

		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: 3000432

Facility Name: Casey Rehab and Nursing

Address: 100 N E 15th Casey 62420

County: Clark

Telephone Number: (217) 932-5217 Fax #: (217) 932-5408

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2024

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

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)

(Type or Print Name)

(Title)

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Casey Rehab and Nursing # 3000432 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	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,921	314	2,235	8
9	SNF/PED									9
10	ICF	4,083	6,296	1,473		3,573			15,425	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,083	6,296	1,473		3,573	1,921	314	17,660	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 70.12%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/24

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/1/24 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 69

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	212,357	6,222	5,015	223,594		223,594		223,594			1
2	Food Purchase		123,468		123,468		123,468		123,468			2
3	Housekeeping	102,276	7,949		110,225		110,225		110,225			3
4	Laundry	83,681	6,504		90,185		90,185		90,185			4
5	Heat and Other Utilities			87,088	87,088		87,088	465	87,553			5
6	Maintenance	47,309	4,332	42,762	94,403		94,403	(27,716)	66,687			6
7	Other (specify):* Waste Disposal			8,813	8,813		8,813		8,813			7
8	TOTAL General Services	445,623	148,475	143,678	737,776		737,776	(27,251)	710,525			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,887,909	103,630	1,472	1,993,011		1,993,011	34,559	2,027,570			10
10a	Therapy											10a
11	Activities	25,535	6,185		31,720		31,720		31,720			11
12	Social Services											12
13	CNA Training			255	255		255		255			13
14	Program Transportation											14
15	Other (specify):* Allocated Home Office Benefit							6,914	6,914			15
16	TOTAL Health Care and Programs	1,913,444	109,815	13,727	2,036,986		2,036,986	41,473	2,078,459			16
	C. General Administration											
17	Administrative	133,210		228,864	362,074		362,074	(223,496)	138,578			17
18	Directors Fees											18
19	Professional Services			52,591	52,591		52,591	50,660	103,251			19
20	Dues, Fees, Subscriptions & Promotions			30,971	30,971		30,971	2,818	33,789			20
21	Clerical & General Office Expenses	85,998	10,468	8,384	104,850		104,850	79,234	184,084			21
22	Employee Benefits & Payroll Taxes			376,550	376,550		376,550		376,550			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,168	1,168		1,168	3,134	4,302			24
25	Other Admin. Staff Transportation			3,011	3,011		3,011	7,809	10,820			25
26	Insurance-Prop.Liab.Malpractice			85,856	85,856		85,856	1,189	87,045			26
27	Other (specify):* Allocated Home Office Benefit							11,415	11,415			27
28	TOTAL General Administration	219,208	10,468	787,395	1,017,071		1,017,071	(67,237)	949,834			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,578,275	268,758	944,800	3,791,833		3,791,833	(53,015)	3,738,818			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							137,002	137,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,500	12,500		12,500	(11,678)	822			32
33	Real Estate Taxes			25,157	25,157		25,157	(19,986)	5,171			33
34	Rent-Facility & Grounds			260,000	260,000		260,000	(35,834)	224,166			34
35	Rent-Equipment & Vehicles			4,545	4,545		4,545		4,545			35
36	Other (specify):* Loan Costs							163,923	163,923			36
37	TOTAL Ownership			302,202	302,202		302,202	233,427	535,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	153,598	63,830	2,559	219,987		219,987	77,218	297,205			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,531	209,531		209,531		209,531			42
43	Other (specify):* Disallowed Costs			206,626	206,626		206,626	(206,626)				43
44	TOTAL Special Cost Centers	153,598	63,830	418,716	636,144		636,144	(129,408)	506,736			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,731,873	332,588	1,665,718	4,730,179		4,730,179	51,004	4,781,183			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	(6,766)	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	137,002	30		9
10	Interest and Other Investment Income	(10,364)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(194,257)	43		24
25	Fund Raising, Advertising and Promotional	(4,173)	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	(329,632)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (409,620)		\$	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)	460,624		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 460,624		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 51,004		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	Offset Purchase Rebates	(46)	10	3
4	Non-Allowable Travel	(1,546)	25	4
5	Disallow Related Party Interest Expense	(213,598)	32	5
6	Capitalize Equipment/Repairs over \$2,500	(28,398)	6	6
7	Capitalize Equipment over \$2,500	(38,290)	10	7
8	Capitalize Equipment over \$2,500	(3,273)	21	8
9	Capitalize Large Allocated Repair-Home Office	(465)	6	9
10	Disallow Non Allowable Allocated Home Office Exp	(6,150)	21	10
11	Disallow Non Allowable Allocated Home Office Exp	(1,648)	25	11
12	Disallow Owner Wages	(33,448)	17	12
13	Disallow Owner Wages	(2,770)	21	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	(329,632)		49

