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: 0058040

Facility Name: Ryze West

Address: 5130 W Jackson Blvd (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 West # 0058040 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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	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	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF						2,029	11,676	13,705	8
9	SNF/PED									9
10	ICF	11,846	49,304	3,237		238		1,001	65,626	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	11,846	49,304	3,237		238	2,029	12,677	79,331	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.88%

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 [X] 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 [X]

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 [X] Date 6/1/23 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 234

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/25 Fiscal Year: 12/31/25

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Ryze West # 0058040 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	703,295	42,035	1,984	747,314		747,314	88,822	836,136			1
2	Food Purchase		551,523		551,523		551,523		551,523			2
3	Housekeeping	505,584	63,749		569,333		569,333		569,333			3
4	Laundry	192,250	33,964	7,549	233,763		233,763		233,763			4
5	Heat and Other Utilities			423,202	423,202		423,202	1,256	424,458			5
6	Maintenance	344,877	61,418	158,592	564,887		564,887	33,744	598,631			6
7	Other (specify):* Waste Rem/Mgmt Alloc of			21,929	21,929		21,929	12,361	34,290			7
8	**TOTAL General Services**	1,746,006	752,689	613,256	3,111,951		3,111,951	136,183	3,248,134			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	6,051,461	470,037	68,244	6,589,742		6,589,742	196,396	6,786,138			10
10a	Therapy											10a
11	Activities	197,654	17,250	1,558	216,462		216,462		216,462			11
12	Social Services	321,232		1,855	323,087		323,087	8,284	331,371			12
13	CNA Training											13
14	Program Transportation			47,461	47,461		47,461		47,461			14
15	Other (specify):* Mgmt Alloc of Benefits							27,297	27,297			15
16	**TOTAL Health Care and Programs**	6,570,347	487,287	143,118	7,200,752		7,200,752	231,977	7,432,729			16
	C. General Administration											
17	Administrative	230,919		2,073,565	2,304,484		2,304,484	(1,971,451)	333,033			17
18	Directors Fees											18
19	Professional Services			586,312	586,312		586,312	(220,598)	365,714			19
20	Dues, Fees, Subscriptions & Promotions			95,041	95,041		95,041	(10,099)	84,942			20
21	Clerical & General Office Expenses	320,528	30,185	82,252	432,965		432,965	637,526	1,070,491			21
22	Employee Benefits & Payroll Taxes			1,335,779	1,335,779		1,335,779	56,529	1,392,308			22
23	Inservice Training & Education			2,441	2,441		2,441		2,441			23
24	Travel and Seminar			2,724	2,724		2,724	871	3,595			24
25	Other Admin. Staff Transportation			8,390	8,390		8,390	22,111	30,501			25
26	Insurance-Prop.Liab.Malpractice			612,645	612,645		612,645	8,538	621,183			26
27	Other (specify):* Mgmt Alloc of Benefits							103,056	103,056			27
28	**TOTAL General Administration**	551,447	30,185	4,799,149	5,380,781		5,380,781	(1,373,517)	4,007,264			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,867,800	1,270,161	5,555,523	15,693,484		15,693,484	(1,005,357)	14,688,127			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.

Facility Name & ID Number Ryze West #0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			88,988	88,988		88,988	470,458	559,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,909	113,909		113,909	1,767,053	1,880,962			32
33	Real Estate Taxes			1,000,775	1,000,775		1,000,775		1,000,775			33
34	Rent-Facility & Grounds			1,664,479	1,664,479		1,664,479	(1,647,166)	17,313			34
35	Rent-Equipment & Vehicles			23,118	23,118		23,118	4,061	27,179			35
36	Other (specify):* Closing/Loan Costs			10,320	10,320		10,320		10,320			36
37	**TOTAL Ownership**			2,901,589	2,901,589		2,901,589	594,406	3,495,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		224,255	527,627	751,882		751,882	11,441	763,323			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,477,445	1,477,445		1,477,445		1,477,445			42
43	Other (specify):* Disallowed Costs	16,380	21,325	547,020	584,725		584,725	(584,725)				43
44	**TOTAL Special Cost Centers**	16,380	245,580	2,552,092	2,814,052		2,814,052	(573,284)	2,240,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,884,180	1,515,741	11,009,204	21,409,125		21,409,125	(984,235)	20,424,890			45

