

		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: 3000477

Facility Name: Ryze at Homewood

Address: 19000 S Halsted St Homewood 60430
Number City Zip Code

County: Cook

Telephone Number: (708) 957-9200 Fax # (708) 957-7828

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2024

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 Ryze at Homewood # 3000477 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>259</u>	Skilled (SNF)	<u>259</u>	<u>94,535</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>259</u>	TOTALS	<u>259</u>	<u>94,535</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						1,772	1,013	2,785	8
9	SNF/PED									9
10	ICF	13,653	27,784	5,299		1,248			47,984	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	13,653	27,784	5,299		1,248	1,772	1,013	50,769	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 53.70%

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 12/1/24

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/1/24 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 259

Medicare Intermediary National Government Services

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	451,880	39,970	4,791	496,641		496,641	92,783	589,424			1
2	Food Purchase		378,303		378,303		378,303		378,303			2
3	Housekeeping	453,858	38,975		492,833		492,833		492,833			3
4	Laundry	74,708	36,932	2,037	113,677		113,677		113,677			4
5	Heat and Other Utilities			264,024	264,024		264,024	1,390	265,414			5
6	Maintenance	126,093	48,302	140,827	315,222		315,222	20,207	335,429			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			21,045	21,045		21,045	13,681	34,726			7
8	TOTAL General Services	1,106,539	542,482	432,724	2,081,745		2,081,745	128,061	2,209,806			8
	B. Health Care and Programs											
9	Medical Director			41,000	41,000		41,000		41,000			9
10	Nursing and Medical Records	5,084,398	356,618	36,246	5,477,262		5,477,262	218,487	5,695,749			10
10a	Therapy											10a
11	Activities	221,495	24,346	2,083	247,924		247,924		247,924			11
12	Social Services	125,873		35	125,908		125,908	9,169	135,077			12
13	CNA Training											13
14	Program Transportation			64,001	64,001		64,001		64,001			14
15	Other (specify):* Mgmt Alloc of Benefits							30,213	30,213			15
16	TOTAL Health Care and Programs	5,431,766	380,964	143,365	5,956,095		5,956,095	257,869	6,213,964			16
	C. General Administration											
17	Administrative	123,271		1,853,884	1,977,155		1,977,155	(1,740,861)	236,294			17
18	Directors Fees											18
19	Professional Services			473,068	473,068		473,068	(153,412)	319,656			19
20	Dues, Fees, Subscriptions & Promotions			80,421	80,421		80,421	(4,833)	75,588			20
21	Clerical & General Office Expenses	282,225	20,352	36,236	338,813		338,813	706,475	1,045,288			21
22	Employee Benefits & Payroll Taxes			887,336	887,336		887,336	62,569	949,905			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,083	6,083		6,083	962	7,045			24
25	Other Admin. Staff Transportation			3,723	3,723		3,723	24,474	28,197			25
26	Insurance-Prop.Liab.Malpractice			480,000	480,000		480,000	9,451	489,451			26
27	Other (specify):* Mgmt Alloc of Benefits							114,068	114,068			27
28	TOTAL General Administration	405,496	20,352	3,820,751	4,246,599		4,246,599	(981,107)	3,265,492			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,943,801	943,798	4,396,840	12,284,439		12,284,439	(595,177)	11,689,262			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			32,527	32,527		32,527	(9,445)	23,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			156,688	156,688		156,688	20,982	177,670			32
33	Real Estate Taxes			855,945	855,945		855,945		855,945			33
34	Rent-Facility & Grounds			821,950	821,950		821,950	19,163	841,113			34
35	Rent-Equipment & Vehicles			31,982	31,982		31,982	4,495	36,477			35
36	Other (specify):*											36
37	TOTAL Ownership			1,899,092	1,899,092		1,899,092	35,195	1,934,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		100,713	391,828	492,541		492,541	12,664	505,205			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			812,870	812,870		812,870		812,870			42
43	Other (specify):* Disallowed Costs		15,835	356,422	372,257		372,257	(372,257)				43
44	TOTAL Special Cost Centers		116,548	1,561,120	1,677,668		1,677,668	(359,593)	1,318,075			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,943,801	1,060,346	7,857,052	15,861,199		15,861,199	(919,575)	14,941,624			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	(11,572)	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	(9,445)	30		9
10	Interest and Other Investment Income	(21,617)	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	(30,238)	43		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	(314,612)	43		24
25	Fund Raising, Advertising and Promotional	(15,835)	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	(23,421)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (426,740)		\$	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)	(492,835)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (492,835)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (919,575)		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	\$ (16,188)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable	(12,484)	17	4
5	Expense Minor Fixed Assets below \$2,500	1,705	1	5
6	Expense Minor Fixed Assets below \$2,500	11,865	6	6
7	Expense Minor Fixed Assets below \$2,500	1,109	10	7
8	Expense Minor Fixed Assets below \$2,500	10,555	21	8
9	Capitalize large repairs	(5,479)	6	9
10	Out of State Travel (Allocated from Home Office)	(7,079)	24	10
11	Out of State Seminar (Allocated from Home Office)	(7,425)	25	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(23,421)		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		\$ 1,390	\$ 1,390	1
