

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0056879

Facility Name: AHVA Care of Stickney

Address: 3900 S Oak Park Ave Stickney 60402
Number City Zip Code

County: Cook

Telephone Number: (708)484-7543 Fax # (708)484-1412

HFS ID Number:

Date of Initial License for Current Owners: 6/25/21

Type of Ownership:

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number AHVA Care of Stickney # 0056879 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 _____

	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	31	Skilled (SNF)	31	11,315	1
2		Skilled Pediatric (SNF/PED)			2
3	20	Intermediate (ICF)	20	7,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,615	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						2,079	1,289	3,368	8
9	SNF/PED									9
10	ICF	4,028	4,892	2,019		1,242			12,181	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,028	4,892	2,019		1,242	2,079	1,289	15,549	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 83.53%

D. How many bed reserve days during this year were paid by the Department? 0 (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

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 6/25/21

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 6/25/21 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of certified beds 43

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	141,498	9,555	7,241	158,294		158,294		158,294			1
2	Food Purchase		94,908		94,908		94,908	(498)	94,410			2
3	Housekeeping	180,957	26,462		207,419		207,419		207,419			3
4	Laundry	36,454	6,848		43,302		43,302		43,302			4
5	Heat and Other Utilities			102,231	102,231		102,231	722	102,953			5
6	Maintenance	39,710	3,953	43,035	86,698		86,698	1,602	88,300			6
7	Other (specify):* Waste Disposal			51,470	51,470		51,470		51,470			7
8	TOTAL General Services	398,619	141,726	203,977	744,322		744,322	1,826	746,148			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,742,528	112,700	3,398	1,858,626		1,858,626	38,171	1,896,797			10
10a	Therapy	96,821		23,800	120,621		120,621	(23,800)	96,821			10a
11	Activities		2,624		2,624		2,624		2,624			11
12	Social Services	60,390		1,470	61,860		61,860		61,860			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co Benefits Alloc							10,023	10,023			15
16	TOTAL Health Care and Programs	1,899,739	115,324	46,668	2,061,731		2,061,731	24,394	2,086,125			16
	C. General Administration											
17	Administrative	178,378		294,782	473,160		473,160	(240,869)	232,291			17
18	Directors Fees											18
19	Professional Services			192,265	192,265		192,265	5,710	197,975			19
20	Dues, Fees, Subscriptions & Promotions			79,261	79,261		79,261	3,491	82,752			20
21	Clerical & General Office Expenses	151,897	5,887	163,547	321,331		321,331	79,038	400,369			21
22	Employee Benefits & Payroll Taxes			291,085	291,085		291,085		291,085			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,537	1,537		1,537	1,759	3,296			24
25	Other Admin. Staff Transportation			10,749	10,749		10,749	(187)	10,562			25
26	Insurance-Prop.Liab.Malpractice			131,292	131,292		131,292	2,482	133,774			26
27	Other (specify):* Mgmt Co Benefits Alloc							42,009	42,009			27
28	TOTAL General Administration	330,275	5,887	1,164,518	1,500,680		1,500,680	(106,567)	1,394,113			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,628,633	262,937	1,415,163	4,306,733		4,306,733	(80,347)	4,226,386			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			19,020	19,020		19,020	82,740	101,760			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			296,377	296,377		296,377	18,555	314,932			32
33	Real Estate Taxes			317,010	317,010		317,010		317,010			33
34	Rent-Facility & Grounds			342,000	342,000		342,000	(334,579)	7,421			34
35	Rent-Equipment & Vehicles			81,640	81,640		81,640	2,905	84,545			35
36	Other (specify):* Loan Fees/Amort			142,310	142,310		142,310		142,310			36
37	TOTAL Ownership			1,198,357	1,198,357		1,198,357	(230,379)	967,978			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,996	457,401	532,397		532,397	(100,606)	431,791			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,280	210,280		210,280		210,280			42
43	Other (specify):* Disallowed Costs		1,601	214,045	215,646		215,646	(215,646)				43
44	TOTAL Special Cost Centers		76,597	881,726	958,323		958,323	(316,252)	642,071			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,628,633	339,534	3,495,246	6,463,413		6,463,413	(626,978)	5,836,435			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	(3,139)	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	65,969	30		9
10	Interest and Other Investment Income	(2,451)	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	(1,381)	17		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(26,895)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,410)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(144,632)	43		24
25	Fund Raising, Advertising and Promotional	(3,965)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(36,259)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,163)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(465,815)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (465,815)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (626,978)		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	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallow Laboratory Expense	(6,292)	43	3
4	Disallow Xray Expense	(7,805)	43	4
5	Disallow Marketing Supplies	(1,601)	43	5
6	Disallow Late Fees	(1,073)	43	6
7	Disallow Prior Year Expense Adjustments	(27,733)	43	7
8	Disallow Income Tax Refund	7,489	43	8
9	Offset Miscellaneous Income	(498)	2	9
10	Offset Miscellaneous Income	(551)	21	10
11	Disallow Marketing Travel Expenses	(208)	25	11
12	Expense Equipment under \$2,500	2,013	21	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				25
26				26
27				27
