

		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: 0058016

Facility Name: Ryze on the Avenue

Address: 3400 S Indiana Ave Chicago 60616

County: Cook

Telephone Number: (312) 842-5000 Fax #: (312) 842-3790

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

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

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze on the Avenue # 0058016 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>302</u>	Skilled (SNF)	<u>302</u>	<u>110,230</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>302</u>	TOTALS	<u>302</u>	<u>110,230</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						2,664	2,497	5,161	8
9	SNF/PED									9
10	ICF	13,948	61,381	3,854		1,111		3,053	83,347	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	13,948	61,381	3,854		1,111	2,664	5,550	88,508	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 80.29%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 6/1/23

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 302

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	766,205	59,043	4,515	829,763		829,763	107,842	937,605			1
2	Food Purchase		620,529		620,529		620,529		620,529			2
3	Housekeeping	461,102	74,008		535,110		535,110		535,110			3
4	Laundry	152,318	45,002	5,257	202,577		202,577		202,577			4
5	Heat and Other Utilities			422,109	422,109		422,109	1,620	423,729			5
6	Maintenance	196,763	76,751	151,626	425,140		425,140	36,781	461,921			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			31,576	31,576		31,576	15,953	47,529			7
8	TOTAL General Services	1,576,388	875,333	615,083	3,066,804		3,066,804	162,196	3,229,000			8
	B. Health Care and Programs											
9	Medical Director			34,863	34,863		34,863		34,863			9
10	Nursing and Medical Records	7,534,429	447,062	40,430	8,021,921		8,021,921	258,658	8,280,579			10
10a	Therapy											10a
11	Activities	256,554	18,006	403	274,963		274,963		274,963			11
12	Social Services	400,078		7,333	407,411		407,411	10,692	418,103			12
13	CNA Training			1,650	1,650		1,650		1,650			13
14	Program Transportation			50,946	50,946		50,946		50,946			14
15	Other (specify):* Mgmt Alloc of Benefits							35,230	35,230			15
16	TOTAL Health Care and Programs	8,191,061	465,068	135,625	8,791,754		8,791,754	304,580	9,096,334			16
	C. General Administration											
17	Administrative	192,972		2,515,628	2,708,600		2,708,600	(2,383,838)	324,762			17
18	Directors Fees											18
19	Professional Services			653,519	653,519		653,519	(232,467)	421,052			19
20	Dues, Fees, Subscriptions & Promotions			106,015	106,015		106,015	(13,033)	92,982			20
21	Clerical & General Office Expenses	360,674	37,244	88,043	485,961		485,961	813,776	1,299,737			21
22	Employee Benefits & Payroll Taxes			1,778,663	1,778,663		1,778,663	72,956	1,851,619			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			1,389	1,389		1,389	1,123	2,512			24
25	Other Admin. Staff Transportation			8,391	8,391		8,391	28,396	36,787			25
26	Insurance-Prop.Liab.Malpractice			732,952	732,952		732,952	11,019	743,971			26
27	Other (specify):* Mgmt Alloc of Benefits							133,005	133,005			27
28	TOTAL General Administration	553,646	37,244	5,887,041	6,477,931		6,477,931	(1,569,063)	4,908,868			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,321,095	1,377,645	6,637,749	18,336,489		18,336,489	(1,102,287)	17,234,202			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			101,841	101,841		101,841	677,320	779,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,845	113,845		113,845	2,346,586	2,460,431			32
33	Real Estate Taxes			996,500	996,500		996,500		996,500			33
34	Rent-Facility & Grounds			1,718,419	1,718,419		1,718,419	(1,696,074)	22,345			34