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

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	(17,384)	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	470,458	30		9
10	Interest and Other Investment Income	(41,418)	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	(70,048)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(443,694)	43		24
25	Fund Raising, Advertising and Promotional	(21,325)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,894)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(24,548)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (163,853)		$	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)	(820,382)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (820,382)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (984,235)		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

Ryze West

ID# 0058040

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (20,358)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Adjust Owner Wages to Allowable Amount	(11,277)	17	4
5	Expense Minor Fixed Assets Below $2,500	6,535	1	5
6	Expense Minor Fixed Assets Below $2,500	21,256	6	6
7	Expense Minor Fixed Assets Below $2,500	8,792	21	7
8	Marketing Director Wages	(16,380)	43	8
9	Offset Miscellaneous Income Against Expense	(12)	21	9
10	Out of State Travel (Allocated from Home Office)	(6,395)	24	10
11	Out of State Seminar (Allocated from Home Office)	(6,709)	25	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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**	(24,548)		49

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	3,971	West SNF Property LLC		$ 1,494,300	$ 1,490,329	1
2	V	32	Amortization of Loan Costs		West SNF Property LLC		279,655	279,655	2
3	V	34	Rent-Facility & Grounds	1,664,479	West SNF Property LLC			(1,664,479)	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			$ 1,668,450			$ 1,773,955	$ * 105,505	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Aliya Healthcare Consulting LLC		$ 1,256	$ 1,256	15
16	V	6	Maintenance		Aliya Healthcare Consulting LLC		2,092	2,092	16
17	V	17	Administrative	1,109,236	Aliya Healthcare Consulting LLC		113,391	(995,845)	17
18	V	19	Professional Services		Aliya Healthcare Consulting LLC		21,582	21,582	18
19	V	20	Dues, Fees, Subscriptions & Promotions		Aliya Healthcare Consulting LLC		10,251	10,251	19
20	V	21	Clerical & General Office		Aliya Healthcare Consulting LLC		25,880	25,880	20
21	V	22	Employee Benefits		Aliya Healthcare Consulting LLC		56,529	56,529	21
22	V	24	Travel & Seminar		Aliya Healthcare Consulting LLC		7,034	7,034	22
23	V	25	Other Admin Staff Transport		Aliya Healthcare Consulting LLC		14,609	14,609	23
24	V	26	Insurance-Prop.Liab.Malpractice		Aliya Healthcare Consulting LLC		8,475	8,475	24
25	V	27	Mgmt Allocation of Benefits		Aliya Healthcare Consulting LLC		23,008	23,008	25
26	V	32	Interest		Aliya Healthcare Consulting LLC		38,487	38,487	26
27	V	34	Rent-Facility & Grounds		Aliya Healthcare Consulting LLC		17,313	17,313	27
28	V	35	Rent-Equipment & Vehicles		Aliya Healthcare Consulting LLC		3,542	3,542	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			$ 1,109,236			$ 343,449	$ * (765,787)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Alyze Healthcare Consulting LLC		$ 82,287	$ 82,287	15
16	V	6	Maintenance		Alyze Healthcare Consulting LLC		10,396	10,396	16
17	V	7	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		12,361	12,361	17
18	V	10	Nursing and Medical Records		Alyze Healthcare Consulting LLC		196,396	196,396	18
19	V	12	Social Services		Alyze Healthcare Consulting LLC		8,284	8,284	19
20	V	15	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		27,297	27,297	20
21	V	17	Administrative	964,329	Alyze Healthcare Consulting LLC		0	(964,329)	21
22	V	19	Professional Services	243,600	Alyze Healthcare Consulting LLC		1,420	(242,180)	22
23	V	20	Dues, Fees, Subscriptions & Promotions		Alyze Healthcare Consulting LLC		8	8	23
24	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		0		24
25	V	21	Clerical & General Office		Alyze Healthcare Consulting LLC		602,866	602,866	25
26	V	24	Travel and Seminar		Alyze Healthcare Consulting LLC		232	232	26
27	V	25	Other Admin Staff Transport		Alyze Healthcare Consulting LLC		14,211	14,211	27
28	V	26	Insurance-Prop.Liab.Malpractice		Alyze Healthcare Consulting LLC		63	63	28
29	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		80,048	80,048	29
30	V	27	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		0		30
31	V	35	Rent-Equipment & Vehicles		Alyze Healthcare Consulting LLC		519	519	31
32	V	39	Therapy		Alyze Healthcare Consulting LLC		10,095	10,095	32
33	V	39	Mgmt Allocation of Benefits		Alyze Healthcare Consulting LLC		1,346	1,346	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,207,929			$ 1,047,829	$ * (160,100)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS **Ownership Listing-1**

