

		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: 0056887

Facility Name: AHVA Care of Winfield

Address: 28W141 Liberty St Winfield 60190
Number City Zip Code

County: Dupage

Telephone Number: (630) 668-9696 Fax # (630) 668-7078

HFS ID Number:

Date of Initial License for Current Owners: 6/25/2021

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 Winfield # 0056887 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	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,370	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						2,333	827	3,160	8
9	SNF/PED									9
10	ICF	5,914	23,699	10,139		2,425			42,177	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,914	23,699	10,139		2,425	2,333	827	45,337	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 90.01%

SEE ACCOUNTANTS' PREPARATION REPORT

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 138

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

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

Facility Name & ID Number AHVA Care of Winfield # 0056887 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	397,291	72,104	17,146	486,541		486,541		486,541			1
2	Food Purchase		386,961		386,961		386,961		386,961			2
3	Housekeeping	348,536	100,863		449,399		449,399		449,399			3
4	Laundry	91,905	22,604		114,509		114,509		114,509			4
5	Heat and Other Utilities			213,698	213,698		213,698	1,561	215,259			5
6	Maintenance	67,095	945	71,347	139,387		139,387	9,894	149,281			6
7	Other (specify):* Waste Disposal			61,394	61,394		61,394		61,394			7
8	TOTAL General Services	904,827	583,477	363,585	1,851,889		1,851,889	11,455	1,863,344			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,069,782	181,512	47,465	4,298,759		4,298,759	74,553	4,373,312			10
10a	Therapy	158,948		23,404	182,352		182,352	(23,404)	158,948			10a
11	Activities	97,325	1,096		98,421		98,421		98,421			11
12	Social Services	312,720		1,055	313,775		313,775		313,775			12
13	CNA Training											13
14	Program Transportation			319	319		319		319			14
15	Other (specify):* Mgmt Co Benefits Alloc							30,762	30,762			15
16	TOTAL Health Care and Programs	4,638,775	182,608	96,243	4,917,626		4,917,626	81,911	4,999,537			16
	C. General Administration											
17	Administrative	157,589		638,831	796,420		796,420	(522,234)	274,186			17
18	Directors Fees											18
19	Professional Services			295,522	295,522		295,522	20,511	316,033			19
20	Dues, Fees, Subscriptions & Promotions			81,504	81,504		81,504	6,006	87,510			20
21	Clerical & General Office Expenses	171,059	18,142	124,565	313,766		313,766	223,829	537,595			21
22	Employee Benefits & Payroll Taxes			645,117	645,117		645,117		645,117			22
23	Inservice Training & Education											23
24	Travel and Seminar			352	352		352	2,810	3,162			24
25	Other Admin. Staff Transportation			9,009	9,009		9,009	(1,331)	7,678			25
26	Insurance-Prop.Liab.Malpractice			263,920	263,920		263,920	13,136	277,056			26
27	Other (specify):* Mgmt Co Benefits Alloc							81,876	81,876			27
28	TOTAL General Administration	328,648	18,142	2,058,820	2,405,610		2,405,610	(175,397)	2,230,213			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,872,250	784,227	2,518,648	9,175,125		9,175,125	(82,031)	9,093,094			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			76,903	76,903		76,903	97,814	174,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			237,929	237,929		237,929	1,669,471	1,907,400			32
33	Real Estate Taxes			108,000	108,000		108,000		108,000			33
34	Rent-Facility & Grounds			1,674,057	1,674,057		1,674,057	(1,658,292)	15,765			34
35	Rent-Equipment & Vehicles			66,796	66,796		66,796	6,283	73,079			35
36	Other (specify):* Loan Fees/Amort			18,682	18,682		18,682		18,682			36
37	TOTAL Ownership			2,182,367	2,182,367		2,182,367	115,276	2,297,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,434	712,491	827,925		827,925	(193,322)	634,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			628,278	628,278		628,278		628,278			42
43	Other (specify):* Disallowed Costs	92,914	10,413	355,748	459,075		459,075	(459,075)				43
