0058032 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	\$	76,650	\$ 1,127	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		76,650	1,877	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	76,650	101,762	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		76,650	19,369	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		76,650	9,200	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	76,650	23,226	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		76,650	50,731	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		76,650	6,312	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		76,650	13,111	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		76,650	7,606	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		76,650	20,649	11
12	32	Interest	Available Bed Days	805,555	13	362,992		76,650	34,539	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		76,650	15,537	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		76,650	3,178	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		\$ 308,224	25

Ending: 2/31/2025

()

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Monticello AM		X	Mortgage	Varies	10/1/24	\$ 25,916,587	\$ 25,916,587	11/26/28	0.0790	\$ 1,392,712	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Monticello AM		X	Working Capital							100,818	6
7												7
8												8
9	TOTAL Facility Related						\$ 25,916,587	\$ 25,916,587			\$ 1,493,530	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			286,437	10
11								Offset Interest Income			(33,608)	11
12								Allocated from Home Office			34,539	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 287,368	14
15	TOTALS (line 9+line14)						\$ 25,916,587	\$ 25,916,587			\$ 1,780,898	15

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	843,232	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		\$	903,835	2
3. Under or (over) accrual (line 2 minus line 1).				\$	60,603	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	952,747	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$		6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	1,013,350	7
Assessed Value from Real Estate Tax Bill:	2024	4,498,755	8			
Real Estate Tax Bill for Calendar Year:	2020	724,022	9			
	2021	686,847	10			
	2022	858,812	11			
	2023	933,191	12			
	2024	903,835	13			
Accrual based on prior year tax bill.						
				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 on 87th COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0058032

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. 19-36-322-011-0000	Long Term Care Property	\$ 126,657.90	\$ 126,657.90
2. 19-36-322-012-0000	Long Term Care Property	\$ 160,297.64	\$ 160,297.64
3. 19-36-322-013-0000	Long Term Care Property	\$ 246,735.84	\$ 246,735.84
4. 19-36-322-014-0000	Long Term Care Property	\$ 177,585.21	\$ 177,585.21
5. 19-36-322-015-0000	Long Term Care Property	\$ 160,297.64	\$ 160,297.64
6. 19-36-322-016-0000	Long Term Care Property	\$ 21,996.63	\$ 21,996.63
7. 19-36-322-017-0000	Long Term Care Property	\$ 5,219.56	\$ 5,219.56
8. 19-36-322-018-0000	Long Term Care Property	\$ 5,044.39	\$ 5,044.39
9.		\$	\$
10.		\$	\$
TOTALS		\$ 903,834.81	\$ 903,834.81

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: 66,911 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (a) Own the Equipment (X) (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 X 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	Nursing Home	51,162	2024	\$ 1,295,000	1
2					2
3	TOTALS	51,162		\$ 1,295,000	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	210		2024	1999	\$ 17,205,000	\$	25	\$ 688,200	\$ 688,200	\$ 860,250	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Repair Generator, Replace Contactors, Controller, Engine Heater			2023	14,847		15	990	990	2,970	9
10	Repair Fire System Backflow			2023	6,089		15	406	406	1,218	10
11	Replace Door Closures/Gasket on Walk-In Freezer			2023	3,788		15	253	253	759	11
12	Repair Booster/Fire Pumps			2023	2,597		15	173	173	519	12
13	Replace 2 fan motors-kitchen			2024	3,120		15	208	208	312	13
14	Install new boiler controller			2024	3,315		15	221	221	332	14
15	Replacement of dual temperature pump			2024	15,776		15	1,052	1,052	1,578	15
16	Upgraded refrigeration system in walk-in cooler			2024	10,700		15	713	713	1,070	16
17	Replaced motor in basement common area boiler			2024	5,000		15	333	333	500	17
18	Remove and replace 2000 sqft of asphalt-parking lot			2024	18,800		15	1,253	1,253	1,880	18
19	Install LVT in front office and hall area			2024	5,800		15	387	387	580	19
20	Repair exterior pump, re assemble check valve			2024	5,285		15	352	352	528	20
21	Reweld generator exhaust black iron pipe, secure to building			2024	7,500		15	500	500	750	21
22	Install LVT/Cove Base in conf room, soc svc and DON office			2024	6,200		15	413	413	620	22
23	Replaced condensor fan motor-walk in freezer			2024	3,098		15	207	207	310	23
24	Install NEMA size 4 starter with overloads			2024	4,100		15	273	273	410	24
25	Repaired fan coil units in 1st fl shower, 2nd fl nurse station, laundry room			2024	16,170		15	1,078	1,078	1,617	25
26	Replaced booster pump			2024	60,545		15	4,036	4,036	6,054	26
27	Installed test cock on backflow			2024	7,343		15	490	490	735	27
28	Install wanderguard electromagnetic lock, delayed egress			2025	3,670		15	122	122	122	28
29	Replace ejector pumps and panel			2025	22,232		15	741	741	741	29
30	Repair leaks on hot water heater-mechanical room			2025	14,610		15	487	487	487	30
31	Install glass in windows-front entrance			2025	2,620		15	87	87	87	31
32	Installation of annunciator at 1st floor nurses station			2025	11,600		15	387	387	387	32
33	Install security cameras			2025	15,133		15	504	504	504	33
34	Reinforce concrete patio, install new ductwork to patio			2025	51,339		15	1,711	1,711	1,711	34
35	Install 5 new 3-speed air conditioner motors			2025	8,974		15	299	299	299	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