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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	(36,259)		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 Page 6 Supplemental		See Page 6 Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation		Ahva Stickney Property, LLC	100.00%	\$ 14,893	\$ 14,893	1
2	V	34	Rent-Facility & Grounds	342,000	Ahva Stickney Property, LLC	100.00%		(342,000)	2
3	V								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			\$ 342,000			\$ 14,893	\$ * (327,107)	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	Utilities	\$	Premier Healthcare Management, LLC	0.00%	\$ 722	\$ 722	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	0.00%	1,602	1,602	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	0.00%	38,171	38,171	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	0.00%	10,023	10,023	18
19	V	17	Administrative	294,782	Premier Healthcare Management, LLC	0.00%	55,294	(239,488)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	0.00%	4,208	4,208	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	0.00%	670	670	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	0.00%	94,367	94,367	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	0.00%	132	132	23
24	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	0.00%	770	770	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	0.00%	37,858	37,858	25
26	V	30	Depreciation		Premier Healthcare Management, LLC	0.00%	1,655	1,655	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	0.00%	6,957	6,957	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	0.00%	2,905	2,905	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			\$ 294,782			\$ 255,334	\$ * (39,448)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Therapy	\$23,800	REX Therapeutics	0.00%	\$	\$(23,800)	15
16	V	19	Professional Services		REX Therapeutics	0.00%	9,912	9,912	16
17	V	20	Fees and Subscriptions		REX Therapeutics	0.00%	2,821	2,821	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	0.00%	8,763	8,763	18
19	V	24	Travel and Seminar		REX Therapeutics	0.00%	1,627	1,627	19
20	V	25	Other Admin Staff Transp		REX Therapeutics	0.00%	21	21	20
21	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	0.00%	1,712	1,712	21
22	V	30	Depreciation		REX Therapeutics	0.00%	223	223	22
23	V	32	Interest Expense		REX Therapeutics	0.00%	21,006	21,006	23
24	V	34	Rent-Facility & Grounds		REX Therapeutics	0.00%	464	464	24
25	V	39	Therapy Management Wages		REX Therapeutics	0.00%	26,066	26,066	25
26	V	39	Therapy Consultant	442,321	REX Therapeutics	0.00%	45	(442,276)	26
27	V								27
28	V	39	Therapy Wages		REX Therapeutics	0.00%	276,646	276,646	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	0.00%	38,958	38,958	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			\$466,121			\$388,264	\$*(77,857)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office Exp	\$ 78,000	Healthcare Solutions Group	0.00%	\$ 52,446	\$ (25,554)	15
16	V	27	Emp Benefit Alloc-Gen Admin		Healthcare Solutions Group	0.00%	4,151	4,151	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 78,000			\$ 56,597	\$ * (21,403)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			Gilman Healthcare Center	Gilman, IL	Premier Healthcare	Skokie, IL	Management Co.	1
2			AHVA Care of Winfield	Winfield, IL	Management, LLC			2
3			Norridge Gardens	Norridge, IL	Premier Healthcare	Skokie, IL	Medical Supply	3
4			Premier Healthcare of New Harmony, LLC	New Harmony, IN	Supplies, LLC			4
5			Avondale Estates of Elgin	Elgin, IL	Ahva Stickney	Stickney, IL	Lessor	5
6					Property LLC			6
7					Ahva Care Consultant	Skokie, IL	Management Co.	7
8					LLC			8
9					REX Therapeutics	Skokie, IL	Therapy	9
10					Healthcare Solutions			10
11					Group	Skokie, IL	Billing Services	11
12					Staffing Solutions			12
13					Partners	Skokie, IL	Staffing Services	13
14								14
15								15
16								16
17								17
18								18
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20								20
21								21
22								22
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29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Barak Bayer	Relative	Administrative	0.00	See Att Sch 7A	3.07	7.68	Alloc Salary	\$ 17,648	17-7	1
2	Sara Bayer	Relative	Clerical	0.00	See Att Sch 7A	0.12	8.00	Alloc Salary	393	21-7	2
3	Chana Bayer	Relative	Administrative	0.00	See Att Sch 7A	2.70	13.50	Alloc Salary	4,084	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,125		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 AHVA Care of Stickney # 0056879 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 Premier Healthcare Management, LLC
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	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	Utilities	Weighted Operating Rev	78,891,476	8	\$ 9,406	\$	6,053,436	\$ 722	1
2	6	Maintenance	Weighted Operating Rev	78,891,476	8	20,881		6,053,436	1,602	2
3	10	Nursing and Medical Records	Weighted Operating Rev	78,891,476	8	497,470	497,470	6,053,436	38,171	3
4	15	Emp Benefit Alloc-Healthcare	Weighted Operating Rev	78,891,476	8	130,621		6,053,436	10,023	4
5	17	Administrative	Weighted Operating Rev	78,891,476	8	720,615	720,615	6,053,436	55,294	5
6	19	Professional Services	Weighted Operating Rev	78,891,476	8	54,836		6,053,436	4,208	6
7	20	Dues, Fees, Subs & Promo	Weighted Operating Rev	78,891,476	8	8,732		6,053,436	670	7
8	21	Clerical & Gen Office Expenses	Weighted Operating Rev	78,891,476	8	1,229,838	1,158,439	6,053,436	94,367	8
9	24	Travel and Seminar	Weighted Operating Rev	78,891,476	8	1,720		6,053,436	132	9
10	26	Insurance-Prop.Liab.Malpractice	Weighted Operating Rev	78,891,476	8	10,039		6,053,436	770	10
11	27	Emp Benefit Alloc-Gen Admin	Weighted Operating Rev	78,891,476	8	493,383		6,053,436	37,858	11
12	30	Depreciation	Weighted Operating Rev	78,891,476	8	21,569		6,053,436	1,655	12
13	34	Rent-Facility & Grounds	Weighted Operating Rev	78,891,476	8	90,656		6,053,436	6,957	13
14	35	Equipment Rental	Weighted Operating Rev	78,891,476	8	37,860		6,053,436	2,905	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,327,626	\$ 2,376,524		\$ 255,334	25