44	TOTAL Special Cost Centers	92,914	125,847	1,696,517	1,915,278		1,915,278	(652,397)	1,262,881			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,965,164	910,074	6,397,532	13,272,770		13,272,770	(619,152)	12,653,618			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	(6,472)	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	(68,932)	30		9
10	Interest and Other Investment Income				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	(2,987)	17		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(85,734)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,282)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(191,649)	43		24
25	Fund Raising, Advertising and Promotional	(2,070)	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	(163,025)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (525,151)		\$	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)	(94,001)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (94,001)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (619,152)		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 Marketing Wages	(92,914)	43	3
4	Disallow Marketing Supplies	(10,413)	43	4
5	Disallow Laboratory	(25,588)	43	5
6	Disallow Xray	(5,292)	43	6
7	Disallow Late Fees	(770)	43	7
8	Miscellaneous Income Offset	(147)	21	8
9	Disallow Prior Year Expense Adjustments	(38,173)	43	9
10	Disallow Marketing Travel Expense	(1,364)	25	10
11	Expense Repairs/Equipment under \$2,500	9,351	6	11
12	Expense Repairs/Equipment under \$2,500	5,207	21	12
13	Capitalize Repair over \$2500	(2,922)	6	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
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(163,025)		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 Winfield Property, LLC	100.00%	\$ 162,821	\$ 162,821	1
2	V	32	Interest		AHVA Winfield Property, LLC	100.00%	1,636,888	1,636,888	2
3	V	34	Rent-Facility & Grounds	1,674,057	AHVA Winfield Property, LLC	100.00%		(1,674,057)	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			\$ 1,674,057			\$ 1,799,709	\$ * 125,652	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%	\$ 1,561	\$ 1,561	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	0.00%	3,465	3,465	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	0.00%	82,554	82,554	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	0.00%	21,676	21,676	18
19	V	17	Administrative	638,831	Premier Healthcare Management, LLC	0.00%	119,584	(519,247)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	0.00%	9,100	9,100	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	0.00%	1,449	1,449	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	0.00%	204,089	204,089	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	0.00%	285	285	23
24	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	0.00%	1,666	1,666	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	0.00%	81,876	81,876	25
26	V	30	Depreciation		Premier Healthcare Management, LLC	0.00%	3,579	3,579	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	0.00%	15,045	15,045	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	0.00%	6,283	6,283	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			\$ 638,831			\$ 552,212	\$ * (86,619)	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	\$23,404	REX Therapeutics	0.00%	\$15,374	\$ (23,404)	15
16	V	19	Professional Services		REX Therapeutics	0.00%	4,376	15,374	16
17	V	20	Fees and Subscriptions		REX Therapeutics	0.00%	13,592	4,376	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	0.00%	2,525	13,592	18
19	V	24	Travel and Seminar		REX Therapeutics	0.00%	33	2,525	19
20	V	25	Other Admin Staff Transp		REX Therapeutics	0.00%	2,656	33	20
21	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	0.00%	346	2,656	21
22	V	30	Depreciation		REX Therapeutics	0.00%	32,583	346	22
23	V	32	Interest Expense		REX Therapeutics	0.00%	720	32,583	23
24	V	34	Rent-Facility & Grounds		REX Therapeutics	0.00%	40,431	720	24
25	V	39	Therapy Management Wages		REX Therapeutics	0.00%	70	40,431	25
26	V	39	Therapy Consultant	699,611	REX Therapeutics	0.00%		(699,541)	26
27	V								27
28	V	39	Therapy Wages		REX Therapeutics	0.00%	408,070	408,070	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	0.00%	57,718	57,718	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			\$723,015			\$578,494	\$ * (144,521)	39