VII. RELATED PARTIES

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

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

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	19	Professional Fees	\$	Casey Rehab Realty LLC		\$ 3,500	\$ 3,500	1
2	V	32	Interest	13,538	Casey Rehab Realty LLC		225,000	211,462	2
3	V	33	Real Estate Taxes	20,965	Casey Rehab Realty LLC			(20,965)	3
4	V	34	Rent	40,000	Casey Rehab Realty LLC		4,166	(35,834)	4
5	V	36	Loan Costs		Casey Rehab Realty LLC		163,923	163,923	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			\$ 74,503			\$ 396,589	\$ * 322,086	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.

☒ 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	5	Heat and Other Utilities	\$	Stern Therapy Consultants, LLC		\$ 465	\$ 465	15
16	V	6	Maintenance		Stern Therapy Consultants, LLC		1,147	1,147	16
17	V	19	Professional Services		Stern Therapy Consultants, LLC		47,160	47,160	17
18	V	20	Dues, Fees, Subscriptions & Promotions		Stern Therapy Consultants, LLC		2,817	2,817	18
19	V	21	Clerical & General Office Expenses		Stern Therapy Consultants, LLC		9,885	9,885	19
20	V	24	Travel and Seminar		Stern Therapy Consultants, LLC		3,134	3,134	20
21	V	25	Other Admin. Staff Transportation		Stern Therapy Consultants, LLC		11,003	11,003	21
22	V	26	Insurance-Prop.Liab.Malpractice		Stern Therapy Consultants, LLC		1,189	1,189	22
23	V	33	Real Estate Taxes		Stern Therapy Consultants, LLC		979	979	23
24	V	34	Rent-Facility & Grounds		Stern Therapy Consultants, LLC		2,348	2,348	24
25	V								25
26	V								26
27	V	10	Nursing and Medical Records		Stern Therapy Consultants, LLC		72,895	72,895	27
28	V	15	Emp. Ben.-Nsg & Med		Stern Therapy Consultants, LLC		6,914	6,914	28
29	V	17	Administrative	228,864	Stern Therapy Consultants, LLC		33,448	(195,416)	29
30	V	21	Clerical & General Office Expenses		Stern Therapy Consultants, LLC		70,829	70,829	30
31	V	27	Emp. Ben.-Gen. Admin.		Stern Therapy Consultants, LLC		9,890	9,890	31
32	V	39	Therapy Wages		Stern Therapy Consultants, LLC		73,305	73,305	32
33	V	39	Emp. Ben.-Therapy		Stern Therapy Consultants, LLC		6,953	6,953	33
34	V								34
35	V	17	Administrative		Stern Therapy Consultants, LLC		5,368	5,368	35
36	V	21	Clerical & General Office Expenses		Stern Therapy Consultants, LLC		10,713	10,713	36
37	V	27	Emp. Ben.-Gen. Admin.		Stern Therapy Consultants, LLC		1,525	1,525	37
38	V								38
39	Total			\$ 228,864			\$ 371,967	\$ * 143,103	39

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

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	20	Dues, Fees, Subscriptions & Promotions	\$	CET Office Holdings, LLC		\$ 1	\$ 1	15
16	V	32	Interest Expense		CET Office Holdings, LLC		822	822	16
17	V	34	Rent	2,348	CET Office Holdings, LLC			(2,348)	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			\$ 2,348			\$ 823	\$ * (1,525)	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	39	Pharmacy	\$ 63,830	Medwiz of Illinois, LLC		\$ 60,790	\$ (3,040)	15
16	V								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			\$ 63,830			\$ 60,790	\$ * (3,040)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Casey Rehab and Nursing