35	Rent-Equipment & Vehicles			13,605	13,605		13,605	5,242	18,847			35
36	Other (specify):* Closing/Loan Costs			5,662	5,662		5,662		5,662			36
37	TOTAL Ownership			2,949,872	2,949,872		2,949,872	1,333,074	4,282,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		227,156	714,988	942,144		942,144	14,768	956,912			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,636,859	1,636,859		1,636,859		1,636,859			42
43	Other (specify):* Disallowed Costs	3,171	27,694	632,721	663,586		663,586	(663,586)				43
44	TOTAL Special Cost Centers	3,171	254,850	2,984,568	3,242,589		3,242,589	(648,818)	2,593,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,324,266	1,632,495	12,572,189	24,528,950		24,528,950	(418,031)	24,110,919			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,553)	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	677,320	30		9
10	Interest and Other Investment Income	(44,009)	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	(93,085)	43		18
19	Entertainment				19
20	Contributions	(225)	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	(508,931)	43		24
25	Fund Raising, Advertising and Promotional	(27,694)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,031)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(34,144)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,352)		\$	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)	(359,679)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (359,679)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (418,031)		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	\$ (26,274)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable Amount	(14,554)	17	4
5	Expense Minor Fixed Assets Below \$2,500	1,640	1	5
6	Expense Minor Fixed Assets Below \$2,500	20,662	6	6
7	Expense Minor Fixed Assets Below \$2,500	5,191	10	7
8	Expense Minor Fixed Assets Below \$2,500	2,352	21	8
9	Marketing Director Wages	(3,171)	43	9
10	Collection Agency Fees	(2,896)	43	10
11	Offset Miscellaneous Income Against Expense	(39)	21	11
12	Nonallowabe Travel Expenses	(143)	25	12
13	Out of State Travel (Allocated from Home Office)	(8,253)	24	13
14	Out of State Seminar (Allocated from Home Office)	(8,659)	25	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(34,144)		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	\$	Avenue SNF Property LLC		\$ 1,887,270	\$ 1,887,270	1
2	V	32	Amortization of Loan Costs		Avenue SNF Property LLC		453,654	453,654	2
3	V	34	Rent-Facility & Grounds	1,718,419	Avenue SNF Property LLC			(1,718,419)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,718,419			\$ 2,340,924	\$ * 622,505	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		\$ 1,620	\$ 1,620	15
16	V	6	Maintenance		Aliya Healthcare Consulting LLC		2,700	2,700	16
17	V	17	Administrative	1,271,067	Aliya Healthcare Consulting LLC		146,344	(1,124,723)	17
18	V	19	Professional Services		Aliya Healthcare Consulting LLC		27,853	27,853	18
19	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		13,230	13,230	19
20	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		33,402	33,402	20
21	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		72,956	72,956	21
22	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		9,077	9,077	22
23	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		18,856	18,856	23
24	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		10,939	10,939	24
25	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		29,695	29,695	25
26	V	32	Interest		Aliya Healthcare Consulting LLC		49,671	49,671	26
27	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		22,345	22,345	27
28	V	35	Rent-Equipment & Vehicles		Aliya Healthcare Consulting LLC		4,572	4,572	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,271,067			\$ 443,260	\$ * (827,807)	39