Facility Name & ID Number Aliya on 87th

0058032

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Install elevator door operator-elevator #1	2025	\$ 14,800	\$	15	\$ 493	\$ 493	\$ 493	37
38	Rehung elevator doors	2025	4,123		15	137	137	137	38
39	Replace panel on monument sign	2025	3,516		15	117	117	117	39
40	Replace generator	2025	129,375		15	4,313	4,313	4,313	40
41	Repair leak-laundry room	2025	4,050		15	135	135	135	41
42	Replace blower motor in kitchen unit	2025	2,805		15	94	94	94	42
43	Replace faucets-resident rooms	2025	4,116		15	137	137	137	43
44	Replace bearing assembly, seal on water pump	2025	3,148		15	105	105	105	44
45	Replace up to 5 new speed motors A/C's	2025	8,437		15	281	281	281	45
46	Install new pipe, wire, and breakers for new outlets-A/Cs on 2nd a	2025	9,750		15	325	325	325	46
47	Install 2 RPZs- kitchen and laundry	2025	5,304		15	177	177	177	47
48	Replace splitter system AC	2025	12,539		15	418	418	418	48
49	Replace water guage, sensor kits-chiller	2025	4,928		15	164	164	164	49
50	Isolate and LOTO the electrical circuit	2025	3,485		15	116	116	116	50
51	Replace boiler-mechanical room	2025	41,429		15	1,381	1,381	1,381	51
52	Install carpet in entryway and lobby	2025	10,800		15	360	360	360	52
53	Rebuild wall, install 2 steel doors-oxygen room	2025	25,900		15	863	863	863	53
54	Replace comfort heating boiler-mechanical room	2025	39,200		15				54
55									55
56									56
57									57
58									58
59									59
60	Financial Statement Depreciation			30,244			(30,244)		60
61									61
62									62
63									63
64	Allocated from Aliya Healthcare Consulting LLC	2024	4,270		15	286	286	428	64
65	Allocated from Aliya Healthcare Consulting LLC	2025	2,323		15	78	78	78	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 17,869,549	\$ 30,244		\$ 715,856	\$ 685,612	\$ 897,452	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	\$149,246	\$38,822	\$14,924	\$(23,898)	10 Yrs	\$27,448	71
72	Current Year Purchases	38,990	4,548	2,381	(2,167)	5-10 Yrs	2,381	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$188,236	\$43,370	\$17,305	\$(26,065)		\$29,829	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)	\$19,352,785	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$73,614	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$733,161	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$659,547	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$927,281	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:
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:				\$	10	10	3
4	Additions							4
5								5
6		Allocated from Home Office			15,537			6
7	TOTAL				\$ 15,537			7

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- N/A
- *

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: \$ 18,831
- Description:
- See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	Allocated from Home Office			466	18
19					19
20					20
21	TOTAL		\$	\$ 466	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

Facility Name:Aliya on 87th

IDPH License ID Number:0058032

Fiscal Year End:12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	8,807
Dietary Equipment	9,414
Office Equipment	2,050
Prior Year Vendor Credits	(4,618)
Allocated from Home Office	3,178
Total - Line 16	18,831

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	\$	\$ 4,125	\$	\$ 4,125
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	\$	\$ 4,125	\$	\$ 4,125
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,125			

