

		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: 0058651

Facility Name: Ryze at the Ridge

Address: 6450 N Ridge Blvd Chicago 60626
Number City Zip Code

County: Cook

Telephone Number: (773) 743-8700 Fax # (773) 743-8700

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2024

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 the Ridge # 0058651 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>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>26</u>	Intermediate (ICF)	<u>26</u>	<u>9,490</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>136</u>	TOTALS	<u>136</u>	<u>49,640</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						1,249	127	1,376	8
9	SNF/PED									9
10	ICF	5,493	35,684	2,691		294			44,162	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,493	35,684	2,691		294	1,249	127	45,538	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.74%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 3/1/2024

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 3/1/2024 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 110

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.

Facility Name & ID Number Ryze at the Ridge # 0058651 Report Period Beginning: 1/1/2025 Ending: 12/31/2025
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	447,568	27,990	1,015	476,573		476,573	51,102	527,675			1
2	Food Purchase		329,553		329,553		329,553		329,553			2
3	Housekeeping	370,007	36,097		406,104		406,104		406,104			3
4	Laundry	94,065	20,383	2,285	116,733		116,733		116,733			4
5	Heat and Other Utilities			177,235	177,235		177,235	730	177,965			5
6	Maintenance	203,603	32,389	88,403	324,395		324,395	21,127	345,522			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			10,720	10,720		10,720	7,184	17,904			7
8	TOTAL General Services	1,115,243	446,412	279,658	1,841,313		1,841,313	80,143	1,921,456			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	3,620,387	164,170	21,908	3,806,465		3,806,465	117,476	3,923,941			10
10a	Therapy											10a
11	Activities	180,895	13,736	6,773	201,404		201,404		201,404			11
12	Social Services	263,527		2,363	265,890		265,890	4,815	270,705			12
13	CNA Training											13
14	Program Transportation			19,035	19,035		19,035		19,035			14
15	Other (specify):* Mgmt Alloc of Benefits							15,865	15,865			15
16	TOTAL Health Care and Programs	4,064,809	177,906	65,079	4,307,794		4,307,794	138,156	4,445,950			16
	C. General Administration											
17	Administrative	188,532		1,137,576	1,326,108		1,326,108	(1,078,227)	247,881			17
18	Directors Fees											18
19	Professional Services			336,872	336,872		336,872	(119,617)	217,255			19
20	Dues, Fees, Subscriptions & Promotions			61,742	61,742		61,742	(3,607)	58,135			20
21	Clerical & General Office Expenses	222,068	9,881	40,007	271,956		271,956	367,077	639,033			21
22	Employee Benefits & Payroll Taxes			747,150	747,150		747,150	32,854	780,004			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			4,859	4,859		4,859	507	5,366			24
25	Other Admin. Staff Transportation			5,240	5,240		5,240	12,851	18,091			25
26	Insurance-Prop.Liab.Malpractice			307,601	307,601		307,601	4,963	312,564			26
27	Other (specify):* Mgmt Alloc of Benefits							59,895	59,895			27
28	TOTAL General Administration	410,600	9,881	2,643,488	3,063,969		3,063,969	(723,304)	2,340,665			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,590,652	634,199	2,988,225	9,213,076		9,213,076	(505,005)	8,708,071			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			33,506	33,506		33,506	25,069	58,575			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,492	23,492		23,492	45,452	68,944			32
33	Real Estate Taxes			437,295	437,295		437,295		437,295			33
34	Rent-Facility & Grounds			940,406	940,406		940,406	(28,994)	911,412			34
35	Rent-Equipment & Vehicles			14,965	14,965		14,965	2,360	17,325			35
36	Other (specify):*											36
37	TOTAL Ownership			1,449,664	1,449,664		1,449,664	43,887	1,493,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,138	258,644	297,782		297,782	6,650	304,432			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			782,918	782,918		782,918		782,918			42
43	Other (specify):* Disallowed Costs		13,971	256,505	270,476		270,476	(270,476)				43
44	TOTAL Special Cost Centers		53,109	1,298,067	1,351,176		1,351,176	(263,826)	1,087,350			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,590,652	687,308	5,735,956	12,013,916		12,013,916	(724,944)	11,288,972			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	(7,090)	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	1,876	30		9
10	Interest and Other Investment Income	(9,562)	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	(18,568)	43		18
19	Entertainment				19
20	Contributions	(3)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(230,844)	43		24
25	Fund Raising, Advertising and Promotional	(13,971)	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	(1,611)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (279,773)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(445,171)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (445,171)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (724,944)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (9,570)	20
2	Other Expenses Related to Lobbying Activities		
3			
4	Adjust Owner Wages to Allowable	(6,554)	17
5	Expense Minor Fixed Assets below \$2,500	3,277	1
6	Expense Minor Fixed Assets below \$2,500	13,869	6
7	Expense Minor Fixed Assets below \$2,500	3,331	10
8	Expense Minor Fixed Assets below \$2,500	1,657	21
9	Offset Miscellaneous Income against Expense	(5)	21
10	Out of State Travel (Allocated from Home Office)	(3,717)	24
11	Out of State Seminar (Allocated from Home Office)	(3,899)	25
12			
13			
14			
15			
16			
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41			
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47			
48			
49	Total	(1,611)	