VII. RELATED PARTIES (continued)

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

☒ 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		\$ 106,202	\$ 106,202	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		13,419	13,419	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		15,953	15,953	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		253,467	253,467	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		10,692	10,692	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		35,230	35,230	20
21	V	17	Administrative	1,244,561	Alyze Healthcare Consulting LLC		0	(1,244,561)	21
22	V	19	Professional Services	262,152	Alyze Healthcare Consulting LLC		1,832	(260,320)	22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		11	11	23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		778,061	778,061	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		299	299	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		18,342	18,342	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		80	80	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		103,310	103,310	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		670	670	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		13,030	13,030	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,738	1,738	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,506,713			\$ 1,352,336	\$ * (154,377)	39

STATE OF ILLINOIS					Ownership Listing-1				
Ryze on the Avenue					Aliya Healthcare Consu Avenue SNF Property LLC				
ID#		0058016							
Report Period Beginning:		1/1/2025							
Ending:		12/31/2025							
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management				
-Owners of companies must be listed instead of company names.					Operator/Licensee				
-Names of trust beneficiaries must be listed.					Building Co.				
Place of Residence					Ownership Percentage				
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Co./Home Office	Ownership Percentage
1	Dvorah	S	Weinfeld	Chicago	IL	48.70520	53.46038	75.50000	1
2	Avrum	P	Weinfeld	Chicago	IL	14.32510	13.87500		2
3	Moshe	M	Erlich	Lincolnwood	IL	14.32510	15.12375	15.00000	3
4	Jordan	E	Reifer	Lincolnwood	IL	9.55000	9.66625	5.00000	4
5	Rebecca	R	Kohn	Lincolnwood	IL	4.72725	0.20604	2.49975	5
6	Henry	NG	Kohn	Lincolnwood	IL	0.01194	0.00052	0.00063	6
7	Oliver	NG	Kohn	Lincolnwood	IL	0.01194	0.00052	0.00063	7
8	Lillian	NG	Kohn	Lincolnwood	IL	0.01194	0.00052	0.00063	8
9	George	NG	Kohn	Lincolnwood	IL	0.01194	0.00052	0.00063	9
10	Nesanel	B	Davis	Chicago	IL	1.91000	0.08325	1.00000	10
11	Sam	NG	Wasserman	Chicago	IL	1.91000	0.08325	1.00000	11
12	Ephraim	Y	Cohen	Lincolnwood	IL	2.99970	3.00000		12
13	Aaron	D	Kraft	Lincolnwood	IL	0.49997	0.50000		13
14	Carrie	A	Eckstein	Bergenfield	NJ	0.49997	0.50000		14
15	Eileen	F	Kraft	Baltimore	MD	0.49997	0.50000		15
16	Avi	NG	Schechter	Surfside	FL		3.00000		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
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72									72
73									73
74									74
75									75

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Aliya of Crestwood	Crestwood, IL			Aliya Healthcare			1
2	Aliya of Evanston	Evanston, IL			Consulting LLC	Skokie, IL	Management Co	2
3	Aliya of Glenwood	Glenwood, IL			Alyze Healthcare			3
4	Aliya of Highwood	Highwood, IL			Consulting LLC	Skokie, IL	Bookkeeping Co.	4
5	Aliya of Homewood	Homewood, IL			Aliya of Palos Park			5
6	Aliya of Oak Lawn	Oak Lawn, IL			ILF LLC	Palos Park, IL	Independent Living	6
7	Aliya of Palatine	Palatine, IL			Wrightwood 87th			7
8	Aliya of Palos Park	Palos Park, IL			SNF Property LLC	Skokie, IL	Lessor	8
9	Aliya on 87th	Chicago, IL			Avenue SNF			9
10	Ryze at Homewood	Homewood, IL			Property LLC	Skokie, IL	Lessor	10
11	Ryze at the Ridge	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	5.47	13.68	Salary	\$ 31,473	L17,C7	1
2	Moshe Erlich	CIO	Administrative	14.3251	See Att Sch P7A	5.47	13.68	Salary	31,473	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	\$ 62,946		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 on the Avenue # 0058016 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	\$	110,230	\$ 1,620	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		110,230	2,700	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	110,230	146,344	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		110,230	27,853	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		110,230	13,230	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	110,230	33,402	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		110,230	72,956	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		110,230	9,077	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		110,230	18,856	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		110,230	10,939	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		110,230	29,695	11
12	32	Interest	Available Bed Days	805,555	13	362,992		110,230	49,671	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		110,230	22,345	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		110,230	4,572	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		\$ 443,260	25

Facility Name & ID Number Ryze on the Avenue # 0058016 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	302	\$ 106,202	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	302	13,419	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		302	15,953	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	302	253,467	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	302	10,692	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		302	35,230	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		302	1,832	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		302	11	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	302	778,061	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		302	299	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		302	18,342	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		302	80	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		302	103,310	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		302	670	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	302	13,030	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		302	1,738	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,558,836	\$ 9,157,901		\$ 1,352,336	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	10/1/24	\$	16,157,654	11/26/28	0.0790	\$	1,887,270	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Monticello AM		X	Working Capital								100,818	6
7													7
8													8
9	TOTAL Facility Related						\$	16,157,654			\$	1,988,088	9
	B. Non-Facility Related*												
10								Amortization of Loan Costs				466,681	10
11								Offset Interest Income				(44,009)	11
12								Allocated from Home Office				49,671	12
13													13
14	TOTAL Non-Facility Related						\$				\$	472,343	14
15	TOTALS (line 9+line14)						\$	16,157,654			\$	2,460,431	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.		\$	1,261,995	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		\$	883,253	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(378,742)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	1,375,242	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.				\$	996,500	7
Assessed Value from Real Estate Tax Bill:	2024	4,380,250	8			
Real Estate Tax Bill for Calendar Year:	2020	718,729	9			
	2021	1,272,114	10			
	2022	1,301,343	11			
	2023	917,501	12			
	2024	883,253	13			
Accrual based on prior year tax bill.						
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ryze on the Avenue COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0058016

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. 17-34-119-048-0000	Long Term Care Property	\$ 284,354.92	\$ 284,354.92
2. 17-34-119-049-0000	Long Term Care Property	\$ 598,898.09	\$ 598,898.09
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 883,253.01	\$ 883,253.01

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.