Facility Name & ID Number AHVA Care of Stickney # 0056879 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 REX Therapeutics
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	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	19	Professional Services	Therapy Revenue	6,682,538	13	\$ 142,107	\$	466,121	\$ 9,912	1
2	20	Fees and Subscriptions	Therapy Revenue	6,682,538	13	40,446		466,121	2,821	2
3	21	Clerical & General Office Exp	Therapy Revenue	6,682,538	13	125,626		466,121	8,763	3
4	24	Travel and Seminar	Therapy Revenue	6,682,538	13	23,337		466,121	1,627	4
5	25	Other Admin Staff Transp	Therapy Revenue	6,682,538	13	302		466,121	21	5
6	26	Insurance-Prop.Liab.Malp	Therapy Revenue	6,682,538	13	24,550		466,121	1,712	6
7	30	Depreciation	Therapy Revenue	6,682,538	13	3,200		466,121	223	7
8	32	Interest Expense	Therapy Revenue	6,682,538	13	301,155		466,121	21,006	8
9	34	Rent-Facility & Grounds	Therapy Revenue	6,682,538	13	6,657		466,121	464	9
10	39	Therapy Management Wages	Therapy Revenue	6,682,538	13	373,688	373,688	466,121	26,066	10
11	39	Therapy Consultant	Therapy Revenue	6,682,538	13	641		466,121	45	11
12										12
13	39	Therapy Wages	Direct	4,422,888	1	4,422,888	4,422,888	276,646	276,646	13
14	39	Allocated Employee Benefits	Total Wages	4,796,576	13	617,291		302,712	38,958	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,081,888	\$ 4,796,576		\$ 388,264	25