- (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	\$	5,601	\$ 345,459	\$	5,601	\$ 345,459	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		855	64,473		855	64,473	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,894	412,849		5,894	412,849	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				207,205		207,205	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(7)	217	9,060				217	9,060	12
13	Other (specify): <u>See Attached Sch 16A</u>	39(3)				173,290			173,290	13
14	TOTAL			\$ 9,060	12,350	\$ 996,071	\$ 207,205	12,567	\$ 1,212,336	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 on 87th

IDPH License ID Number:0058032

Fiscal Year End:12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	61,750
Radiology	12,212
Dialysis	99,328
Total - Line 16	173,290

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$88,868	\$158,751	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance1,096,517)	3,755,556	3,755,556	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	252,823	252,823	6
7	Other Prepaid Expenses	17,137	120,551	7
8	Accounts Receivable (owners or related parties)	6,075,621	5,666,195	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$10,190,005	\$9,953,876	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,295,000	13
14	Buildings, at Historical Cost		17,205,000	14
15	Leasehold Improvements, at Historical Cost	711,736	664,549	15
16	Equipment, at Historical Cost	280,501	188,236	16
17	Accumulated Depreciation (book methods)	(112,011)	(927,281)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,255,322	21
22	Other Long-Term Assets (specify) Loan Costs	14,473	889,013	22
23	Other(specify): Deposits	299,079	299,079	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$1,193,778	\$20,868,918	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$11,383,783	\$30,822,794	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$976,633	\$976,633	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	720,667	720,667	30
31	Accrued Taxes Payable (excluding real estate taxes)	116,362	116,362	31
32	Accrued Real Estate Taxes(Sch.IX-B)	952,747	952,747	32
33	Accrued Interest Payable	4,240	71,278	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	604,672	546,545	36
37	Due to Related Party	3,362,885	4,834,995	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$6,738,206	\$8,219,227	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		25,916,587	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)	\$	\$25,916,587	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$6,738,206	\$34,135,814	46
47	TOTAL EQUITY(page 18, line 24)	\$4,645,577	\$(3,313,020)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$11,383,783	\$30,822,794	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 800,785	1
2	Restatements (describe):		2
3	Rent Expense	691,225	3
4	Depreciation Expense	(34,275)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,457,735	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,187,842	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)	\$ 3,187,842	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)	\$ 4,645,577	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aliya on 87th

0058032

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	\$ 34,405,751	1
2	Discounts and Allowances for all Levels	(10,085,573)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 24,320,178	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,831	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 164,831	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	40	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	2,638	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)	\$ 2,678	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33,608	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,608	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records Income	125	28
28a	C.N.A. Initiative/QIP Revenue	841,773	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 841,898	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 25,363,193	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,712,304	31
32	Health Care	8,140,185	32
33	General Administration	5,302,165	33
	B. Capital Expense		
34	Ownership	3,021,072	34
	C. Ancillary Expense		
35	Special Cost Centers	1,854,039	35
36	Provider Participation Fee	1,145,586	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,175,351	40
41	Income before Income Taxes (line 30 minus line 40)**	3,187,842	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,187,842	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 5,280,661	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	11,089,331	45
46	MMAI-Medicaid is the Primary Payer	1,279,212	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	720,911	48
49	Medicare Part A	3,121,628	49
50	Other-(specify) Medicare Replacement	2,041,739	50
51	Other-(specify) Insurance	786,696	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)	\$ 24,320,178	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	2,456	2,552	\$ 190,718	\$ 74.73	1
2	Assistant Director of Nursing	2,055	2,271	129,546	57.04	2
3	Registered Nurses	17,638	18,701	857,451	45.85	3
4	Licensed Practical Nurses	49,630	52,566	2,125,824	40.44	4
5	CNAs & Orderlies	123,207	132,425	3,329,311	25.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,768	4,160	135,221	32.51	9
10	Activity Assistants	7,093	8,008	201,680	25.18	10
11	Social Service Workers	6,991	7,328	210,095	28.67	11
12	Dietician	100	100	4,046	40.46	12
13	Food Service Supervisor	2,067	2,203	75,952	34.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,797	24,945	515,985	20.68	15
16	Dishwashers					16
17	Maintenance Workers	3,732	4,044	126,525	31.29	17
18	Housekeepers	20,063	21,666	444,499	20.52	18
19	Laundry	7,121	7,777	162,055	20.84	19
20	Administrator	2,008	2,136	137,431	64.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,403	11,031	313,511	28.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,840	2,080	44,039	21.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	13,816	14,702	511,214	34.77	33
34	TOTAL (lines 1 - 33)	296,785	318,695	\$ 9,515,103 *	\$ 29.86	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	88	14,667	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	27,299	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	152	11,023	L39, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,978	L11, C3	44
45	Social Service Consultant	26	1,785	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	294	\$ 56,752		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Aliya on 87th