Ryze West

ID# **0058040**

Report Period Beginning: **1/1/2025**

Ending: **12/31/2025**

Aliya Healthcare Consu

West 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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management 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
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74									74
75									75

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 on the Avenue	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

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Efriam Weinfeld	COO	Administrative	0.00	See Att Sch P7A	4.24	10.60	Salary	$ 24,386	L17,C7	1
2	Moshe Erlich	CIO	Administrative	14.3251	See Att Sch P7A	4.24	10.60	Salary	24,386	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	$ 48,772		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Ryze West # 0058040 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Available Bed Days	805,555	13	$ 11,842	$	85,410	$ 1,256	1
2	6	Maintenance	Available Bed Days	805,555	13	19,730		85,410	2,092	2
3	17	Administrative	Available Bed Days	805,555	13	1,069,470	1,069,470	85,410	113,391	3
4	19	Professional Services	Available Bed Days	805,555	13	203,552		85,410	21,582	4
5	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	805,555	13	96,686		85,410	10,251	5
6	21	Clerical & General Office	Available Bed Days	805,555	13	244,094	120,899	85,410	25,880	6
7	22	Employee Benefits	Available Bed Days	805,555	13	533,161		85,410	56,529	7
8	24	Travel & Seminar	Available Bed Days	805,555	13	66,339		85,410	7,034	8
9	25	Other Admin Staff Transport	Available Bed Days	805,555	13	137,791		85,410	14,609	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	805,555	13	79,937		85,410	8,475	10
11	27	Mgmt Allocation of Benefits	Available Bed Days	805,555	13	217,007		85,410	23,008	11
12	32	Interest	Available Bed Days	805,555	13	362,992		85,410	38,487	12
13	34	Rent-Facility & Grounds	Available Bed Days	805,555	13	163,288		85,410	17,313	13
14	35	Rent-Equipment & Vehicles	Available Bed Days	805,555	13	33,403		85,410	3,542	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		$ 343,449	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Licensed Beds	2,201	13	$ 773,991	$ 773,991	234	$ 82,287	1
2	6	Maintenance	Licensed Beds	2,201	13	97,782	97,782	234	10,396	2
3	7	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	116,264		234	12,361	3
4	10	Nursing and Medical Records	Licensed Beds	2,201	13	1,847,295	1,847,295	234	196,396	4
5	12	Social Services	Licensed Beds	2,201	13	77,922	77,922	234	8,284	5
6	15	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	256,755		234	27,297	6
7	17	Administrative	Direct Allocation	1	1	503,103	503,103			7
8	19	Professional Services	Licensed Beds	2,201	13	13,355		234	1,420	8
9	20	Dues, Fees, Subscriptions & Prom	Licensed Beds	2,201	13	73		234	8	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	234	602,866	11
12	24	Travel and Seminar	Licensed Beds	2,201	13	2,179		234	232	12
13	25	Other Admin Staff Transport	Licensed Beds	2,201	13	133,667		234	14,211	13
14	26	Insurance-Prop.Liab.Malpractice	Licensed Beds	2,201	13	591		234	63	14
15	27	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	752,934		234	80,048	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		234	519	17
18	39	Therapy	Licensed Beds	2,201	13	94,957	94,957	234	10,095	18
19	39	Mgmt Allocation of Benefits	Licensed Beds	2,201	13	12,664		234	1,346	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,558,836	$ 9,157,901		$ 1,047,829	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Monticello AM		X	Mortgage	Varies	10/1/24	$	$ 22,925,760	11/26/28	0.0790	$ 1,494,300	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Monticello AM		X	Working Capital							100,882	6
7												7
8												8
9	TOTAL Facility Related						$	$ 22,925,760			$ 1,595,182	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			292,682	10
11								Offset Interest Income			(45,389)	11
12								Allocated from Home Office			38,487	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 285,780	14
15	TOTALS (line 9+line14)						$	$ 22,925,760			$ 1,880,962	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.)