Facility Name & ID Number AHVA Care of Stickney # 0056879 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 Healthcare Solutions Group
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & General Office Exp	Total Charges	577,500	5	\$ 388,302	\$ 385,894	78,000	\$ 52,446	1
2	27	Emp Benefit Alloc-Gen Admin	Total Charges	577,500	5	30,734		78,000	4,151	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	TOTALS					\$ 419,036	\$ 385,894		\$ 56,597	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	Haymarket Insurance		X	Mortgage		6/24/2021	\$ 1,000,000	\$ 1,000,000	6/24/2024	Various	\$	1	
2												2	
3												3	
4	Ace Funding, LLC		X	Working Capital		2/26/25	470,000				89,266	4	
5	Ace Funding, LLC		X	Working Capital		1/6/25	3,150,000	681,896			1,049,015	5	
	Working Capital												
6	Dash Funding Source		X	Working Capital		9/30/24	500,000		2/17/25	0.1545	46,025	6	
7	Dash Funding Source		X	Working Capital		10/28/24	366,000		2/20/25	0.1279	8,203	7	
8	Ace Funding, LLC		X	Working Capital		12/31/24	313,000		4/10/25	0.1197	30,565	8	
9	TOTAL Facility Related						\$ 5,799,000	\$ 1,681,896			\$ 1,223,074	9	
	B. Non-Facility Related*												
10								Allocated Int to/From Other Facilities		(926,697)		10	
11								Allocated from REX Therapeutics		21,006		11	
12								Offset Interest Income			(2,451)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (908,142)	14	
15	TOTALS (line 9+line14)						\$ 5,799,000	\$ 1,681,896			\$ 314,932	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.		\$	785,899	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.)				\$		2
3. Under or (over) accrual (line 2 minus line 1).				\$	(785,899)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	1,102,909	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.				\$	317,010	7
Assessed Value from Real Estate Tax Bill:	2024	904,920	8			
Real Estate Tax Bill for Calendar Year:	2020	226,214	9			
	2021	306,918	10			
	2022	317,011	11			
	2023	301,693	12			
	2024	319,364	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 AHVA Care of Stickney COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056879

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 19-06-103-035-0000	Long Term Care Property	\$ 234,304.35	\$ 234,304.35
2. 19-06-103-034-0000	Long Term Care Property	\$ 85,060.04	\$ 85,060.04
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 319,364.39	\$ 319,364.39

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:16,845
- B. General Construction Type:ExteriorBrickFrameNumber of Stories3
- 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.
- G. Have you properly capitalized all major repairs and equipment purchases?
- H. Are you presently operating under a sale and leaseback arrangement?

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)?