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	3,880	4,120	174,716	42.41
Admissions Coordinator	1,968	2,072	67,525	32.59
Infection Preventist	2,130	2,242	94,243	42.04
Central Supply	1,864	2,048	51,380	25.09
Staffing Coordinator	1,830	1,940	52,630	27.13
Transitional Care Liaison	72	80	5,752	71.90
Customer Experience Director	2,072	2,200	64,968	29.53
TOTAL	13,816	14,702	511,214	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Tawana Lee-Daniel	Administrator	0	\$ 68,058
Richard Ogunniyi	Administrator	0	46,731
Justin Chandler	Administrator	0	22,642
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,431
B. Administrative - Other			
Description			Amount
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7		\$	1,219,292
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			865,423
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 2,084,715
C. Professional Services			
Vendor/Payee	Type		Amount
Alyze Healthcare Consulting	Bookkeeping	\$	228,000
Templin Healthcare Accounting	Accounting		5,926
Roth & Company	Accounting		36,984
NYX Health, LLC	Accounting		923
Waystar	Data Processing		3,861
Point Click Care	Data Processing		103,900
Paylocity	Payroll Processing		37,358
Personnel Planners, Inc	Unemployment Consulting		3,170
Nancy Given	PBJ Preparation		4,800
See Legal Attachment	Legal Services		23,466
See Attached Schedule 21A			133,282
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 581,670
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	81,713
Unemployment Compensation Insurance			54,650
FICA Taxes			716,620
Employee Health Insurance			375,535
Employee Meals			8,085
Illinois Municipal Retirement Fund (IMRF)*			
Pension/401k Expense			56,839
Employee Meals/Food/Activities			29,615
Uniforms			8,814
Physical Exams			152
Other Employee Benefits			25,759
Allocated from Home Office			50,731
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,408,513
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		\$	509
Advertising: Employee Recruitment			26,481
Health Care Worker Background Check (Indicate # of checks performed 58)			2,881
Patient Background Checks 745			8,192
Association Dues (total from pg 22, #4)			36,540
Telemedicine Solutions			4,055
The Joint Commission			3,355
Various Dues & Subscriptions, Licenses			7,935
Allocated from Home Office			9,207
Less: Public Relations Expense (			)
PAC and Lobbying payments			(18,270)
All non-allowable advertising (			)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 80,885
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			1,804
Allocated from Home Office			781
Entertainment Expense (			)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	2,585

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

****See instructions.**

Facility Name: Aliya on 87th
IDPH License ID Number: 0058032
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	1,470
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,600
Certisurv LLC	State Survey Consulting	450
Compliagent	Data Processing	171
Complihealth Corp	Data Processing	5,728
Creative Technology Solutions, LLC	Data Processing	39,755
CTI III, LLC	Business Consultant	668
DiningRD	EHR Integration	496
Direct Supply	Data Processing	1,688
Guided Care	Data Processing	250
Inovalon Provider, Inc.	Data Processing	762
MedaSync Inc.	Data Processing	1,500
Medicaid Done Right LLC	Billing Consultant	1,200
Mega Data Health Systems	Data Processing	6,359
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	8,800
Pax8	Data Processing	11,504
Premier Risk Solutions	Security Consulting	447
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	5,988
Reside Admissions	Data Processing	4,082
Sage Intacct, Inc	Data Processing	3,245
Stout Risius Ross, LLC	Appraisal	6,007
Third Eye Health Inc.	Data Processing	9,000
Wellsky	Data Processing	5,890
Total		133,282

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)	18,270
	18,270 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)	18,270
	18,270 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	36,540
	36,540 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	82,701	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.

\$	1,145,586
----	-----------

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.

\$	8,085	Has any meal income been offset against related costs?	No	Indicate the amount.	\$ N/A
----	-------	--	----	----------------------	--------
- (12) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A
- (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.