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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.**		$ 890,123	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	$ 789,065	2
3. Under or (over) accrual (line 2 minus line 1).		$ (101,058)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 1,101,833	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. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 1,000,775	7

Assessed Value from Real Estate Tax Bill:	2024	3,927,500	8
Real Estate Tax Bill for Calendar Year:	2020	675,949	9
	2021	804,230	10
	2022	885,522	11
	2023	923,082	12
	2024	789,065	13

Accrual based on prior year tax bill.

	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 West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0058040

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-209-002-0000	Long Term Care Property	$ 789,065.30	$ 789,065.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 789,065.30	$ 789,065.30

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 provide copies of their original **second installment** tax bill.

Facility Name & ID Numb Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	89,364	2024	$ 980,000	1
2					2
3	TOTALS	89,364		$ 980,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234		2024	1987	$ 9,610,000	$	25	$ 384,400	$ 384,500	$ 480,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Repairs to Kitchen Drain Piping, Replace Backflow, Install New Sink			2023	8,866		15	591	591	1,478	9
10	Rebuild Ejector Pump			2023	3,944		15	263	263	657	10
11	Replace Signage			2023	11,880		15	792	792	1,980	11
12	Install New Fire Sprinkler Protection			2023	2,977		15	198	198	495	12
13	Repair Leak-Walk in Freezer			2023	6,194		15	413	413	1,032	13
14	Repair Walk in Freezer-Concrete/Tiles/Seal			2023	4,202		15	280	280	700	14
15	Replace Relief Valves on Boiler			2023	3,934		15	262	262	655	15
16	Freezer Repair			2024	6,292		15	419	419	629	16
17	Replaced check valve and gasket on water booster pump-basemen			2024	2,942		15	196	196	294	17
18	Repair elevator door restrictor, install hatch latch and phone			2024	13,774		15	918	918	1,377	18
19	Replace elevator phones			2024	2,500		15	167	167	250	19
20	Install door protection system-elevators			2024	9,720		15	648	648	972	20
21	Replaced piping-generator room			2024	3,626		15	242	242	363	21
22	Replaced pipe and pendant sprinkler head-2nd floor stairwel			2024	3,696		15	246	246	369	22
23	Install 25 gallon day tank system			2024	17,317		15	1,154	1,154	1,731	23
24	Repiped 4" cast iron pipe-Rm 415			2024	3,052		15	203	203	305	24
25	Repiped water feed on boiler			2024	5,075		15	338	338	507	25
26	Installed 3 fire rated doors			2024	9,179		15	612	612	918	26
27	Replace flush valves on 4 toilets			2024	2,837		15	189	189	284	27
28	Install evaporator coil, receiver, condenser and drier-walk in cooler #1 and			2024	14,370		15	958	958	1,437	28
29	Install new 250 gallon water heater			2024	60,500		15	4,033	4,033	6,050	29
30	Replace damaged elevator car door, tracks, hangers, pickup assembly, and			2024	14,800		15	987	987	1,480	30
31	Repair fence post, pour concrete, rehang panels			2024	3,500		15	233	233	350	31
32	Repack peerless fire pump			2024	3,290		15	219	219	329	32
33	Install pump, seal kit and wiring-chiller			2024	4,357		15	290	290	435	33
34	Repair plumbing leak and replace damaged floor tile-4th floor			2024	3,500		15	233	233	350	34
35	Replace roof-front overhang, repair upper perimeter and gravel roof			2024	21,050		15	1,403	1,403	2,105	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Ryze West # 0058040 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Installed seal kit, impellar and gasket-chiller	2024	7,112	$	15	$ 474	$ 474	$ 711	37
38	Installed new roof drain and copper piping	2024	$ 4,431		15	295	295	443	38
39	Install carpet tile-Lobby	2024	3,727		15	403	403	604	39
40	Repair and adjust latches on doors	2024	2,846		15	190	190	285	40
41	Elevator Upgrades-install escalator, pit Ladder, key switch	2025	125,493		15	4,183	4,183	4,183	41
42	control board, cube relays, ribbon cables, recall system								42
43	Replace three defective coils	2025	30,924		15	1,031	1,031	1,031	43
44	Repair face and bypass dampers	2025	4,150		15	138	138	138	44
45	Install water heater-kitchen	2025	36,465		15	1,216	1,216	1,216	45
46	Install door magnets	2025	2,955		15	99	99	99	46
47	Replace ceiling tiles	2025	4,594		15	153	153	153	47
48	Install Chime Strobe	2025	2,660		15	89	89	89	48
49	Replaced starter, batteries on generator	2025	4,038		15	135	135	135	49
50	Replace bearings on air handler	2025	4,860		15	162	162	162	50
51	Roof work-replace gravel, vapor barrier, metal, skylight	2025	15,960		15	532	532	532	51
52	Replace oil pump for the chiller	2025	11,501		15	383	383	383	52
53	Replace seal kit, sleeve, and motor for taco pump	2025	8,824		15	294	294	294	53
54	Repair drain pipe in ceiling	2025	5,473		15	182	182	182	54
55	Install custom roller shades	2025	41,631		15	1,388	1,388	1,388	55
56	Repair kitchen drain	2025	6,648		15	222	222	222	56
57	Replace 435 windows	2025	389,000		15	12,967	12,967	12,967	57
58	Repair doors that were not closing-welding, sanding, metal channe	2025	3,505		15	117	117	117	58
59	Install new circulating pump and repair the leaking piping	2025	3,391		15	113	113	113	59
60	Install outlets-beauty shop	2025	3,165		15	106	106	106	60
61	Replace RTU, wiring, fuse breaker, piping	2025	14,698		15	490	490	490	61
62	Install 2 actuators for combustion air dampers	2025	3,498		15	117	117	117	62
63	Installation of alarm for 2 doors on 4th floor stairwell	2025	5,656		15	189	189	418	63
64	Rebuild kit from carrier on chiller	2025	4,791		15	160	160	160	64
65									65
66	Financial Statement Depreciation			33,948			(33,948)		66
67									67
68	Allocated from Aliya Healthcare Consulting LLC	2024	4,757		15	317	317	476	68
69	Allocated from Aliya Healthcare Consulting LLC	2025	2,588		15	86	86	86	69
70	TOTAL (lines 4 thru 69)		$ 10,616,715	$ 33,948		$ 427,118	$ 393,170	$ 535,332	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	$ 1,279,991	$ 40,008	$ 127,999	$ 87,991	10 Yrs	$ 167,925	71
72	Current Year Purchases	76,523	15,032	4,329	(10,703)	5-10 Yrs	4,329	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,356,514	$ 55,040	$ 132,328	$ 77,288		$ 172,254	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)	$ 12,953,229	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,988	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 559,446	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 470,458	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 707,586	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.