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 37,686	Staffing Solutions Partners, LLC	0.00%	\$ 29,685	\$ (8,001)	15
16	V	15	Emp Benefit Alloc-Healthcare		Staffing Solutions Partners, LLC	0.00%	9,086	9,086	16
17	V	19	Professional Services		Staffing Solutions Partners, LLC	0.00%	319	319	17
18	V	20	Fees and Subscriptions		Staffing Solutions Partners, LLC	0.00%	181	181	18
19	V	21	Clerical & General Office Exp		Staffing Solutions Partners, LLC	0.00%	1,088	1,088	19
20	V	26	Insurance-Prop.Liab.Malp		Staffing Solutions Partners, LLC	0.00%	8,814	8,814	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			\$ 37,686			\$ 49,173	\$ * 11,487	39

Ownership Listing-1

0056887

2/31/2025

AHVA Winfield Property, LLC

Operator/Licensee

Operator/Licensee

Operator/Licensee

Names of trust beneficiaries must be listed.			Place of Residence		Ownership Percentage	Ownership Percentage	Ownership Percentage
	First Name	M.I.	Last Name	City	State		
1	Joseph		Knopf	Chicago	IL	2.90000	2.90000
2	Ayelet		Knopf	Chicago	IL	2.90000	2.90000
3	Naomi		Lopin	Chicago	IL	2.90000	2.90000
4	Yisroel		Lopin	Chicago	IL	2.90000	2.90000
5	Michael & Carol		Knopf	Chicago	IL	1.45000	1.45000
6	Shalom		Zupnik	Chicago	IL	1.45000	1.45000
7	Elana		Baver	Chicago	IL	85.50000	84.78000
8	Isaac & Rachel		Knopf	Chicago	IL		0.72000
9	Barak		Baver	Chicago	IL		100.00000
10							
11							
12							
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75							

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Gilman Healthcare Center	Gilman, IL	Premier Healthcare	Skokie, IL	Management Co.	1
2			AHVA Care of Stickney	Stickney, 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 Winfield	Winfield, 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
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
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	6.64	16.60	Alloc Salary	\$ 38,168	17-7	1
2	Sara Bayer	Relative	Clerical	0.00	See Att Sch 7A	0.25	16.67	Alloc Salary	\$ 850	21-7	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	\$ 39,018		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 Winfield # 0056887 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	\$	13,091,857	\$ 1,561	1
2	6	Maintenance	Weighted Operating Rev	78,891,476	8	20,881		13,091,857	3,465	2
3	10	Nursing and Medical Records	Weighted Operating Rev	78,891,476	8	497,470	497,470	13,091,857	82,554	3
4	15	Emp Benefit Alloc-Healthcare	Weighted Operating Rev	78,891,476	8	130,621		13,091,857	21,676	4
5	17	Administrative	Weighted Operating Rev	78,891,476	8	720,615	720,615	13,091,857	119,584	5
6	19	Professional Services	Weighted Operating Rev	78,891,476	8	54,836		13,091,857	9,100	6
7	20	Dues, Fees, Subs & Promo	Weighted Operating Rev	78,891,476	8	8,732		13,091,857	1,449	7
8	21	Clerical & Gen Office Expenses	Weighted Operating Rev	78,891,476	8	1,229,838	1,158,439	13,091,857	204,089	8
9	24	Travel and Seminar	Weighted Operating Rev	78,891,476	8	1,720		13,091,857	285	9
10	26	Insurance-Prop.Liab.Malpractice	Weighted Operating Rev	78,891,476	8	10,039		13,091,857	1,666	10
11	27	Emp Benefit Alloc-Gen Admin	Weighted Operating Rev	78,891,476	8	493,383		13,091,857	81,876	11
12	30	Depreciation	Weighted Operating Rev	78,891,476	8	21,569		13,091,857	3,579	12
13	34	Rent-Facility & Grounds	Weighted Operating Rev	78,891,476	8	90,656		13,091,857	15,045	13
14	35	Equipment Rental	Weighted Operating Rev	78,891,476	8	37,860		13,091,857	6,283	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		\$ 552,212	25