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	\$	Ridge SNF Property LLC		\$ 23,193	\$ 23,193	1
2	V	32	Interest		Ridge SNF Property LLC		32,500	32,500	2
3	V	32	Amortization of Loan Costs		Ridge SNF Property LLC		146	146	3
4	V	34	Rent-Facility & Grounds	39,056	Ridge SNF Property LLC			(39,056)	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			\$ 39,056			\$ 55,839	\$ * 16,783	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	\$	Aliya Healthcare Consulting LLC		\$ 730	\$ 730	15
16	V	6	Maintenance		Aliya Healthcare Consulting LLC		1,216	1,216	16
17	V	17	Administrative	577,111	Aliya Healthcare Consulting LLC		65,903	(511,208)	17
18	V	19	Professional Services		Aliya Healthcare Consulting LLC		12,543	12,543	18
19	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		5,958	5,958	19
20	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		15,042	15,042	20
21	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		32,854	32,854	21
22	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		4,089	4,089	22
23	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		8,491	8,491	23
24	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		4,926	4,926	24
25	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		13,372	13,372	25
26	V	32	Interest		Aliya Healthcare Consulting LLC		22,368	22,368	26
27	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		10,062	10,062	27
28	V	35	Rent-Equipment & Vehicles		Aliya Healthcare Consulting LLC		2,058	2,058	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			\$ 577,111			\$ 199,612	\$ * (377,499)	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. ☒ 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		\$ 47,825	\$ 47,825	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		6,042	6,042	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		7,184	7,184	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		114,145	114,145	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		4,815	4,815	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		15,865	15,865	20
21	V	17	Administrative	560,465	Alyze Healthcare Consulting LLC		0	(560,465)	21
22	V	19	Professional Services	132,985	Alyze Healthcare Consulting LLC		825	(132,160)	22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		5	5	23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		350,383	350,383	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		135	135	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		8,259	8,259	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		37	37	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		46,523	46,523	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		302	302	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		5,867	5,867	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		783	783	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 693,450			\$ 608,995	\$ * (84,455)	39

STATE OF ILLINOIS

Ownership Listing-1

Ryze at the Ridge

ID#0058651

Report Period Beginning:1/1/2025

Ending:12/31/2025

Aliya Healthcare Consu

Ridge SNF Property LLC

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Co./Home Office

Management

Ownership Percentage

Ownership Percentage

Place of Residence

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1DvorahSWeinfeldChicagoIL46.8139546.8139575.500001