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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:				$			3
4	Additions							4
5								5
6		Allocated from Home Office			17,313			6
7	TOTAL				$ 17,313 **			7

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

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

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	$

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: $ 15,327 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	Resident	2025 Ford E450 Econoline	$ 2,163.31	$ 11,333	17
18	Allocated from Home Office			519	18
19					19
20					20
21	TOTAL		$ 2,163.31	$ 11,852	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Ryze West**
IDPH License ID Number: **0058040**
Fiscal Year End: **12/31/2025**

Schedule 14A

XII. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	9,986
Office Equipment	1,799
Allocated from Home Office	3,542
Total - Line 16	**15,327**

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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	$	$	$	$
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)	$			

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

Facility Name & ID Number Ryze West STATE OF ILLINOIS # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	2,604	$ 148,202	$	2,604	$ 148,202	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,009	72,402		1,009	72,402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,749	160,015		2,749	160,015	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				224,255		224,255	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(7)	243	10,095				243	10,095	12
13	Other (specify): See Attached Sch 16A	39(3)				133,545			133,545	13
14	TOTAL			$ 10,095	6,362	$ 514,164	$ 224,255	6,605	$ 748,514	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 West**
IDPH License ID Number: **0058040**
Fiscal Year End: **12/31/2025**

Schedule 16A

XIV. Special Services
Line 13 Other Ancillary Outside Practitioner

Outside Practitioner	Amount
Laboratory	27,215
Radiology	2,427
Dialysis	103,903
Total - Line 16	**133,545**