Facility Name & ID Number AHVA Care of Winfield # 0056887 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	\$	723,015	\$ 15,374	1
2	20	Fees and Subscriptions	Therapy Revenue	6,682,538	13	40,446		723,015	4,376	2
3	21	Clerical & General Office Exp	Therapy Revenue	6,682,538	13	125,626		723,015	13,592	3
4	24	Travel and Seminar	Therapy Revenue	6,682,538	13	23,337		723,015	2,525	4
5	25	Other Admin Staff Transp	Therapy Revenue	6,682,538	13	302		723,015	33	5
6	26	Insurance-Prop.Liab.Malp	Therapy Revenue	6,682,538	13	24,550		723,015	2,656	6
7	30	Depreciation	Therapy Revenue	6,682,538	13	3,200		723,015	346	7
8	32	Interest Expense	Therapy Revenue	6,682,538	13	301,155		723,015	32,583	8
9	34	Rent-Facility & Grounds	Therapy Revenue	6,682,538	13	6,657		723,015	720	9
10	39	Therapy Management Wages	Therapy Revenue	6,682,538	13	373,688	373,688	723,015	40,431	10
11	39	Therapy Consultant	Therapy Revenue	6,682,538	13	641		723,015	70	11
12										12
13	39	Therapy Wages	Direct	4,422,888	1	4,422,888	4,422,888	408,070	408,070	13
14	39	Allocated Employee Benefits	Total Wages	4,796,576	13	617,291		448,501	57,718	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		\$ 578,494	25

Facility Name & ID Number AHVA Care of Winfield # 0056887 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 Staffing Solutions Partners, 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 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	10	Nursing and Medical Records	Direct Allocation	61,663	2	\$ 61,663	\$ 61,663	29,685	\$ 29,685	1
2	15	Emp Benefit Alloc-Healthcare	Total Charges	74,724	2	18,016		37,686	9,086	2
3	19	Professional Services	Total Charges	74,724	2	633		37,686	319	3
4	20	Fees and Subscriptions	Total Charges	74,724	2	358		37,686	181	4
5	21	Clerical & General Office Exp	Total Charges	74,724	2	2,157		37,686	1,088	5
6	26	Insurance-Prop.Liab.Malp	Total Charges	74,724	2	17,476		37,686	8,814	6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 100,303	\$ 61,663		\$ 49,173	25

SEE ACCOUNTANTS' PREPARATION REPORT

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 Company		X	Mortgage		6/24/2021	\$ 15,650,000	\$ 15,650,000	6/24/2024	Various	\$ 1,636,888	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	SLR Healthcare		X	Line of Credit		3/31/22	2,000,000	683,005	3/31/25	Various	95,047	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 17,650,000	\$ 16,333,005			\$ 1,731,935	9	
	B. Non-Facility Related*												
10								Allocated Working Capital Loan Interest			142,882	10	
11								Allocated from REX/Staff. Solutions			32,583	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 175,465	14	
15	TOTALS (line 9+line14)						\$ 17,650,000	\$ 16,333,005			\$ 1,907,400	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AHVA Care of Winfield COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0056887

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. 04-14-201-010	Long Term Care Property	\$ 98,952.56	\$ 98,952.56
2. 04-14-201-011	Long Term Care Property	\$ 823.08	\$ 823.08
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 99,775.64	\$ 99,775.64

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

16,845

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

3
- C.

Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F.

List the bed capacity for the building if it differs from the licensed total.

N/A
- G.

Have you properly capitalized all major repairs and equipment purchases?

Yes
- H.

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- I.

Are you presently operating under a sublease agreement?

No
- J.

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

X

NO

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

Winfield Woods Healthcare Center #0052100 (6/25/21)

- K.