2	V	6	Maintenance		Aliya Healthcare Consulting LLC		2,315	2,315	2
3	V	17	Administrative	786,529	Aliya Healthcare Consulting LLC		125,507	(661,022)	3
4	V	19	Professional Services		Aliya Healthcare Consulting LLC		23,888	23,888	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		11,346	11,346	5
6	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		28,645	28,645	6
7	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		62,569	62,569	7
8	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		7,785	7,785	8
9	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		16,170	16,170	9
10	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		9,381	9,381	10
11	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		25,467	25,467	11
12	V	32	Interest		Aliya Healthcare Consulting LLC		42,599	42,599	12
13	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		19,163	19,163	13
14	Total			\$ 786,529			\$ 376,225	\$ * (410,304)	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		\$ 3,920	\$ 3,920	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			\$			\$ 3,920	\$ * 3,920	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		\$ 91,078	\$	91,078 15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		11,506		11,506 16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		13,681		13,681 17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		217,378		217,378 18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		9,169		9,169 19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		30,213		30,213 20
21	V	17	Administrative	1,067,355	Alyze Healthcare Consulting LLC		0		(1,067,355) 21
22	V	19	Professional Services	178,872	Alyze Healthcare Consulting LLC		1,572		(177,300) 22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		9		9 23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		0 24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		667,275		667,275 25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		256		256 26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		15,729		15,729 27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		70		70 28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		88,601		88,601 29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		0 30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		575		575 31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		11,174		11,174 32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,490		1,490 33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,246,227			\$ 1,159,776	\$ *	(86,451) 39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS					Ownership Listing-1			
Ryze at Homewood								
ID#		3000477						
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)							Aliya Healthcare Consu	
-Owners of companies must be listed instead of company names.					Operator/Licensee		Building Co.	
-Names of trust beneficiaries must be listed.					Ownership Percentage		Ownership Percentage	
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	Dvorah	S	Weinfeld	Chicago	IL	45.01000		75.50000
2	Avrum	P	Weinfeld	Chicago	IL	13.23768		
3	Moshe	M	Erlich	Lincolnwood	IL	13.23768		15.00000
4	Jordan	E	Reifer	Lincolnwood	IL	8.83000		5.00000
5	Rebecca	R	Kohn	Lincolnwood	IL	4.41000		2.49975
6	Nesanel	B	Davis	Chicago	IL	1.76500		1.00000
7	Sam	NG	Wasserman	Chicago	IL	1.76500		1.00000
8	Avi	NG	Schechter	Surfside	FL	8.74910		
9	Aaron	NG	Kraft	Lincolnwood	IL	2.99970		
10								
11								
12	Remaining Owners of Aliya Healthcare Consulting LLC							
13	Henry	NG	Kohn	Lincolnwood	IL			0.00063
14	Oliver	NG	Kohn	Lincolnwood	IL			0.00063
15	Lillian	NG	Kohn	Lincolnwood	IL			0.00063
16	George	NG	Kohn	Lincolnwood	IL			0.00063
17								
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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 Palatine	Palatine, IL			Consulting LLC	Skokie, IL	Management Co	2
3	Aliya of Highwood	Highwood, IL			Alyze Healthcare			3
4	Aliya of Homewood	Homewood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	4
5	Aliya of Oak Lawn	Oak Lawn, IL			Aliya of Palos Park			5
6	Aliya of Crestwood	Crestwood, IL			ILF LLC	Palos Park, IL	Independent Living	6
7	Aliya of Palos Park	Palos Park, IL			Wrightwood 87th			7
8	Aliya on 87th	Chicago, IL			SNF Property LLC	Skokie, IL	Lessor	8
9	Aliya of Glenwood	Glenwood, 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	4.69	11.73	Salary	\$ 26,991	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	4.69	11.73	Salary	26,991	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	\$ 53,982		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 Ryze at Homewood # 3000477 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	\$	94,535	\$ 1,390	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		94,535	2,315	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	94,535	125,507	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		94,535	23,888	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		94,535	11,346	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	94,535	28,645	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		94,535	62,569	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		94,535	7,785	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		94,535	16,170	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		94,535	9,381	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		94,535	25,467	11
12	32	Interest	Available Bed Days	805,555	13	362,992		94,535	42,599	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		94,535	19,163	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		94,535	3,920	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		\$ 380,145	25