STATE OF ILLINOIS

Facility Name & ID Number Ryze West **#** 0058040 **Report Period Beginning:** 1/1/2025 **Ending:** 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2025 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (333,706)	$ (291,371)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,014,242)	4,060,501	4,060,501	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	273,892	273,892	6
7	Other Prepaid Expenses	55,660	83,947	7
8	Accounts Receivable (owners or related parties)	1,810,633	7,384,025	8
9	Other(specify): Rent Receivable		1,131,291	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,866,980	$ 12,642,285	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		980,000	13
14	Buildings, at Historical Cost		9,610,000	14
15	Leasehold Improvements, at Historical Cost	967,109	1,006,715	15
16	Equipment, at Historical Cost	341,443	1,356,514	16
17	Accumulated Depreciation (book methods)	(135,986)	(707,586)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		903,241	21
22	Other Long-Term Assets (spe See Att Sch 17A	14,473	2,897,701	22
23	Other(specify): Deposits	258,974	258,974	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,446,013	$ 16,305,559	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,312,993	$ 28,947,844	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,214,502	$ 1,214,502	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	406,047	406,047	30
31	Accrued Taxes Payable (excluding real estate taxes)	119,282	119,282	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,101,833	1,101,833	32
33	Accrued Interest Payable	4,240	451,305	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	289,603	573,186	36
37	Due to Related Party	2,635,618	3,924,860	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,771,125	$ 7,791,015	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,925,760	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)**	$	$ 22,925,760	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,771,125	$ 30,716,775	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,541,868	$ (1,768,931)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,312,993	$ 28,947,844	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Ryze West**
IDPH License ID Number: **0058040**
Fiscal Year End: **12/31/2025**

Schedule 17A

XV. Balance Sheet

Line 22 Other Long Term Assets (specify):

Description	Operating	After Consolidation
Organization Costs		6,708
Loan Origination Costs	14,473	944,435
Goodwill		2,240,000
Accum Amortization - Loan Origination Costs		(293,442)
Total - Line 22	**14,473**	**2,897,701**

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (375,696)	1
2	Restatements (describe):		2
3	**Rent Expense**	623,572	3
4	**Depreciation Expense**	(46,999)	4
5	**Miscellaneous**	4,109	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 204,986	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,336,882	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)**	$ 1,336,882	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)**	$ 1,541,868	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 32,762,626	1
2	Discounts and Allowances for all Levels	(10,648,716)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 22,113,910	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,861	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 79,861	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	20	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	4,966	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)**	$ 4,986	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41,418	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,418	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income/Medical Records Income**	12	28
28a	**C.N.A. Initiative/QIP Revenue**	505,820	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 505,832	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 22,746,007	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,111,951	31
32	Health Care	7,200,752	32
33	General Administration	5,380,781	33
	B. Capital Expense		
34	Ownership	2,901,589	34
	C. Ancillary Expense		
35	Special Cost Centers	1,336,607	35
36	Provider Participation Fee	1,477,445	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,409,125	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,336,882	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,336,882	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 3,139,410	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	13,066,476	45
46	MMAI-Medicaid is the Primary Payer	857,865	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	63,139	48
49	Medicare Part A	1,561,158	49
50	Other-(specify) **Medicare Replacement**	499,047	50
51	Other-(specify) **Insurance**	2,508,637	51
52	Other-(specify) **Veterans**	418,178	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)	$ 22,113,910	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,091	2,123	$ 138,120	$ 65.06	1
2	Assistant Director of Nursing	1,737	1,809	88,824	49.10	2
3	Registered Nurses	8,831	9,277	432,967	46.67	3
4	Licensed Practical Nurses	51,754	54,329	2,233,733	41.11	4
5	CNAs & Orderlies	101,643	109,354	2,756,699	25.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,112	52,567	24.89	9
10	Activity Assistants	5,786	6,374	145,087	22.76	10
11	Social Service Workers	8,639	9,058	237,448	26.21	11
12	Dietician	144	160	6,616	41.35	12
13	Food Service Supervisor	1,880	2,040	63,950	31.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,173	29,466	632,729	21.47	15
16	Dishwashers					16
17	Maintenance Workers	5,632	6,048	175,858	29.08	17
18	Housekeepers	22,889	24,662	505,584	20.50	18
19	Laundry	8,751	9,411	192,250	20.43	19
20	Administrator	2,070	2,190	173,211	79.09	20
21	Assistant Administrator	1,368	1,424	57,708	40.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,995	8,467	227,254	26.84	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	2,008	2,072	51,800	25.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	21,661	23,268	711,775	30.59	33
34	TOTAL (lines 1 - 33)	284,052	303,644	$ 8,884,180 *	$ 29.26	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	30,884	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	186	13,463	L39, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,558	L11, C3	44
45	Social Service Consultant	27	1,855	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	235	$ 71,760		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	182	$ 7,853	L10, C3	50
51	Licensed Practical Nurses	132	5,833	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	314	$ 13,686		53