YESXNO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

Pershing Gardens HC Center #0051854 (6/25/21)

- K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

XNO

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 | Facility | | 2021 | \$14,786 | 1 |
| 2 | | | | | 2 |
| 3 | TOTALS | | | \$14,786 | 3 |
- SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number AHVA Care of Stickney

0056879

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	51		2021	1964	\$ 1,220,815	\$	35	\$ 34,880	\$ 34,880	\$ 441,479	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic Wet Pipe Fire Sprinkler System			2012	67,793		20	3,390	3,390	47,459	9
10	Fire Protection Coverage-1St & 2Nd Floor Dining Rooms			2012	4,560		20	228	228	3,192	10
11	Removal Of Underground Storage Tank			2012	4,036		20	202	202	2,827	11
12	Installation Of Wander System And Cables			2012	5,721		20	286	286	4,003	12
13	New Signage			2012	9,858		20	493	493	6,902	13
14	Replace A/C System On Second Floor			2012	3,000		20	150	150	2,100	14
15	Fire Alarm Installation			2012	3,200		20	160	160	2,240	15
16	A: 1St Floor Day Room- New Blinds And Custom Fireplace			2012	3,857		20	193	193	2,701	16
17	B: Porch- Demolish Existing Porches And Build New Stairs Railings And			2012	9,904		20	495	495	6,931	17
18	C: Lobby- New Custom Baseboard Heaters			2012	3,792		20	190	190	2,658	18
19	D: 1St Floor Day Room-Structural Wood Repair; Replace Ceiling; New D			2012	28,689		20	1,434	1,434	20,078	19
20	E: Lobby-New Flooring;Ceiling; Lighting;Wallcoverings;Window Treatm			2012	19,878		20	994	994	13,916	20
21	F: Basement Corridor-New Flooring; Signage; Lighting			2012	6,453		20	323	323	4,521	21
22	G: Therapy Room-New Flooring;Wall Partitions; Lighting; Electrical; Do			2012	54,039		20	2,702	2,702	37,828	22
23	H: 1St Floor Corridor-Removal Of Old Cove Base; New Flooring;Wall Ba			2012	30,741		20	1,537	1,537	21,518	23
24	I: 2Nd Floor Corridor- New Flooring; Removal Of Old Cove Base; New W			2012	35,164		20	1,758	1,758	24,613	24
25	J: New Elevator			2012	8,123		20	406	406	5,685	25
26	K: 2Nd Floor Day Room- Replace Ceiling; Millwork Base; Window Treat			2012	18,891		20	945	945	13,228	26
27	L: Resident Rooms- New Flooring; Paint Walls; Lighting; Cubicle Curtai			2012	82,484		20	4,124	4,124	58,588	27
28	M: Various Areas-New Wooden Handrails And Bumper Gaurds; Painting			2012	65,457		20	3,273	3,273	45,821	28
29	New Fire Alarm Panel Analog Notifier			2012	4,950		20	248	248	3,470	29
30	Various Bathroom Remodels: Remove & Replace Tub,Toilet,Sink, New F			2012	48,310		20	2,416	2,416	28,991	30
31	New Wiring And Motor For Kitchen Exhaust Fan			2013	2,837		20	142	142	1,846	31
32	New Outlets For Window A/C Units			2013	2,900		20	145	145	1,825	32
33	New Generator, New 400 Amp Main Service			2013	141,085		20	7,054	7,054	87,588	33
34	Additional Work On Exterior Remodel: Demo Existing, New Concrete, D			2013	16,903		20	845	845	10,422	34
35	Fire Alarm Installation Charge			2013	9,423		20	471	471	5,652	35
36											36