2AvrumPWeinfeldChicagoIL12.1500012.150002

3MosheMERlichLincolnwoodIL13.2435013.2435015.000003

4JordanEReiferLincolnwoodIL8.464508.464505.000004

5RebeccaRKohnLincolnwoodIL0.180430.180432.499755

6HenryNGKohnLincolnwoodIL0.000460.000460.000636

7OliverNGKohnLincolnwoodIL0.000460.000460.000637

8LillianNGKohnLincolnwoodIL0.000460.000460.000638

9GeorgeNGKohnLincolnwoodIL0.000460.000460.000639

10NesanelBDavisChicagoIL0.072900.072901.0000010

11SamNGWassermanChicagoIL0.072900.072901.0000011

12EphraimYCohenLincolnwoodIL2.500002.5000012

13AaronDKraftLincolnwoodIL1.000001.0000013

14CarrieAEcksteinBergenfieldNJ1.000001.0000014

15EileenFKraftBaltimoreMD1.000001.0000015

16AviNGSchechterSurfsideFL5.000005.0000016

17EliNGWebsterChicagoIL3.000003.0000017

18MarshallNGMeyersChicagoIL3.000003.0000018

19ShaiYBerdugoLincolnwoodIL2.500002.5000019

2020

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6161

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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		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		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			
2	Aliya of Evanston	Evanston, IL			Consulting LLC	Skokie, IL	Management Co	
3	Aliya of Glenwood	Glenwood, IL			Alyze Healthcare			
4	Aliya of Highwood	Highwood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	
5	Aliya of Homewood	Homewood, IL			Aliya of Palos Park			
6	Aliya of Oak Lawn	Oak Lawn, IL			ILF LLC	Palos Park, IL	Independent Living	
7	Aliya of Palatine	Palatine, IL			Wrightwood 87th			
8	Aliya of Palos Park	Palos Park, IL			SNF Property LLC	Skokie, IL	Lessor	
9	Aliya on 87th	Chicago, IL			Avenue SNF			
10	Ryze at Homewood	Homewood, IL			Property LLC	Skokie, IL	Lessor	
11	Ryze on the Avenue	Chicago, IL			West SNF			
12	Ryze West	Chicago, IL			Property LLC	Skokie, IL	Lessor	
13					Evanston SNF			
14					Property LLC	Skokie, IL	Lessor	
15					Highwood SNF			
16					Property LLC	Skokie, IL	Lessor	
17					Ridge SNF			
18					Property LLC	Skokie, IL	Lessor	
19					Palos SNF			
20					Property LLC	Skokie, IL	Lessor	
21					Illuminate Hospice LL	Oakbrook Terrace, IL	Hospice	
22								
23								
24								
25								
26								
27								
28								
29								
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	2.46	6.15	Salary	\$ 14,173	L17,C7	1
2	Moshe Erlich	CIO	Administrative	15.00	See Att Sch P7A	2.46	6.15	Salary	14,173	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	\$ 28,346		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 the Ridge # 0058651 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	\$	49,640	\$ 730	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		49,640	1,216	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	49,640	65,903	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		49,640	12,543	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		49,640	5,958	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	49,640	15,042	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		49,640	32,854	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		49,640	4,089	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		49,640	8,491	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		49,640	4,926	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		49,640	13,372	11
12	32	Interest	Available Bed Days	805,555	13	362,992		49,640	22,368	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		49,640	10,062	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		49,640	2,058	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		\$ 199,612	25

Facility Name & ID Number Ryze at the Ridge # 0058651 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	136	\$ 47,825	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	136	6,042	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		136	7,184	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	136	114,145	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	136	4,815	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		136	15,865	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		136	825	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		136	5	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	136	350,383	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		136	135	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		136	8,259	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		136	37	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		136	46,523	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		136	302	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	136	5,867	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		136	783	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,558,836	\$ 9,157,901		\$ 608,995	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Monticello AM		X	Mortgage	Varies	12/17/25	\$ 9,280,000	\$ 9,280,000	12/17/27	0.0750	\$ 32,500	1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6	Optimum		X	Working Capital		5/3/24			5/23/25	0.1050	7,775	6		
7												7		
8												8		
9	TOTAL Facility Related						\$ 9,280,000	\$ 9,280,000			\$ 40,275	9		
	B. Non-Facility Related*													
10								Amortization of Loan Costs			15,863	10		
11								Offset Interest Income			(9,562)	11		
12								Allocated from Home Office			22,368	12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$ 28,669	14		
15	TOTALS (line 9+line14)						\$ 9,280,000	\$ 9,280,000			\$ 68,944	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.		\$	300,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024		\$	321,205	2
3. Under or (over) accrual (line 2 minus line 1).				\$	21,205	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	416,090	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.				\$	437,295	7
Assessed Value from Real Estate Tax Bill:	2024	1,912,250	8			
Real Estate Tax Bill for Calendar Year:	2020	272,712	9			
	2021	264,414	10			
	2022	315,001	11			
	2023	404,528	12			
	2024	384,186	13			
Accrual based on prior year tax bill.						
The Taxes Paid Above on Line 2 Consist of 2 Payment out of Escrow of \$186,017 and \$135,188						