A. Square Feet: 72,844

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

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 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	80,457	2024	\$ 1,400,000	1
2					2
3	TOTALS	80,457		\$ 1,400,000	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	302		2024	1977	\$ 13,890,000	\$	25	\$ 555,600	\$ 555,600	\$ 694,500
5										
6										
7										
8										
	Improvement Type**									
9	Install Sewage Pumps			2023	4,070		15	271	271	678
10	Install Exterior Sign			2023	6,974		15	465	465	1,162
11	Replaced 22 Sprinkler Heads in Kitchen			2023	8,606		15	574	574	1,435
12	Replace Ejector Pump			2023	38,820		15	2,588	2,588	6,470
13	Replace Kitchen/Laundry Water Heater			2023	17,000		15	1,133	1,133	2,833
14	Replace Boiler			2023	94,921		15	6,328	6,328	15,820
15	Repair Boiler-Installed New Controller and Terminated Wiring			2023	8,834		15	589	589	1,472
16	Repair Make-up Air Units			2023	5,981		15	399	399	997
17	Repair Circulating Pump-Basement			2023	7,928		15	529	529	1,322
18	Repair Exhaust Fan			2023	2,541		15	169	169	423
19	Repair Leak in Kitchen-Shut Off Valve			2023	3,258		15	217	217	543
20	Replaced mixing valve on hot water heater			2024	14,535		15	969	969	1,454
21	Install new Evaporator/Condensing Coil Assembly-walk in cooler			2024	12,500		15	833	833	1,250
22	Remove/replace shower ceiling, tiles, decking, concrete and drain			2024	12,033		15	802	802	1,203
23	Repair Hot Water Heater			2024	8,685		15	579	579	869
24	Repiped/Repaired leaks on Hot Water Heater in Laundry area			2024	4,467		15	298	298	447
25	Repair roof top motor that control exhaust fans			2024	3,640		15	243	243	364
26	Repaired plumbing riser and added purge point			2024	4,343		15	290	290	435
27	Replace mercoird switch on jockey pump,Replace one 4" control valve			2024	12,460		15	831	831	1,246
28	Installed all new exhaust fans			2024	8,629		15	575	575	863
29	Replace valve on jockey pump			2024	7,266		15	484	484	726
30	Repair door detector on elevator			2024	12,750		15	850	850	1,275
31	30 new LED overbed fixtures			2024	5,036		15	336	336	504
32	Installed line voltage wiring for Tower Fan Motor Starter and replaced L			2024	3,606		15	240	240	360
33	Repair shower valve, drain, p-trap, and damaged drywall			2024	4,900		15	327	327	490
34	Repaired cracked drain pipe in ceiling of basement			2024	4,250		15	283	283	425
35	Repair catch basin			2024	2,993		15	200	200	300
36										