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2021	\$ 460,000	1
2					2
3	TOTALS			\$ 460,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	138		2021	1971	\$ 4,400,000	\$	35	\$ 125,714	\$ 125,714	\$ 1,382,854
5										
6										
7										
8										
	Improvement Type**									
9	Rci Delayed Egress Mag Lock With Internal Sounder			2013	3,716		20	186	186	4,585
10	5 New Wall Outlets: 3 On Second Floor, 2 On First Floor			2013	2,800		20	140	140	1,738
11	Electric Installation Of Emergency Outlets			2013	30,100		20	1,505	1,505	16,407
12	Landscaping			2014	3,400		20	170	170	1,796
13	Elevator Door Repair			2014	3,750		20	188	188	1,978
14	Rooftop Replacement			2014	11,268		20	563	563	5,872
15	Replace Water Heater/Pipes/Valves For Kitchen/Laundry Room			2015	7,749		20	387	387	4,257
16	Installation Of Electrical Sources/Wiring In Mechanical Room			2015	6,455		20	323	323	3,553
17	Rebuilding Of Chimney/Tuckpointing			2015	8,700		20	435	435	4,785
18	Instal Of New Heat Exchanger/New Burners/Rollout Switch			2015	7,438		20	372	372	4,092
19	Wanderguard Id/Wall Mounts/Signaling Device/Magnetic Locks			2015	29,745		20	1,487	1,487	16,357
20	Install Roam Alert System/Door Controller/Electrical			2015	31,619		20	1,581	1,581	17,391
21	Install Roam Alert Eco Door Control/Excitor Antenna/Annunciator			2015						
22	Generator			2015	3,136		20	157	157	2,041
23	Generator			2015	3,136		20	157	157	2,041
24	Installed New Motor, Housing and Backplate at RTU #1			2016	2,529		20	126	126	1,197
25	Installed 16 New Smoke/Fire Damper Motors			2016	8,221		20	411	411	3,905
26	Clean, Patch, Seal and Stripe Parking Lot			2016	5,700		20	285	285	2,708
27	Re-pipe Generator Feed			2016	3,428		20	171	171	1,625
28	Parking Lot Repaving			2016	5,352		20	268	268	2,546
29	Install 9 Door Alarms and Nursing Station Annunciators			2016	6,295		20	315	315	2,992
30	Install Emergency Call System			2016	18,600		20	930	930	8,835
31	Elevator Repairs-Replaced Micro-chip, Adjust Rollers, Rebuilt Starter			2016	3,157		20	158	158	1,501
32	Repairs/Maintenance on HVAC Units			2017	8,015		20	401	401	3,408
33	Install Electric Booster Heater			2017	3,435		20	172	172	1,462
34	Replace Compressor in HVAC Unit			2017	4,357		20	218	218	1,853
35	Install Rheem 7.5 Ton Furnace			2018	12,800		20	640	640	4,800
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 Winfield