3000432

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Carmi Manor Rehab & Nursing Center	Carmi, IL	Stern Therapy	Pomona, NY	Back Office and	1
2			Countryside Care Center	Macomb, IL	Consultants, LLC		Therapy Mgmt	2
3			Gallatin Manor	Ridgway, IL	Casey Rehab Realty L	Pomona, NY	Property Co.	3
4			Henry Rehab and Nursing	Henry, IL	CET Office Holdings I	Pomona, NY	Stern Building	4
5			Lacon Rehab and Nursing	Lacon, IL	HCIT LLC	Bardonia, NY	IT Consulting	5
6			Macomb Post Acute Care Center	Macomb, IL	Medwiz of Illinois, LL	Bardonia, NY	Pharmacy	6
7			Marshall Rehabilitation and Nursing	Marshall, IL	CBE Funding, LLC	Pomona, NY	Finance Company	7
8			Mascoutah Rehab and Nursing	Mascoutah, IL				8
9			Mercer Manor Rehabilitation	Aledo, IL				9
10			Monmouth Rehab and Nursing	Monmouth, IL				10
11			Robinson Rehab & Nursing	Robinson, IL				11
12			Springfield Suites Rehab & Nursing	Springfield, IL				12
13			Twin Lakes Extended Care	Paris, IL				13
14			Northwoods Rehabilitation	Moravia, NY				14
15			Agawam North Rehab and Nursing	Agawam, MA				15
16			Agawam South Rehab and Nursing	Agawam, MA				16
17			Agawam East Rehab and Nursing	Agawam, MA				17
18			Agawam West Rehab and Nursing	Agawam, MA				18
19			Ayer Valley Rehab and Nursing	Ayer, MA				19
20			Andover Manor Rehab and Nursing	Andover, MA				20
21			Andover Forest Post Acute Care Center	North Andover, MA				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	Benjamin Friedman	CFO	Administrative	15.00	See Att. Sch 7A	1.60	4.00	Alloc. Salary	\$ 5,368	17-7	1
2	Dina Hirsch	Controller	Administrative	2.00	See Att. Sch 7A	1.68	4.18	Alloc. Salary	8,197	21-7	2
3	Daniella Unger	Regional MDS Coord	Nursing	1.50	See Att. Sch 7A	1.68	4.18	Alloc. Salary	10,467	10-7	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	\$ 24,032		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 Casey Rehab and Nursing # 3000432 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 Stern Therapy Consultants, LLC
Street Address 7B Medical Park Drive
City / State / Zip Code Pomona, NY 10970
Phone Number (845) 414-3300
Fax Number (845) 517-4796

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Heat and Other Utilities	Evenly Over Units	23	23	\$ 10,705	\$	1	\$ 465	1
2	6	Maintenance	Evenly Over Units	23	23	26,392		1	1,147	2
3	19	Professional Services	Evenly Over Units	23	23	1,084,691		1	47,160	3
4	20	Dues, Fees, Subscriptions & Prom	Evenly Over Units	23	23	64,789		1	2,817	4
5	21	Clerical & General Office Expense	Evenly Over Units	23	23	227,348		1	9,885	5
6	24	Travel and Seminar	Evenly Over Units	23	23	72,075		1	3,134	6
7	25	Other Admin. Staff Transportatio	Evenly Over Units	23	23	253,068		1	11,003	7
8	26	Insurance-Prop.Liab.Malpractice	Evenly Over Units	23	23	27,342		1	1,189	8
9	33	Real Estate Taxes	Evenly Over Units	23	23	22,524		1	979	9
10	34	Rent-Facility & Grounds	Evenly Over Units	23	23	54,000		1	2,348	10
11								1		11
12										12
13	10	Nursing and Medical Records	Operating Months	24	21	1,749,468	1,749,468	1	72,895	13
14	15	Emp. Ben.-Nsg & Med	Operating Months	24	21	165,929		1	6,914	14
15	17	Administrative	Operating Months	24	21	802,749	802,749	1	33,448	15
16	21	Clerical & General Office Expense	Operating Months	24	21	1,699,900	1,699,900	1	70,829	16
17	27	Emp. Ben.-Gen. Admin.	Operating Months	24	21	237,364		1	9,890	17
18	39	Therapy Wages	Operating Months	24	21	1,759,324	1,759,324	1	73,305	18
19	39	Emp. Ben.-Therapy	Operating Months	24	21	166,863		1	6,953	19
20										20
21	17	Administrative	Operating Months	25	25	134,198	134,198	1	5,368	21
22	21	Clerical & General Office Expense	Operating Months	25	25	267,826	267,826	1	10,713	22
23	27	Emp. Ben.-Gen. Admin.	Operating Months	25	25	38,130		1	1,525	23
24										24
25	TOTALS					\$ 8,864,685	\$ 6,413,465		\$ 371,967	25

Ending: 2/31/2025

(845) 517-4796

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Casey Rehab and Nursing # 3000432 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 Medwiz of Illinois, LLC
Street Address 167 Route 304
City / State / Zip Code Bardonia, NY 10954
Phone Number (845) 624-8080
Fax Number (845) 624-8055