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

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

Facility Name & ID Number Ryze on the Avenue

0058016

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Repair boiler room fan/coil heater and flu pipe connection	2024	3,358	\$	15	\$ 224	\$ 224	\$ 336	37
38	Installed 2 seal kits to pumps	2024	3,059		15	204	204	306	38
39	Replaced Floor Mounted Unitaire Fan Coil Unit with top outlet	2024	2,566		15	171	171	257	39
40	Fire alarm upgrades-Replace 40 pipes/fittings	2025	8,252		15	275	275	275	40
41	Replaced Flooring in Office/Lobby	2025	3,168		15	106	106	106	41
42	Install and Replace Cameras	2025	2,656		15	89	89	89	42
43	Replace Valve on Heat Pump	2025	7,705		15	257	257	257	43
44	Replace Fencing	2025	36,800		15	1,227	1,227	1,227	44
45	Replace Sink and Wall Cabinets-Pantry Room	2025	10,094		15	336	336	336	45
46	Replace a 6" OS+Valve-Pump Room	2025	11,180		15	373	373	373	46
47	Replace Oil Pump, Wiring, Piping, Drains, Plugs-AC	2025	127,674		15	4,256	4,256	4,256	47
48	Replace 459 Windows Throughout Building	2025	397,360		15	13,245	13,245	13,245	48
49	Replace Oil Pump-Chiller	2025	8,363		15	279	279	279	49
50	Installed Pipe between 3rd and 4th Floor	2025	20,244		15	675	675	675	50
51	Replace Valve on Boiler	2025	6,680		15	223	223	223	51
52	Install Backflow Prevention Device	2025	2,705		15	90	90	90	52
53	Replace Toilet-Resident Room	2025	2,816		15	94	94	94	53
54	Repair OS&Y Valves-Fire Pump/Stairwell #1	2025	5,246		15	175	175	175	54
55	Repair Hot Water Piping at Lower Level	2025	13,321		15	444	444	444	55
56	Replaced Magnet, Panel Relay-Fire Door	2025	4,818		15	161	161	161	56
57	Tear Out Drywall, Ceiling Tiles, Insulation Throughout 1st Fl-Floor	2025	66,310		15	2,210	2,210	2,210	57
58	Replace Leaking Angle Stop-4th Fl Pantry Sink	2025	3,296		15	110	110	110	58
59	Repair Elevator-Imminent Breakdown Risk	2025	18,600		15	620	620	620	59
60	Replace Fan Coil Unit-AC in Mechanical Rm	2025	2,998		15	100	100	100	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)		\$ 14,980,295	\$		\$ 602,946	\$ 602,946	\$ 766,110	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	
1	Totals from Page 12A, Carried Forward		\$ 14,980,295	\$		\$ 602,946	\$ 602,946	\$ 766,110	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Financial Statement Depreciation			38,244			(38,244)		25
26									26
27									27
28	Allocated from Aliya Healthcare Consulting LLC	2024	6,139		15	409	409	615	28
29	Allocated from Aliya Healthcare Consulting LLC	2025	3,342		15	111	111	111	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,989,776	\$ 38,244		\$ 603,466	\$ 565,222	\$ 766,836	34

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	\$ 1,709,334	\$ 57,362	\$ 170,934	\$ 113,572	10 Yrs	\$ 223,201	71
72	Current Year Purchases	82,073	6,235	4,761	(1,474)		4,761	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,791,407	\$ 63,597	\$ 175,695	\$ 112,098		\$ 227,962	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 18,181,183	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,841	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 779,161	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 677,320	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 994,798	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	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$	10	10	3
4	Additions							4
5								5
6		Allocated from Home Office			22,345			6
7	TOTAL				\$22,345			7

**

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

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

N/A

N/A

9. Option to Buy:

☐ YES☐ NO

Terms:

N/A

*

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

15. Is Movable equipment rental included in building rental?

☒ YES☐ NO
16. Rental Amount for movable equipment: \$18,177Description:

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			670	18
19					19
20					20
21	TOTAL		\$	\$670	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

Facility Name:

Ryze on the Avenue

IDPH License ID Number:

0058016

Fiscal Year End:

12/31/2025

Schedule 14A

XII. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	12,303
Office Equipment	1,302
Allocated from Home Office	4,572
Total - Line 16	18,177

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
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,650	\$	\$ 1,650
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	\$	\$ 1,650	\$	\$ 1,650
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,650			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,085	\$ 208,740	\$	6,085	\$ 208,740	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,626	88,455		1,626	88,455	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		5,270	218,574	174	5,270	218,748	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				226,982		226,982	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(7)	313	13,030				313	13,030	12
13	Other (specify): <u>See Attached Sch 16A</u>	39(3)				199,219			199,219	13
14	TOTAL			\$ 13,030	12,981	\$ 714,988	\$ 227,156	13,294	\$ 955,174	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 on the Avenue

IDPH License ID Number:

0058016

Fiscal Year End:

12/31/2025

Schedule 16A

XIV. Special Services

Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	21,016
Radiology	5,957
Dialysis	172,246
Total - Line 16	199,219