0056887

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	Elevator Repair	2018	\$ 3,660	\$	20	\$ 183	\$ 183	\$ 1,281	37
38	HVAC/Ductwork Repairs	2019	17,373		20	869	869	5,648	38
39	Repair Main Entrance Handicap Door	2019	2,515		20	126	126	819	39
40	Electrical Repair	2019	3,091		20	155	155	1,007	40
41	Bathroom Plumbing Repair	2019	3,188		20	159	159	1,034	41
42	Replace Air Conditioner	2019	24,890		20	1,245	1,245	8,092	42
43	Sealcoat/Striping/Patching Parking Lot	2019	8,442		20	422	422	2,743	43
44	Replaced Fire Dampers	2020	9,490		20	475	475	2,612	44
45	Remove Old and Replace with Industrial Drain and Cover	2020	5,000		20	250	250	1,375	45
46	Addition to Emergency Generator Systems	2020	7,225		20	361	361	1,986	46
47	Elevator Modernization and Cylinder Replacement	2021	97,521		20	4,876	4,876	21,942	47
48	Installation and Wiring of Lobby Paging System	2021	6,150		20	308	308	1,386	48
49	Generator Repair	2021	6,046		20	302	302	1,359	49
50	Replace Bearing and Heat Exchanger	2021	8,719		20	436	436	1,962	50
51	Install New Water Heater	2021	12,809		20	640	640	2,880	51
52	Replace Concrete Sidewalks	2022	4,300		20	215	215	753	52
53	Replace Heat Exchanger on Roof Top Unit #5	2022	3,593		20	180	180	630	53
54	Fire Sprinkler Backflow Preventer Repair	2022	2,991		20	150	150	525	54
55	New Paging System	2022	3,075		20	154	154	539	55
56	Replace Backflow Online to Fire Protection System to Code	2023	14,450		20	723	723	1,807	56
57	Elevator Programming Repair/Replace 24 Heat Detectors	2023	2,694		20	135	135	337	57
58	Replace 31 Smoke Detectors	2023	5,700		20	285	285	713	58
59	Repair Damaged Ductwork Outside	2024	5,545		20	277	277	416	59
60	Repair Walk In Cooler	2024	4,173		20	209	209	313	60
61	Install and Mount New Actuator	2024	2,723		20	136	136	204	61
62	Replaced & Reconfigured Magnetic Lock for Front Door	2024	2,674		20	134	134	201	62
63	Replace Faulty Nurse Call Switches Throughout Facility	2024	7,564		20	378	378	567	63
64	Replace Hot Water Heater	2024	11,999		20	600	600	900	64
65	Install Rebuild Kit for Mixing Valve & Thermostat	2024	3,894		20	195	195	292	65
66	Replaced 4" Leaking Pipe Under Floor to Bathroom	2025	2,922		20	73	73	73	66
67	Replace Dry Rotted Gaskets/Replace Main Drain Piping	2025	2,730		20	68	68	68	67
68	Parking Lot-Repair Holes/Clean and Prepare for New Asphalt	2025	5,000		20	125	125	125	68
69	Remove and Replace Roof Top Unit	2025	20,871		20	522	522	522	69
70	TOTAL (lines 4 thru 69)		\$ 4,957,918	\$		\$ 152,826	\$ 152,826	\$ 1,571,690	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number AHVA Care of Winfield

0056887

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	
1	Totals from Page 12A, Carried Forward		\$ 4,957,918	\$		\$ 152,826	\$ 152,826	\$ 1,571,690	1
2	Elevator - Install New Soft Starter	2025	3,363		20	84	84	84	2
3	Replaced 6 Thermostats with New Thermostats w/ Remote Sensor	2025	4,110		20	103	103	103	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	6,880		20	344	344	860	13
14	Allocated from Premier Healthcare Management LLC.	2024	2,656		20	133	133	199	14
15									15
16									16
17	Financial Statement Depreciation			76,903			(76,903)		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)		\$ 4,974,927	\$ 76,903		\$ 153,490	\$ 76,587	\$ 1,572,936	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	\$940,951	\$	\$16,340	\$16,340	10 yrs	\$876,742	71
72	Current Year Purchases	28,778		1,439	1,439	10 yrs	1,439	72
73	Fully Depreciated Assets	172,503					172,503	73
74	Premier Healthcare Mgmt LLC/REX Therapeutics			3,448	3,448			74
75	TOTALS	\$1,142,232	\$	\$21,227	\$21,227		\$1,050,684	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	Resident	2020 Ford Elkhart Coach ECII	2019	\$63,209	\$	\$	\$	4	\$63,209	76
77										77
78										78
79										79
80	TOTALS			\$63,209	\$	\$	\$		\$63,209	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)	\$6,640,368	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$76,903	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$174,717	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$97,814	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,686,829	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.				15,045			5
6	Allocated from REX Therapeutics				720			6
7	TOTAL				\$15,765			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: \$69,938
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19	Allocated from Management Co			3,141	19
20					20
21	TOTAL		\$	\$3,141	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 Winfield

IDPH License ID Number:

0056887

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	50,646
Office Equipment	14,837
Time Clock	1,313
Allocated from Premier Healthcare Mgmt	3,142
Total - Line 16	69,938