Facility Name & ID Number Ryze at Homewood # 3000477 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	259	\$ 91,078	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	259	11,506	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		259	13,681	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	259	217,378	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	259	9,169	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		259	30,213	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		259	1,572	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		259	9	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	259	667,275	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		259	256	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		259	15,729	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		259	70	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		259	88,601	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		259	575	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	259	11,174	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		259	1,490	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,558,836	\$ 9,157,901		\$ 1,159,776	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		3/13/25		1,134,869	3/18/28	0.1025	137,359	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	1,134,869				\$ 137,359	9						
	B. Non-Facility Related*																		
10								Amortization of Loan Costs			19,329	10							
11								Offset Interest Income			(21,617)	11							
12								Allocated from Home Office			42,599	12							
13												13							
14	TOTAL Non-Facility Related						\$					\$ 40,311	14						
15	TOTALS (line 9+line14)						\$	1,134,869				\$ 177,670	15						

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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.		\$	70,500	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		\$	96,849	2
3. Under or (over) accrual (line 2 minus line 1).				\$	26,349	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	829,596	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.				\$	855,945	7
Assessed Value from Real Estate Tax Bill:	2024	2,572,259	8			
Real Estate Tax Bill for Calendar Year:	2020	561,886	9			
	2021	729,965	10			
	2022	755,330	11			
	2023	821,900	12			
	2024	1,140,314	13			
Accrual based on prior year tax bill.						
Ryze at Homewood Paid \$96,849 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 Ryze at Homewood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 3000477

CONTACT PERSON REGARDING THIS REPORT Victor Vidal

TELEPHONE (847) 287-5991 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 32-05-400-011-0000	Long Term Property Care	\$ 1,140,313.64	\$ 1,140,313.64
2.			\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,140,313.64	\$ 1,140,313.64

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: 74,542B. General Construction Type: ExteriorFrameNumber of Stories