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	\$ (4,277)	\$ 6,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,074,060)	4,456,479	4,456,479	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	335,643	335,643	6
7	Other Prepaid Expenses	92,571	92,571	7
8	Accounts Receivable (owners or related parties)	5,785,153	4,995,158	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,665,569	\$ 9,885,851	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,400,000	13
14	Buildings, at Historical Cost		13,890,000	14
15	Leasehold Improvements, at Historical Cost	1,128,462	1,099,776	15
16	Equipment, at Historical Cost	366,958	1,791,407	16
17	Accumulated Depreciation (book methods)	(166,452)	(994,798)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,194,822	21
22	Other Long-Term Assets (see Att.Sch 17A)	14,473	4,578,385	22
23	Other(specify): Deposits	226,206	226,206	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,569,647	\$ 23,185,798	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,235,216	\$ 33,071,649	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 863,064	\$ 863,064	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	834,919	834,919	30
31	Accrued Taxes Payable (excluding real estate taxes)	285,624	285,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,375,242	1,375,242	32
33	Accrued Interest Payable	4,240	57,970	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	423,044	406,967	36
37	Due to Related Party	7,510,658	15,334,173	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,296,791	\$ 19,157,959	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,157,654	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)	\$	\$ 16,157,654	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,296,791	\$ 35,315,613	46
47	TOTAL EQUITY(page 18, line 24)	\$ 938,425	\$ (2,243,964)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,235,216	\$ 33,071,649	48

Facility Name: Ryze on the Avenue

IDPH License ID Number: 0058016

Fiscal Year End: 12/31/2025

Schedule 17A

XV. Balance Sheet

Line 22 Other Long Term Assets (specify):

Description	Operating	After Consolidation
Loan Origination Costs	14,473	1,943,308
Goodwill		3,200,000
Accum Amortization - Loan Origination Costs		(564,923)
Total - Line 22	14,473	4,578,385

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,727,425)	1
2	Restatements (describe):		2
3	Rent Expense	819,674	3
4	Depreciation Expense	(59,724)	4
5	Rounding	(4)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (967,479)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,905,904	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)	\$ 1,905,904	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)	\$ 938,425	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze on the Avenue

0058016

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	\$ 39,085,887	1
2	Discounts and Allowances for all Levels	(13,885,629)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 25,200,258	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	221,082	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 221,082	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	180	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	269	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	1,248	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,697	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,009	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,009	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	39	28
28a	C.N.A. Initiative/QIP Revenue	967,769	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 967,808	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,434,854	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,066,804	31
32	Health Care	8,791,754	32
33	General Administration	6,477,931	33
	B. Capital Expense		
34	Ownership	2,949,872	34
	C. Ancillary Expense		
35	Special Cost Centers	1,605,730	35
36	Provider Participation Fee	1,636,859	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 24,528,950	40
41	Income before Income Taxes (line 30 minus line 40)**	1,905,904	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,905,904	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,662,513	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	16,117,631	45
46	MMAI-Medicaid is the Primary Payer	1,011,996	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	302,460	48
49	Medicare Part A	2,049,847	49
50	Other-(specify) Medicare Replacement	256,909	50
51	Other-(specify) Insurance	596,153	51
52	Other-(specify) Veterans	1,202,749	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)	\$ 25,200,258	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	2,021	2,110	\$ 139,315	\$ 66.03	1
2	Assistant Director of Nursing	2,266	2,402	127,924	53.26	2
3	Registered Nurses	21,381	22,059	1,073,924	48.68	3
4	Licensed Practical Nurses	53,523	56,067	2,327,083	41.51	4
5	CNAs & Orderlies	128,034	138,153	3,428,741	24.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,866	2,080	58,926	28.33	9
10	Activity Assistants	8,916	9,784	197,628	20.20	10
11	Social Service Workers	6,905	7,231	210,689	29.14	11
12	Dietician	80	80	3,077	38.46	12
13	Food Service Supervisor	1,976	2,080	73,289	35.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,756	31,899	689,839	21.63	15
16	Dishwashers					16
17	Maintenance Workers	3,790	4,088	114,123	27.92	17
18	Housekeepers	21,764	23,244	461,102	19.84	18
19	Laundry	6,256	6,983	152,318	21.81	19
20	Administrator	1,856	2,162	119,002	55.04	20
21	Assistant Administrator	1,635	1,675	73,970	44.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,367	10,053	283,338	28.18	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	1,912	2,088	50,613	24.24	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	24,744	25,836	739,365	28.62	33
34	TOTAL (lines 1 - 33)	327,048	350,074	\$ 10,324,266 *	\$ 29.49	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	34,863	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	30,498	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	6	403	L11, C3	44
45	Social Service Consultant	105	7,333	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	111	\$ 73,097		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.