	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	39	Pharmacy	Direct Cost	60,790	1	\$ 60,790	\$	60,790	\$ 60,790	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 60,790	\$		\$ 60,790	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	CIBC		X	Mortgage	\$37,917.00	12/10/25	\$ 5,300,000	\$ 5,300,000	12/10/28	0.0700	\$	1	
2	CBE Funding LLC	X			\$18,750.00	11/15/24	1,500,000	1,500,000	11/14/30	0.1500	225,000	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Intercompany Loan	X		Working Capital	\$12,500.00	11/15/24	1,000,000		11/14/30	0.1500	12,500	6	
7								Offset Interet on Intercompany			(12,500)	7	
8												8	
9	TOTAL Facility Related				\$69,167.00		\$ 7,800,000	\$ 6,800,000			\$ 225,000	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(11,402)	10	
11								CET Office Holdings Alloc			822	11	
12								Disallow Remaining Rel Party Int			(213,598)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (224,178)	14	
15	TOTALS (line 9+line14)						\$ 7,800,000	\$ 6,800,000			\$ 822	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.)

** 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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
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.)				\$	4,1922
3. Under or (over) accrual (line 2 minus line 1).				\$	4,1923
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	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.		Allocated from Home Office		979	
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.				\$	5,1717
Assessed Value from Real Estate Tax Bill: 2024 319,689 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 25,157 13					
Facility does not accrue for real estate taxes.					
Line 2: 2024 Taxes		25157		16	16
Credit at Closing		-20965		17	17
Total		4192		17	17

FOR BHF USE ONLY	
14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
15	PLUS APPEAL COST FROM LINE 5 \$ 15
16	LESS REFUND FROM LINE 6 \$ 16
17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Casey Rehab and Nursing COUNTY Clark

FACILITY IDPH LICENSE NUMBER 3000432

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. 03-11-17-20-403-005	Long Term Care Property	\$ 25,157.40	\$ 25,157.40
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 25,157.40	\$ 25,157.40

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: 20,200 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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		2024	\$ 822,000	1
2	Alloc CET Office Holdings, LLC		1989	2,609	2
3	TOTALS			\$ 824,609	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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69		2024	1972	\$ 4,658,000	\$	35	\$ 133,086	\$ 133,086	\$ 144,176	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install 32 Channel COM System			2025	15,050		20	376	376	376	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											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2021	530		20	27	27	522	46
47	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2023	1,319		20	66	66	198	47
48	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2024	1,167		20	58	58	117	48
49	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2025	465		20	23	23	23	49
50	Allocated from CET Office Holdings, LLC - Building	1989	15,475		20	397	397	3,073	50
51	Allocated from CET Office Holdings, LLC-Leasehold Improvements	2018	4,457		20	223	223	1,709	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,696,463	\$		\$ 134,256	\$ 134,256	\$ 150,194	70

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	54,911		2,746	2,746	10 yrs	2,746	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 54,911	\$	\$ 2,746	\$ 2,746		\$ 2,746	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)	\$ 5,575,983	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 137,002	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 137,002	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 152,940	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Petersen SNF Holdings
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:	1972	69	11/1/24	\$ 224,166			3
4	Additions							4
5								5
6								6
7	TOTAL		69		\$ 224,166			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: \$ 4,545
- 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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name:

Casey Rehab and Nursing

IDPH License ID Number:

3000432

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	936
Dietary Equipment	1,080
Laundry Equipment	2,529
Total - Line 16	4,545

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
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		255		255
9	TOTALS	\$	\$ 255	\$	\$ 255
10	SUM OF line 9, col. 1 and 2 (e)	\$ 255			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(1)	339	hrs	\$ 18,435		\$	339	\$ 18,435	1
2	Licensed Speech and Language Development Therapist	39(1)	317	hrs	18,386			317	18,386	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	39(1)	2882	hrs	116,777			2,882	116,777	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			63,830		63,830	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): Lab/X-Ray	39(3)				2,559			2,559	12
13	Other (specify): Home Office Allocation	39(7)			80,258				80,258	13
14	TOTAL				\$ 233,856	\$ 2,559	\$ 63,830	3,538	\$ 300,245	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number	Casey Rehab and Nursing
---------------------------	-------------------------