Ryze West

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

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator		3,784	4,159	177,107	42.58
Admissions Coordinator		1,872	2,080	81,449	39.16
Infection Preventist		1,611	1,680	74,227	44.18
Security		6,783	7,216	169,019	23.42
Transporation		3,258	3,483	83,784	24.06
Central Supply		2,039	2,103	54,086	25.72
Staffing Coordinator		1,528	1,729	43,898	25.39
Transitional Care Liaison		182	198	11,825	59.72
Customer Experience Director		604	620	16,380	26.42
	TOTAL	21,661	23,268	711,775	

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laquitta Jones	Administrator	0	$ 173,211
Levita Brock	Asst Administrator	0	57,708
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 230,919

B. Administrative - Other

Description	Amount
Aliya Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7	$ 1,109,236
Alyze Healthcare Consulting Mgmt Fees-Eliminated on P 3, C 7	964,329
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,073,565
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alyze Healthcare Consulting	Bookkeeping	$ 243,600
Templin Healthcare Accounting	Accounting	5,926
Roth & Company	Accounting	36,796
NYX Health, LLC	Accounting	923
Waystar	Data Processing	3,861
Point Click Care	Data Processing	109,266
Paylocity	Payroll Processing	35,117
Personnel Planners, Inc	Unemployment Consulting	2,373
Nancy Given	PBJ Preparation	3,400
See Legal Attachment	Legal Services	13,920
See Attached Schedule 21A		131,130
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 586,312

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,698
Unemployment Compensation Insurance	93,001
FICA Taxes	671,502
Employee Health Insurance	339,464
Employee Meals	18,497
Illinois Municipal Retirement Fund (IMRF)*	
401k Expense	69,197
Employee Meals/Food/Activities	52,352
Uniforms	17,025
Other Employee Benefits	25,043
Allocated from Home Office	56,529
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,392,308

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,516
Advertising: Employee Recruitment	26,182
Health Care Worker Background Check	
(Indicate # of checks performed 106)	5,429
Patient Background Checks 863	9,489
Association Dues (total from pg 22, #4)	40,716
Telemedicine Solutions	4,055
Various Dues & Subscriptions, Licenses	7,654
Allocated from Home Office	10,259
Less: Public Relations Expense	( )
PAC and Lobbying payments	(20,358)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 84,942

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,724
Allocated from Home Office	871
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,595

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Ryze West**
IDPH License ID Number: **0058040**
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	1,544
AR Proactive	Data Processing	4,764
Bill.com	Data Processing	640
Careflow CRM	Data Processing	3,600
Certisurv LLC	State Survey Consulting	1,800
Compliagent	Data Processing	171
Creative Technology Solutions, LLC	Data Processing	37,242
CTI III, LLC	Business Consultant	667
DiningRD	EHR Integration	850
Direct Supply	Data Processing	1,688
Guided Care	Data Processing	6,763
Inovalon Provider, Inc.	Data Processing	762
Life Safety Resources, LLC	Life Safety Consultant	4,200
Medicaid Done Right LLC	Billing Consultant	5,460
Mega Data Health Systems	Data Processing	6,359
Netsmart Technologies	Data Processing	3,696
Olio Health, Inc.	Data Processing	1,350
OneSpan	Data Processing	109
Onyx Procurement Solutions	Procurement Services	9,600
Pax8	Data Processing	11,297
Premier Risk Solutions LLC	Security Consultant	447
Quantum Informatics LLC	IT Consultant	500
Radar Apps	Data Processing	4,188
Reproduction Consultants	Zoning - FOIA Request	1,157
Reside Admissions	Data Processing	4,082
Sage Intacct, Inc	Data Processing	3,245
Stout Risius Ross	Appraisal	5,522
Wellsky	Data Processing	5,890
Total		**131,130**

Facility Name & ID Number Ryze West # 0058040 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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)	20,358
	20,358 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)	20,358
	20,358 Total

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

HEALTH CARE COUNCIL OF IL (HCCI)	40,716
	40,716 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 76,109 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. $ 1,477,445
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. $ 18,497 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 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.