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

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

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

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

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze at Homewood

3000477

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replace exterior sign			2025	10,727		15	358	358	358	9
10	Install CAT5e cable, (10-12 boxes), jacks, plates, caddy adapters			2025	15,909		15	530	530	530	10
11	Repair water main			2025	127,107		15	4,237	4,237	4,237	11
12	Repair leaking RPZ			2025	5,003		15	167	167	167	12
13	Replaced heat exchanger in RTU			2025	2,975		15	99	99	99	13
14	Replaced circulating pump-heating/cooling system-basement			2025	6,498		15	217	217	217	14
15	Repair the cracked sewer line in the elevator mechanical room			2025	4,156		15	139	139	139	15
16	Replace boiler hand hole gasket			2025	4,337		15	145	145	145	16
17	Install infinity shades throughout building			2025	35,675		15	1,189	1,189	1,189	17
18	Replaced condensor fan motor, blade, and capacitor-admin office RTU			2025	4,280		15	143	143	143	18
19	Saw cut and remove 1,061SF of deteriorated asphalt			2025	8,062		15	269	269	269	19
20	Replaced compressor-A/C			2025	7,290		15	243	243	243	20
21	Installation of key pads for service elevator for 1st and 2nd floors			2025	4,024		15	134	134	134	21
22	Repair power supply/charger-fire alarm			2025	8,396		15	280	280	280	22
23	Furnish and install a new packing seal (passenger elevator)			2025	2,860		15	95	95	95	23
24	Installed magnetic lock and siren for 2nd floor stairwell			2025	2,523		15	84	84	84	24
25	Installed delayed egress electromagnetic lock w/ build-in sounder			2025	2,984		15	99	99	99	25
26	Remove/replace eight (8) pendant sprinkler heads			2025	3,588		15	120	120	120	26
27	Install tile-kitchen			2025	5,400		15	180	180	180	27
28	Bathroom/Shower Upgrade-Install new showers, drains, tile, paint			2025	20,188		15	673	673	673	28
29	lighting, remove tub, plumbing										29
30	Replaced belt and fall out switch on 2 RTU units			2025	2,781		15	93	93	93	30
31	Replaced blower motor and pulley-boiler			2025	4,702		15	157	157	157	31
32											32
33											33
34											34
35											35
36											36

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

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

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	Financial Statement Depreciation			12,267			(12,267)		46
47									47
48									48
49	Allocated from Aliya Healthcare Consulting LLC	2024	5,266		15	351	351	527	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	2,865		15	96	96	96	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)		\$ 297,596	\$ 12,267		\$ 10,098	\$ (2,169)	\$ 10,274	70

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	\$ 38,131	\$ 8,327	\$ 7,626	\$ (701)	5 Yrs	\$ 3,813	71
72	Current Year Purchases	107,164	11,933	5,358	(6,575)	10 Yrs	5,358	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 145,295	\$ 20,260	\$ 12,984	\$ (7,276)		\$ 9,171	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)	\$ 442,891	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,527	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,082	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,445)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 19,445	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:Homewood Mercy Property, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

X

YESNO

If NO, see instructions.

		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:	1976	259	12/1/24	\$821,950	10	10	3
4	Additions							4
5								5
6		Allocated from Home Office			19,163			6
7	TOTAL		259		\$841,113			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/AN/A.
9. Option to Buy:

X

YESNO

Terms: Exercisable after 5 yrs*

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

15. Is Movable equipment rental included in building rental?

X

YESNO
16. Rental Amount for movable equipment: \$35,902Description: 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			575	18
19					19
20					20
21	TOTAL		\$	\$575	21

10. Effective dates of current rental agreement:
Beginning12/1/24
Ending11/30/34

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

	Fiscal Year Ending	Annual Rent
12.	11/30/2026	\$803,400
13.	11/30/2027	\$827,502
14.	11/30/2028	\$852,327

* 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:

Ryze at Homewood

IDPH License ID Number:

3000477

Fiscal Year End:

12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	22,477
Dietary Equipment	3,226
Office Equipment	6,279
Allocated from Home Office	3,920
Total - Line 16	35,902

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	2,972	\$ 138,461	\$	2,972	\$ 138,461	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		742	58,539		742	58,539	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,459	167,316		3,459	167,316	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				100,713		100,713	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(7)	267	11,174				267	11,174	12
13	Other (specify): See Attached Sch 16A	39(3)				27,312			27,312	13
14	TOTAL			\$ 11,174	7,173	\$ 391,628	\$ 100,713	7,440	\$ 503,515	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:

Ryze at Homewood

IDPH License ID Number:

3000477

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	23,414
Radiology	3,898
Total - Line 16	27,312

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (398,214)	\$ (398,214)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 337,630)	2,565,864	2,565,864	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	233,340	233,340	6
7	Other Prepaid Expenses	262,414	262,414	7
8	Accounts Receivable (owners or related parties)	781,429	781,429	8
9	Other(specify): Deposit	400,000	400,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,844,833	\$ 3,844,833	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	288,263	297,596	15
16	Equipment, at Historical Cost	166,253	145,295	16
17	Accumulated Depreciation (book methods)	(32,527)	(19,445)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	963,151	963,151	21
22	Other Long-Term Assets (specify) Loan Costs	55,838	55,838	22
23	Other(specify): Deposits	36,505	36,505	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,477,483	\$ 1,478,940	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,322,316	\$ 5,323,773	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 659,719	\$ 659,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,134,869	1,134,869	29
30	Accrued Salaries Payable	372,485	372,485	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,259	18,259	31
32	Accrued Real Estate Taxes(Sch.IX-B)	829,596	829,596	32
33	Accrued Interest Payable	64,950	64,950	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	61,145	61,145	36
37	Due to Related Party	1,891,790	1,891,790	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,032,813	\$ 5,032,813	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)	\$ 5,032,813	\$ 5,032,813	46
47	TOTAL EQUITY (page 18, line 24)	\$ 289,503	\$ 290,960	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,322,316	\$ 5,323,773	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (11,373)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (11,373)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	300,876	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)	\$ 300,876	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)	\$ 289,503	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze at Homewood

3000477

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	\$ 24,013,235	1
2	Discounts and Allowances for all Levels	(8,413,138)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,600,097	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	134,811	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 134,811	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,617	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,617	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	C.N.A. Initiative/QIP Revenue	405,550	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 405,550	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,162,075	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,081,745	31
32	Health Care	5,956,095	32
33	General Administration	4,246,599	33
	B. Capital Expense		
34	Ownership	1,899,092	34
	C. Ancillary Expense		
35	Special Cost Centers	864,798	35
36	Provider Participation Fee	812,870	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,861,199	40
41	Income before Income Taxes (line 30 minus line 40)**	300,876	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 300,876	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,834,523	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,803,294	45
46	MMAI-Medicaid is the Primary Payer	1,488,254	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	348,246	48
49	Medicare Part A	1,363,733	49
50	Other-(specify) Medicare Replacement	675,536	50
51	Other-(specify) Insurance	86,511	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)	\$ 15,600,097	56

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,834	2,020	\$ 136,149	\$ 67.40	1
2	Assistant Director of Nursing	1,874	1,957	104,352	53.32	2
3	Registered Nurses	17,409	18,241	835,771	45.82	3
4	Licensed Practical Nurses	27,705	29,106	1,216,477	41.79	4
5	CNAs & Orderlies	93,298	100,929	2,475,515	24.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,972	2,036	49,483	24.30	9
10	Activity Assistants	7,495	8,331	172,012	20.65	10
11	Social Service Workers	3,916	4,134	125,445	30.34	11
12	Dietician					12
13	Food Service Supervisor	1,744	1,916	60,895	31.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,172	21,701	390,985	18.02	15
16	Dishwashers					16
17	Maintenance Workers	4,011	4,269	126,093	29.54	17
18	Housekeepers	21,727	24,065	453,858	18.86	18
19	Laundry	3,746	4,085	74,708	18.29	19
20	Administrator	1,776	1,931	123,271	63.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,686	9,302	220,828	23.74	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	1,793	1,889	44,627	23.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Pg 20A</u>	8,941	9,511	333,332	35.05	33
34	TOTAL (lines 1 - 33)	228,099	245,423	\$ 6,943,801 *	\$ 28.29	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	Monthly	41,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	18,383	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	200	L39, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	2,083	L11, C3	44
45	Social Service Consultant	1	35	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	33	\$ 61,701		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	135	\$ 7,758	L10, C3	50
51	Licensed Practical Nurses	165	7,263	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	300	\$ 15,021		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Ryze at Homewood