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 the Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0058651

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. 11-31-401-068-0000	Long Term Care Property	\$ 77,833.08	\$ 77,833.08
2. 11-31-401-088-0000	Long Term Care Property	\$ 306,352.82	\$ 306,352.82
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 384,185.90	\$ 384,185.90

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: 29,742 B. General Construction Type: Exterior Brick Frame Number of Stories 3

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

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

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

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

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

1. Total Amount Incurred: 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	Nursing Home		2025	\$ 1,120,000	1
2					2
3	TOTALS			\$ 1,120,000	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	136		2025		\$ 6,720,000	\$	25	\$ 22,400	\$ 22,400	\$ 22,400
5										
6										
7										
8										
	Improvement Type**									
9	Refurbish Canvas Awning			2024	7,817		15	521	521	782
10	Connect existing relays in each elevator machine room			2024	5,924		15	395	395	592
11	Install Closet Doors/Cabinets-Resident Rooms			2024	20,900		15	1,393	1,393	2,090
12	Reroute water lines and repair mixing valve on hot water heater			2024	15,000		15	1,000	1,000	1,500
13	Install new fire alarm conduit and wiring for three (3) new sprinkler tamp			2024	5,242		15	349	349	524
14	Repair Electric Panel-3rd Floor South			2024	3,141		15	209	209	314
15	Pipe Insulation Repair			2024	2,900		15	193	193	290
16	Replaced fire dampers			2024	12,451		15	830	830	1,245
17	Install Doors, Frames and Kick Plates			2024	7,290		15	486	486	729
18	Elevator shunt strip repair			2024	5,624		15	375	375	562
19	Replaced recirculation pump for domestic storage tanks			2024	3,281		15	219	219	328
20	Installed RPZ by slop sink			2025	5,247		15	175	175	175
21	Installed transponder indicator circuit card			2025	2,854		15	95	95	95
22	Installed metal wall mount speaker			2025	5,874		15	196	196	196
23	Installed security system			2025	9,747		15	325	325	325
24	Installed RPZ to the dishwashing chemical dispensers			2025	3,500		15	117	117	117
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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			7,753			(7,753)		46
47									47
48									48
49	Allocated from Aliya Healthcare Consulting LLC	2024	2,765		15	184	184	276	49
50	Allocated from Aliya Healthcare Consulting LLC	2025	1,504		15	50	50	50	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)		\$ 6,841,061	\$ 7,753		\$ 29,512	\$ 21,759	\$ 32,590	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	\$ 73,512	\$ 17,266	\$ 7,351	\$ (9,915)	10 Yrs	\$ 11,027	71
72	Current Year Purchases	2,300,898	8,487	21,712	13,225	10 Yrs	21,712	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,374,410	\$ 25,753	\$ 29,063	\$ 3,310		\$ 32,739	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)	\$ 10,335,471	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,506	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,575	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,069	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 65,329	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:

West Ridge Propco LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	136	3/1/24	\$891,750	5	5	3
4	Additions							4
5		Parking Spaces (8)			9,600			5
6		Allocated from Home Office			10,062			6
7	TOTAL		136		\$911,412			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

N/A

N/A

9. Option to Buy:

☒ X

 YES

☐

 NO

Terms: Purchased Facility in Dec 2025

*

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

15. Is Movable equipment rental included in building rental?

☒ X YES☐ NO
16. Rental Amount for movable equipment: \$17,023

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					18
19	Allocated from Home Office			302	19
20					20
21	TOTAL		\$	\$302	21

10. Effective dates of current rental agreement:

Beginning3/1/24

Ending2/28/29

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

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

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

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

Facility Name:

Ryze at the Ridge

IDPH License ID Number:

0058651

Fiscal Year End:

12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	1,047
Office Equipment	13,918
Allocated from Home Office	2,058
Total - Line 16	17,023

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	\$	3,558	\$ 104,001	\$	3,558	\$ 104,001	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		414	27,658		414	27,658	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		3,903	119,001	44	3,903	119,045	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				39,094		39,094	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(7)	140	5,867				140	5,867	12
13	Other (specify): See Attached Sch 16A	39(3)				7,984			7,984	13
14	TOTAL			\$ 5,867	7,875	\$ 258,644	\$ 39,138	8,015	\$ 303,649	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 the Ridge

IDPH License ID Number: 0058651

Fiscal Year End: 12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	6,305
Radiology	1,679
Total - Line 16	7,984

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	\$ (287,891)	\$ (287,891)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 417,278)	1,443,810	1,443,810	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	126,508	126,508	6
7	Other Prepaid Expenses	12,966	12,966	7
8	Accounts Receivable (owners or related parties)	9,079,901	9,079,901	8
9	Other(specify): Deposit	35,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,410,294	\$ 10,375,294	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,120,000	13
14	Buildings, at Historical Cost		6,720,000	14
15	Leasehold Improvements, at Historical Cost	130,424	121,061	15
16	Equipment, at Historical Cost	175,433	2,374,410	16
17	Accumulated Depreciation (book methods)	(43,388)	(65,329)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	507,698	798,197	21
22	Other Long-Term Assets (specify) Loan Costs/Goodwill		1,331,138	22
23	Other(specify): Deposits	100,000	100,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 870,167	\$ 12,499,477	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,280,461	\$ 22,874,771	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 280,398	\$ 280,398	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	471,144	471,144	30
31	Accrued Taxes Payable (excluding real estate taxes)	52,691	52,691	31
32	Accrued Real Estate Taxes(Sch.IX-B)	416,090	416,090	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	70,388	31,332	36
37	Due to Related Party	6,758,379	6,758,379	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,049,090	\$ 8,010,034	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,280,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Net LT Lease Liability	106,131	106,131	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 106,131	\$ 9,386,131	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,155,221	\$ 17,396,165	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,125,240	\$ 5,478,606	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,280,461	\$ 22,874,771	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,141,442	1
2	Restatements (describe):		2
3	Rent Expense	(106,131)	3
4	Depreciation Expense	(9,881)	4
5	Rounding	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,025,431	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	99,809	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)	\$ 99,809	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)	\$ 3,125,240	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze at the Ridge

0058651

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	\$ 14,840,271	1
2	Discounts and Allowances for all Levels	(3,407,545)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,432,726	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	136,704	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 136,704	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	280	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,759	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)	\$ 2,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,562	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,562	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5	28
28a	C.N.A. Initiative/QIP Revenue	532,689	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 532,694	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,113,725	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,841,313	31
32	Health Care	4,307,794	32
33	General Administration	3,063,969	33
	B. Capital Expense		
34	Ownership	1,449,664	34
	C. Ancillary Expense		
35	Special Cost Centers	568,258	35
36	Provider Participation Fee	782,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,013,916	40
41	Income before Income Taxes (line 30 minus line 40)**	99,809	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 99,809	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,288,546	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	8,370,740	45
46	MMAI-Medicaid is the Primary Payer	631,254	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	88,200	48
49	Medicare Part A	929,739	49
50	Other-(specify) Medicare Replacement	119,322	50
51	Other-(specify) Insurance	4,925	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)	\$ 11,432,726	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	2,566	2,622	\$ 151,969	\$ 57.96	1
2	Assistant Director of Nursing	1,703	1,816	87,611	48.24	2
3	Registered Nurses	14,627	15,490	699,863	45.18	3
4	Licensed Practical Nurses	24,200	25,465	1,034,878	40.64	4
5	CNAs & Orderlies	51,621	55,661	1,374,523	24.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,728	1,840	43,920	23.87	9
10	Activity Assistants	6,493	7,006	136,975	19.55	10
11	Social Service Workers	6,677	6,957	192,117	27.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,144	61,907	28.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,115	19,432	385,661	19.85	15
16	Dishwashers					16
17	Maintenance Workers	5,936	6,240	145,120	23.26	17
18	Housekeepers	16,315	18,190	370,007	20.34	18
19	Laundry	3,534	4,056	94,065	23.19	19
20	Administrator	3,000	3,328	171,920	51.66	20
21	Assistant Administrator	424	440	16,612	37.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,432	8,930	222,068	24.87	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	1,932	2,044	47,944	23.46	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Pg 20A</u>	12,896	13,483	353,492	26.22	33
34	TOTAL (lines 1 - 33)	182,279	195,144	\$ 5,590,652 *	\$ 28.65	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	15,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	19,617	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	97	6,773	L11, C3	44
45	Social Service Consultant	34	2,363	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	131	\$ 43,753		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.