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

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

Facility Name & ID Number AHVA Care of Stickney

0056879

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Install Door Automator To Front Entry	2013	\$ 5,575	\$	20	\$ 279	\$ 279	\$ 3,347	37
38	Various Areas: Light Fixtures;Floor & Wall Tile;	2013	24,566		20	1,228	1,228	14,737	38
39	Main Entrance Exterior Remodel: Demolish Entire Old Exterior-	2013	59,204		20	2,960	2,960	35,520	39
40	Fire System	2014	3,103		20	155	155	1,860	40
41	Tuckpoint Wall Where Overhang From Roof Was Removed	2014	5,800		20	290	290	3,480	41
42	Hot Water Tank Wiring	2014	3,125		20	156	156	1,873	42
43	Champion Roofing	2014	2,850		20	143	143	1,715	43
44	Install Wire Panelboard In Boiler Room	2014	7,000		20	350	350	4,200	44
45	Elevator Wiring & Shunt Trip Breaker	2014	19,000		20	950	950	11,400	45
46	Champion Roofing	2014	3,248		20	162	162	1,945	46
47	New Elevator	2014	2,500		20	125	125	1,500	47
48	Elevator Modernization	2014	125,000		20	6,250	6,250	75,000	48
49	Install Fire Alarm System In Basement Elevator Room	2014	10,548		20	527	527	5,270	49
50	Repaired 2 Lower Level Circuits, 1 Battery Pack, And 2 Fluoresce	2015	7,675		20	384	384	4,224	50
51	Rewired Kitchen With Two 20 Amp 120 Volt Circuits	2015	4,750		20	238	238	2,618	51
52	Replace Kitchen Door and Drywall in Dining Rm Ceiling	2017	4,125		20	206	206	1,751	52
53	Install New Circuit and Feeder in Laundry Room	2017	4,215		20	211	211	1,793	53
54	Replace Condenser Unit on Walk-In-Freezer	2018	4,739		20	237	237	1,777	54
55	Remove and Replace Door	2019	2,637		20	132	132	858	55
56	Repair Elevator Circuit Breaker	2019	3,265		20	163	163	1,060	56
57	New Roof	2020	74,624		20	3,731	3,731	20,521	57
58	Install Additional Outlets in Room #30 and #31	2021	18,750		20	938	938	4,221	58
59	Repair Walk in Freezer	2021	2,817		20	141	141	634	59
60	Replace Door/Hinges	2021	3,543		20	177	177	797	60
61	Excavate & Repair Leaking Pipe on Southwest end of Building	2022	7,077		20	354	354	1,239	61
62	New Double-Sided LED Illuminated Laser-Cut Sign	2022	9,947		20	497	497	1,740	62
63	Install New Ejector Pit/Pump and Reconfigure Drain to Bring to C	2023	11,375		20	569	569	1,422	63
64	Lift Station Pump/Plumbing Repairs	2023	5,050		20	253	253	632	64
65	Repair Walk in Freezer	2023	3,388		20	169	169	423	65
66	Replace Pump Motor in North Boiler Room	2023	2,716		20	136	136	340	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,355,075	\$		\$ 91,595	\$ 91,595	\$ 1,115,979	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$2,355,075	\$		\$91,595	\$91,595	\$1,115,979	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13	Allocated from Premier Healthcare Management LLC.	2023	3,181		20	159	159	398	13
14	Allocated from Premier Healthcare Management LLC.	2024	1,228		20	61	61	92	14
15									15
16									16
17	Financial Statement Depreciation			19,020			(19,020)		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	TOTAL (lines 1 thru 33)		\$2,359,484	\$19,020		\$91,815	\$72,795	\$1,116,469	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$92,069	\$	\$8,130	\$8,130	10 yrs	\$65,387	71
72	Current Year Purchases	3,135		157	157	10 yrs	157	72
73	Fully Depreciated Assets	272,447					272,447	73
74	Premier Healthcare Mgmt LLC/REX Therapeutics			1,658	1,658			74
75	TOTALS	\$367,651	\$	\$9,945	\$9,945		\$337,991	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										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)	\$2,741,921	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$19,020	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$101,760	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$82,740	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,454,460	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	N/A	\$	\$	\$	86
87					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: N/A
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	Allocated from Management Co.				6,957			5
6	Allocated from REX Therapeutics				464			6
7	TOTAL				\$ 7,421			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: \$ 63,116
- 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	Facility	2022 Ford Transit	\$ 1,664.75	\$ 19,977	17
18					18
19	Allocated from Management Co			1,452	19
20					20
21	TOTAL		\$ 1,664.75	\$ 21,429	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:

AHVA Care of Stickney

IDPH License ID Number:

0056879

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	44,300
Office Equipment	11,330
Laundry Equipment	2,320
Dietary Equipment	3,020
Timeclock	693
Allocated from Premier Healthcare Mgmt	1,453
Total - Line 16	63,116

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8						
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39(7)	2878	hrs	\$	114,220		\$	2,878	\$	114,220	1		
2	Licensed Speech and Language Development Therapist	39(7)	1111	hrs		44,096			1,111		44,096	2		
3	Licensed Recreational Therapist			hrs								3		
4	Licensed Physical Therapist	39(7)	2980	hrs		118,330			2,980		118,330	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 prescripts				74,996			74,996	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10		
11	Academic Education			hrs								11		
12	Other (specify): <u>Therapy Mgr-Allocated</u>	39(7)	352			26,066			352		26,066	12		
13	Other (specify): <u>Allocated Empl Benefit</u>	39(7)				38,958					38,958	13		
14	TOTAL				\$	341,670		\$	74,996	\$	7,321	\$	416,666	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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,593,400	\$ 2,593,426	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,312,704	1,312,704	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	167,420	167,420	6
7	Other Prepaid Expenses	30,910	30,797	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): CNA Incentive Receivable	50,255	50,255	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,154,689	\$ 4,154,602	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		14,786	13
14	Buildings, at Historical Cost		1,220,815	14
15	Leasehold Improvements, at Historical Cost	1,241,549	1,138,669	15
16	Equipment, at Historical Cost	374,742	367,651	16
17	Accumulated Depreciation (book methods)	(1,475,209)	(1,454,460)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch 17A	1,134,390	1,134,390	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,275,472	\$ 2,421,851	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,430,161	\$ 6,576,453	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,219,816	\$ 1,220,741	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,904	183,904	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,471	2,471	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,102,909	1,102,909	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Att Sch 17A	1,315,940	411,440	36
37	Due to Related Parties	534,277	1,147,508	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,359,317	\$ 4,068,973	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	681,896	1,681,896	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Long Term Lease Liability	1,006,667	1,006,667	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,688,563	\$ 2,688,563	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,047,880	\$ 6,757,536	46
47	TOTAL EQUITY(page 18, line 24)	\$ (617,719)	\$ (181,083)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,430,161	\$ 6,576,453	48

Facility Name:AHVA Care of Stickney

IDPH License ID Number:0056879

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Unamortized Loan Costs	76,056	76,056
Right of Use Asset	1,058,334	1,058,334
Total - Line 23	1,134,390	1,134,390

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due to Prior Owner	120,129	120,129
Accrued Rent	904,500	
Accrued Management Fees	286,681	286,681
Payroll Withholdings	3,312	3,312
Due to Others	1,318	1,318
Total - Line 36	1,315,940	411,440

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (214,153)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (214,153)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(403,566)	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)	\$ (403,566)	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)	\$ (617,719)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number AHVA Care of Stickney

0056879

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	\$ 6,000,290	1
2	Discounts and Allowances for all Levels	(284,807)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,715,483	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,674	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 173,674	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,840	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,480	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,451	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,451	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,049	28
28a	CNA/Quality Incentives	160,710	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 161,759	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,059,847	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	744,322	31
32	Health Care	2,061,731	32
33	General Administration	1,500,680	33
	B. Capital Expense		
34	Ownership	1,198,357	34
	C. Ancillary Expense		
35	Special Cost Centers	748,043	35
36	Provider Participation Fee	210,280	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,463,413	40
41	Income before Income Taxes (line 30 minus line 40)**	(403,566)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (403,566)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,194,548.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,430,841.00	45
46	MMAI-Medicaid is the Primary Payer	590,529.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	448,048.00	48
49	Medicare Part A	1,463,706.00	49
50	Other-(specify) Insurance	309,110.00	50
51	Other-(specify) Managed Care A	278,701.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,715,483	56