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

\$

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(7)	3064	hrs	\$ 133,983		\$	3,064	\$ 133,983	1
2	Licensed Speech and Language Development Therapist	39(7)	2650	hrs	115,876			2,650	115,876	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	39(7)	3617	hrs	158,211			3,617	158,211	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			115,434		115,434	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)	558		40,431			558	40,431	12
13	Other (specify): <u>Allocated Empl Benefit</u>	39(7)			57,718				57,718	13
14	TOTAL				\$ 506,219		\$ 115,434	9,889	\$ 621,653	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

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	\$ 867	\$ 809	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 187,299)	1,224,929	1,224,929	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	329,442	329,442	6
7	Other Prepaid Expenses	43,088	42,974	7
8	Accounts Receivable (owners or related parties)	1,456,736	425,688	8
9	Other(specify): Deposits	124,089	124,089	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,179,151	\$ 2,147,931	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		460,000	13
14	Buildings, at Historical Cost		4,400,000	14
15	Leasehold Improvements, at Historical Cost	480,808	574,927	15
16	Equipment, at Historical Cost	696,685	1,205,441	16
17	Accumulated Depreciation (book methods)	(855,902)	(2,686,829)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Loan Costs	5,000	5,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,591	\$ 3,958,539	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,505,742	\$ 6,106,470	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,357,568	\$ 3,998,237	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,266	333,266	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,738	30,738	31
32	Accrued Real Estate Taxes(Sch.IX-B)	355,500	431,333	32
33	Accrued Interest Payable	6,612	278,330	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Att Sch 17A	2,424,505	927,977	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,508,189	\$ 5,999,881	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	683,005	16,333,005	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Net Long Term Lease Liability	399,903	399,903	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,082,908	\$ 16,732,908	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,591,097	\$ 22,732,789	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,085,355)	\$ (16,626,319)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,505,742	\$ 6,106,470	48

Facility Name:

AHVA Care of Winfield

IDPH License ID Number:

0056887

Fiscal Year End:

12/31/2025

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due to Prior Owner	172,877	172,877
Accrued Expenses	2,251,628	755,100
Total - Line 36	2,424,505	927,977

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,299,885)	1
2	Restatements (describe):		2
3	Prior Period Adjustments - Operating Lease Expense	(1,744,010)	3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,043,894)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(41,461)	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)	\$ (41,461)	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)	\$ (4,085,355)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number AHVA Care of Winfield

0056887

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	\$ 12,536,154	1
2	Discounts and Allowances for all Levels	(200,018)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,336,136	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	427,600	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 427,600	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	12,594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	297	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,891	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	147	28
28a	See Attached Schedule 19A	454,535	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 454,682	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,231,309	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,851,889	31
32	Health Care	4,917,626	32
33	General Administration	2,405,610	33
	B. Capital Expense		
34	Ownership	2,182,367	34
	C. Ancillary Expense		
35	Special Cost Centers	1,287,000	35
36	Provider Participation Fee	628,278	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,272,770	40
41	Income before Income Taxes (line 30 minus line 40)**	(41,461)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (41,461)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,397,455.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,603,904.00	45
46	MMAI-Medicaid is the Primary Payer	2,397,484.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	805,224.00	48
49	Medicare Part A	1,731,484.00	49
50	Other-(specify) Insurance	256,786.00	50
51	Other-(specify) Managed Care A	143,799.00	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)	\$ 12,336,136	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

AHVA Care of Winfield

IDPH License ID Number:

0056887

Fiscal Year End:

12/31/2025

Schedule 19A		Amount
XVII. INCOME STATEMENT		
Line 28a- Other Income		
Quality Incentive		37,943
CNA Initiative		277,287
Bad Debt Recoveries		139,305
Total		454,535