Ryze on the Avenue

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	4,432	4,544	218,112	48.00
Admissions Coordinator	2,000	2,080	72,022	34.63
Security	4,071	4,160	82,640	19.87
Insurance Case Manager	152	160	5,314	33.21
Infection Preventist	1,316	1,380	59,788	43.32
Transportation	8,752	9,195	189,389	20.60
Central Supply	1,944	2,080	46,800	22.50
Staffing Coordinator	1,874	2,018	57,240	28.36
Transitional Care Liaison	72	80	4,889	61.11
Customer Experience Director	131	139	3,171	22.81
TOTAL	24,744	25,836	739,365	

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		
Sharmain Chatman	Administrator	0	\$ 70,752	Workers' Compensation Insurance	\$	258,276	IDPH License Fee	\$	1,956		
Sarah Parker	Administrator	0	48,250	Unemployment Compensation Insurance		96,837	Advertising: Employee Recruitment		26,089		
Justin Chandler	Asst Administrator	0	43,355	FICA Taxes		780,850	Health Care Worker Background Check				
Marquis Thomas	Asst Administrator	0	18,096	Employee Health Insurance		468,836	(Indicate # of checks performed 132)		6,312		
Patricia Wiley	Asst Administrator	0	12,519	Employee Meals		16,341	Patient Background Checks 860		9,457		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		52,548		
				Pension/401k Expense		75,257	Telemedicine Solutions		4,055		
				Employee Meals/Food/Activities		34,117					
				Uniforms		25,835	Various Dues & Subscriptions, Licenses		5,598		
				Non-CNA Tuition Reimbursement		5,064	Allocated from Home Office		13,241		
				Other Employee Benefits		17,250	Less: Public Relations Expense (				
							PAC and Lobbying payments		(26,274)		
				Allocated from Home Office		72,956	All non-allowable advertising (				
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,851,619	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 92,982		
(List each licensed administrator separately.)			\$ 192,972								
B. Administrative - Other											
Description			Amount								
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			\$ 1,271,067								
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7			1,244,561								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,515,628								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Alyze Healthcare Consulting	Bookkeeping	\$	263,112			\$	Out-of-State Travel	\$			
Templin Healthcare Accounting	Accounting		5,926	N/A							
Roth & Company	Accounting		24,292								
NYX Health, LLC	Accounting		923				In-State Travel				
Waystar	Data Processing		3,861								
Point Click Care	Data Processing		140,931								
Paylocity	Payroll Processing		43,261								
Personnel Planners, Inc	Unemployment Consulting		3,803				Seminar Expense		1,389		
Nancy Given	PBJ Preparation		4,150								
See Legal Attachment	Legal Services		26,170				Allocated from Home Office		1,123		
See Attached Schedule 21A			137,090				Entertainment Expense (				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)				
(For legal fee disclosure, see page 39 of instructions)			\$ 653,519				TOTAL		\$ 2,512		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Ryze on the Avenue
IDPH License ID Number: 0058016
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	2,295
Allegro Data Solutions	Data Processing	1,470
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	2,340
Certisurv LLC	State Survey Consulting	1,425
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	46,813
CTI III, LLC	Business Consultant	668
DiningRD	EHR Integration	708
Direct Supply	Data Processing	1,688
Guided Care	Data Processing	8,013
Inovalon Provider, Inc.	Data Processing	762
Life Safety Resources, LLC	Life Safety Consultant	4,200
Mega Data Health Systems	Data Processing	6,359
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	110
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	13,664
Premier Risk Solutions LLC	Security Consultant	447
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	4,188
Reside Admissions	Data Processing	4,082
Sage Intacct, Inc	Data Processing	3,245
Stout Risius Ross	Appraisal	5,500
Wellsky	Data Processing	7,150
Prior Year Accrual Reversals		
Total		137,090

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 |
|---|---------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>26,274</u> |
| | |
| | |
| | <u>26,274</u> 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.
- | | |
|---|---------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>26,274</u> |
| | |
| | |
| | |
| | <u>26,274</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>52,548</u> |
| | |
| | |
| | |
| | <u>52,548</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 66,614 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 1,636,859
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. \$ 16,341 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out 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.