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,248	1,352	\$ 81,744	\$ 60.46	1
2	Assistant Director of Nursing	872	908	46,855	51.60	2
3	Registered Nurses	11,581	12,550	561,395	44.73	3
4	Licensed Practical Nurses	6,855	7,748	290,098	37.44	4
5	CNAs & Orderlies	30,229	32,663	752,976	23.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,225	1,426	38,268	26.84	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,872	2,004	60,390	30.13	11
12	Dietician					12
13	Food Service Supervisor	1,955	2,130	57,689	27.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,345	4,668	83,809	17.95	15
16	Dishwashers					16
17	Maintenance Workers	984	1,000	39,710	39.71	17
18	Housekeepers	9,086	10,023	180,957	18.05	18
19	Laundry	2,201	2,383	36,454	15.30	19
20	Administrator	1,928	2,256	178,378	79.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,547	4,830	151,897	31.45	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	1,471	1,535	68,013	44.31	33
34	TOTAL (lines 1 - 33)	80,399	87,476	\$ 2,628,633 *	\$ 30.05	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	119	\$ 7,241	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,398	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				44
45	Social Service Consultant	21	1,470	L12,C3	45
46	Other(specify) Rehab Consultant	Monthly	23,800	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	140	\$ 53,909		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.

AHVA Care of Stickney

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/Care Plan Coordinator	223	227	9,460	41.67
Restorative Nurse	1,248	1,308	58,553	44.77
TOTAL	1,471	1,535	68,013	

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	
Richard Taylor	Administrator	0	\$ 173,378	Workers' Compensation Insurance	\$	26,993	IDPH License Fee	\$ 1,990	
Shibu Perumbully	Administrator	0	5,000	Unemployment Compensation Insurance		25,526	Advertising: Employee Recruitment	56,871	
				FICA Taxes		200,134	Health Care Worker Background Check		
				Employee Health Insurance		34,730	(Indicate # of checks performed 6)	63	
				Employee Meals		185	Patient Background Checks	33 241	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				Other Employee Benefits		3,517	Providence	6,000	
							Licenses & Permits	5,683	
							Dues & Subscriptions	8,413	
							Allocated from Mgmt Co./REX	3,491	
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 178,378				PAC and Lobbying payments	()	
B. Administrative - Other							All non-allowable advertising	()	
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 294,782				\$ 82,752		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 294,782	TOTAL (agree to Schedule V, line 22, col.8)			\$ 291,085		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
See Attached	Legal	\$	27,451			\$	Out-of-State Travel	\$	
Templin Healthcare Accounting	Accounting		6,636						
Roth & Company LLP	Accounting		20,425						
Ability Network Inc./Wellsky	Data Processing		12,681				In-State Travel		
Change Healthcare	Data Processing		741						
Claimex, LLC	Billing Consultant		3,191						
Dyatech, LLC	Benefits Consultant		375						
eSolutions, Inc	Data Processing		2,370				Seminar Expense	1,537	
Experian Health Inc.	Revenue Cycle Management		319						
GCHMO, Inc	Managed Care Contracting Serv		27,564				Allocated from Mgmt Co./REX	1,759	
See Attached Schedule 21A			90,512				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)			\$ 192,265			\$	TOTAL	\$ 3,296	

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

****See instructions.**

Facility Name:

AHVA Care of Stickney

IDPH License ID Number:

0056879

Fiscal Year End:

12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Collaborative Healthcare Urgency Group	Healthcare Emergency Preparedness	
IPR Tech Group	Data Processing	9,607
MatrixCare	Data Processing	3,086
Pax8	Data Processing	3,986
Paycom/Paycor	Payroll Processing	16,345
Personnel Planners	Unemployment Consultants	1,100
PointClickCare Technologies Inc	Accounting Software/Data Processing	26,563
Sage Intacct, Inc	Data Processing	9,385
SNF Metrics LLC	Data Processing	6,945
Wellsky	Data Processing	13,495
Total		90,512

XX. GENERAL INFORMATION:

- (1)

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

No
- (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

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.

Total
- (4)

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

Total
- (5)

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

\$ 22,397

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.

\$ 210,280

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.

\$ 185

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$ N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$ N/A
- (13)

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

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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