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

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	1,952	2,080	96,070	46.19
Infection Preventist	336	344	15,474	44.98
Security	2,845	2,905	58,483	20.13
Transportation	3,672	3,815	71,410	18.72
Central Supply	1,888	2,080	49,152	23.63
Staffing Coordinator	2,203	2,259	62,903	27.85
TOTAL	12,896	13,483	353,492	

Facility Name & ID Number		Ryze at the Ridge		STATE OF ILLINOIS		Report Period Beginning:		1/1/2025		Page 21			
				# 0058651				Ending:		12/31/2025			
XIX. SUPPORT SCHEDULES													
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		Ownership %		Amount		Description		Amount			
Dovber Emanuel		Administrator		0		\$ 122,975		Workers' Compensation Insurance		\$ 30,514			
Samantha Mocka		Administrator		0		48,945		Unemployment Compensation Insurance		40,907			
Samantha Mocka		Asst Administrator		0		3,077		FICA Taxes		424,080			
Brittany Ward		Asst Administrator		0		13,535		Employee Health Insurance		175,391			
								Employee Meals		5,948			
								Illinois Municipal Retirement Fund (IMRF)*					
								Pension/401k Expense		31,493			
								Employee Meals/Food/Activities		18,505			
								Uniforms		6,451			
								Other Employee Benefits		13,861			
								Allocated from Home Office		32,854			
								TOTAL (agree to Schedule V, line 22, col.8)		\$ 780,004			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 188,532							
B. Administrative - Other													
Description						Amount							
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7						\$ 577,111							
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7						560,465							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)						\$ 1,137,576		E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
C. Professional Services													
Vendor/Payee		Type				Amount		Description		Line # Amount			
Alyze Healthcare Consulting		Bookkeeping				\$ 132,985		N/A					
Templin Healthcare Accounting		Accounting				5,926							
Roth & Company		Accounting				15,996							
NYX Health, LLC		Accounting				923							
Waystar		Data Processing				3,861							
Point Click Care		Data Processing				65,519							
Paylocity		Payroll Processing				21,513							
Personnel Planners, Inc		Unemployment Consulting				855							
Nancy Given		PBJ Preparation				4,800							
See Legal Attachment		Legal Services				19,962							
See Attached Schedule 21A						64,532							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)						\$ 336,872		TOTAL		\$			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Ryze at the Ridge

IDPH License ID Number: 0058651

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	588
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,600
Certisurv LLC	State Survey Consulting	800
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	22,324
CTI III, LLC	Business Consultant	667
DiningRD	EHR Integration	850
Direct Supply	Data Processing	1,688
Guided Care	Data Processing	12,759
Inovalon Provider, Inc.	Data Processing	762
Medicaid Done Right LLC	Billing Consultant	600
Mega Data Health Systems	Data Processing	6,361
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	6,649
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	4,188
Reside Admissions	Data Processing	4,082
Sage Intacct, Inc	Data Processing	2,924
Wellsky	Data Processing	7,632
Prior Year Accrual Reversals		(35,935)
Total		64,532

XX. GENERAL INFORMATION:

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

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	9,570
	9,570 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	9,570
	9,570 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	19,140
	19,140 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	14,782	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.

\$	782,918
----	---------

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.

\$	5,948	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.