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	1,680	1,859	\$ 127,028	\$ 68.33	1
2	Assistant Director of Nursing	1,822	1,908	85,852	45.00	2
3	Registered Nurses	16,667	17,620	928,288	52.68	3
4	Licensed Practical Nurses	17,240	18,303	861,591	47.07	4
5	CNAs & Orderlies	63,337	67,590	1,933,134	28.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,886	2,132	64,536	30.27	8
9	Activity Director	1,867	1,944	49,159	25.29	9
10	Activity Assistants	2,515	2,696	48,166	17.87	10
11	Social Service Workers	8,631	9,261	312,720	33.77	11
12	Dietician					12
13	Food Service Supervisor	1,557	1,841	63,458	34.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,885	16,804	333,833	19.87	15
16	Dishwashers					16
17	Maintenance Workers	1,621	1,880	67,095	35.69	17
18	Housekeepers	16,790	18,499	348,536	18.84	18
19	Laundry	4,465	4,753	91,905	19.34	19
20	Administrator	1,616	1,844	157,589	85.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,748	1,840	59,194	32.17	23
24	Clerical	3,411	3,737	111,865	29.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,721	1,872	39,498	21.10	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	5,138	5,619	281,717	50.14	33
34	TOTAL (lines 1 - 33)	169,597	182,002	\$ 5,965,164 *	\$ 32.78	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	324	\$ 17,146	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,779	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	15	1,055	L12,C3	45
46	Other(specify) Rehab Consultant	Monthly	23,404	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	339	\$ 75,384		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	111	\$ 8,058	L10, C3	50
51	Licensed Practical Nurses	423	29,628	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	534	\$ 37,686		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

AHVA Care of Winfield

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	1,747	1,844	94,391	51.19
Restorative Nurse	1,771	1,935	94,412	48.79
Marketing Coordinator	1,620	1,840	92,914	50.50
TOTAL	5,138	5,619	281,717	

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		
Nora O'Gorman	Administrator	0	\$ 157,589	Workers' Compensation Insurance	\$ 58,024	IDPH License Fee	\$ 1,824		
				Unemployment Compensation Insurance	26,929	Advertising: Employee Recruitment	61,828		
				FICA Taxes	443,426	Health Care Worker Background Check			
				Employee Health Insurance	107,469	(Indicate # of checks performed)			
				Employee Meals	772	Patient Background Checks	64 916		
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)			
				Other Employee Benefits	8,497	Providence	6,000		
						Licenses & Permits	1,587		
						Dues & Subscriptions	9,349		
						Allocated from Mgmt Co./REX/SS	6,006		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	()		
						PAC and Lobbying payments	()		
						All non-allowable advertising	()		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (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									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal		\$ 40,328				Out-of-State Travel	\$	
Templin Healthcare Accounting	Accounting		6,636						
Roth & Company LLP	Accounting		20,100						
SLR Healthcare ABL	Accounting		5,500				In-State Travel		
Ability Network Inc.	Data Processing		25,771						
Change Healthcare	Data Processing		741						
eSolutions, Inc	Data Processing		4,743						
Experian Health Inc.	Revenue Cycle Management		319				Seminar Expense	352	
							Allocated from Mgmt Co./REX	2,810	
See Attached Schedule 21A			191,384				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 3,162	

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

****See instructions.**

Facility Name:	AHVA Care of Winfield
IDPH License ID Number:	0056887
Fiscal Year End:	12/31/2025

Schedule 21A

XIX. Support Schedules

C. Professional Services

Vendor/Payee	Type	Amount
Bais HaVaad Halacha Center	Religious Consultant	
Collaborative Healthcare Urgency Group	Healthcare Emergency Preparedness	1,321
GCHMO, Inc	Managed Care Contracting Services	22,303
IPR Tech Group	Data Processing	22,585
MatrixCare	Data Processing	8,421
Pax8	Data Processing	8,181
Paycor/Paycom	Payroll Processing	26,199
Personnel Planners	Unemployment Consultants	867
PointClickCare Technologies Inc	Accounting Software/Data Processing	77,640
Sage Intacct, Inc	Data Processing	8,778
SNF Metrics LLC	Data Processing	6,945
Wellsky	Data Processing	8,144
Total		191,384

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. \$ 52,436 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. \$ 628,278
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. \$ 772 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? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.