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	2,541	2,766	124,118	44.87
Admissions Coordinator	1,768	1,948	61,397	31.52
Infection Preventist	1,395	1,435	60,260	41.99
Central Supply	1,546	1,594	38,075	23.89
Transportation	16	16	428	26.75
Staffing Coordinator	1,675	1,752	49,054	28.00
TOTAL	8,941	9,511	333,332	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description	Amount		
Juliet Abram	Administrator	0	\$ 23,343	Workers' Compensation Insurance		\$ 75,587	IDPH License Fee	\$ 1,920		
Aasta James	Administrator	0	78,293	Unemployment Compensation Insurance		76,559	Advertising: Employee Recruitment	31,926		
Louise Mikle	Administrator	0	21,635	FICA Taxes		525,048	Health Care Worker Background Check			
				Employee Health Insurance		117,303	(Indicate # of checks performed 50)	2,231		
				Employee Meals		17,114	Patient Background Checks 522	5,742		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	32,375		
				Pension/401k Expense		12,883	Telemedicine Solutions	3,405		
				Employee Meals/Food/Activities		27,669	Various Licenses & Fees	2,822		
				Uniforms		15,411				
				Other Employee Benefits		19,762	Allocated from Home Office	11,355		
							Less: Public Relations Expense (			
				Allocated from Home Office		62,569	PAC and Lobbying payments	(16,188)		
							All non-allowable advertising (			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,271	TOTAL (agree to Schedule V, line 22, col.8)			\$ 949,905	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description			Line #	Amount	Description	Amount
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			\$ 786,529	N/A					Out-of-State Travel	\$
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			1,067,355							
									In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,853,884							
C. Professional Services										
Vendor/Payee		Type	Amount							
Alyze Healthcare Consulting		Bookkeeping	\$ 178,872							
Roth & Company		Accounting	996							
NYX Health, LLC		Accounting	923							
Waystar		Data Processing	3,861							
Point Click Care		Data Processing	128,094							
Paylocity		Payroll Processing	30,055							
Personnel Planners, Inc		Unemployment Consulting	1,836							
Nancy Given		PBJ Preparation	4,800							
See Legal Attachment		Legal Services	18,204							
See Attached Schedule 21A			105,427							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 473,068	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		
								TOTAL		

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

****See instructions.**

Facility Name: Ryze at Homewood
IDPH License ID Number: 3000477
Fiscal Year End: 12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
AcctZen, LLC	Accounting Services	370
ADDA Infusion	HR Consulting	886
Adelpo	Data Processing	1,920
Allegro Data Solutions	Data Processing	1,176
AR Proactive	Data Processing	4,367
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,300
Certisurv LLC	State Survey Consulting	1,225
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	27,353
CTI III, LLC	Business Consultant	668
DiningRD	EHR Integration	850
Direct Supply	Data Processing	1,602
Guided Care	Data Processing	15,700
Inovalon Provider, Inc.	Data Processing	762
Mega Data Health Systems	Data Processing	5,941
Midwest Care Management Services	Guardianship Consultant	366
Netsmart Technologies	Data Processing	3,588
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	7,782
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	3,839
Reside Admissions	Data Processing	4,772
Sage Intacct, Inc	Data Processing	2,981
Wellsky	Data Processing	6,608
Prior Year Accrual Reversals		(3,000)
Total		105,427

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	16,187
	16,187 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	16,188
	16,188 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	32,375
	32,375 Total
- (5)

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

\$ 53,610

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.

\$ 812,870

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.

\$ 17,114

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$ N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$ N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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