3000432

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025

____ (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 366,918	\$ 611,465	1
2	Cash-Patient Deposits	20,982	20,982	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,044,402	1,044,402	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,038	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,432,302	\$ 1,677,887	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		824,609	13
14	Buildings, at Historical Cost		4,658,000	14
15	Leasehold Improvements, at Historical Cost		38,463	15
16	Equipment, at Historical Cost		54,911	16
17	Accumulated Depreciation (book methods)		(152,940)	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): Closing Costs		31,488	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 5,454,531	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,432,302	\$ 7,132,418	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 135,810	\$ 401,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,917	20,917	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,659	20,659	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Good Faith Deposit</u>		30,000	36
37	<u>Due to Prior Owner</u>	4,761	4,761	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 182,147	\$ 478,147	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	979,341	1,500,000	39
40	Mortgage Payable		5,300,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u></u>			43
44	<u></u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 979,341	\$ 6,800,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,161,488	\$ 7,278,147	46
47	TOTAL EQUITY(page 18, line 24)	\$ 270,814	\$ (145,729)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,432,302	\$ 7,132,418	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$78,950	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$78,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	191,864	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)	\$191,864	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)	\$270,814	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Casey Rehab and Nursing

3000432

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	\$ 4,821,260	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,821,260	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,233	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 85,233	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	3,401	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,401	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,364	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,364	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rebates	46	28
28a	CNA Initiative	1,739	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,785	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,922,043	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	737,776	31
32	Health Care	2,036,986	32
33	General Administration	1,017,071	33
	B. Capital Expense		
34	Ownership	302,202	34
	C. Ancillary Expense		
35	Special Cost Centers	426,613	35
36	Provider Participation Fee	209,531	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,730,179	40
41	Income before Income Taxes (line 30 minus line 40)**	191,864	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 191,864	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 872,234.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,360,652.00	45
46	MMAI-Medicaid is the Primary Payer	318,336.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	850,620.00	48
49	Medicare Part A	1,253,366.00	49
50	Other-(specify) Insurance/Managed Care	166,052.00	50
51	Other-(specify)		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)	\$ 4,821,260	56

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,366	2,466	\$ 117,075	\$ 47.48	1
2	Assistant Director of Nursing	2,116	2,330	88,689	38.06	2
3	Registered Nurses	11,449	11,878	507,100	42.69	3
4	Licensed Practical Nurses	7,333	7,599	262,237	34.51	4
5	CNAs & Orderlies	40,308	41,510	884,415	21.31	5
6	CNA Trainees					6
7	Licensed Therapist	3,474	3,538	153,598	43.41	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,464	1,472	25,535	17.35	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,177	12,446	212,357	17.06	15
16	Dishwashers					16
17	Maintenance Workers	1,957	2,053	47,309	23.04	17
18	Housekeepers	6,503	6,595	102,276	15.51	18
19	Laundry	5,321	5,396	83,681	15.51	19
20	Administrator	2,402	2,578	133,210	51.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,304	3,344	85,998	25.72	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	1,436	1,500	28,393	18.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,610	104,705	\$ 2,731,873 *	\$ 26.09	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	72	\$ 5,015	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	\$ 17,015		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.

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	
Amanda Jordan	Administrator	0	\$ 58,402	Workers' Compensation Insurance	\$	17,508	IDPH License Fee	\$ 1,991	
Nicole Nichol	Administrator	0	37,308	Unemployment Compensation Insurance		48,355	Advertising: Employee Recruitment	26,000	
James McGill	Regional Admin	0	37,500	FICA Taxes		208,525	Health Care Worker Background Check		
				Employee Health Insurance		96,951	(Indicate # of checks performed 10)	227	
				Employee Meals			Patient Background Checks 88	2,042	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				Other Employee Benefits		5,211	Dues & Subscriptions	37	
TOTAL (agree to Schedule V, line 17, col. 1)							Licenses & Fees	674	
(List each licensed administrator separately.)			\$ 133,210						
B. Administrative - Other							Home Office/CET Office Holdings Alloc	2,818	
Description			Amount				Less: Public Relations Expense	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 228,864				PAC and Lobbying payments	()	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 228,864	TOTAL (agree to Schedule V, line 22, col.8)			\$ 376,550	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 33,789
(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	
Direct Supply	Life Safety Compliance	\$	889			\$	Out-of-State Travel	\$	
IT Computing Services	Computer Service		2,735						
Natl Datacare Corp	Fund Management		1,365						
Pointclickcare	Computer Service		15,165				In-State Travel		
Streamline Verify LLC	Computer Service		394						
Whentowork	Employee Scheduling Software		520						
Bernath and Rosenberg, P.C	Accounting		5,080						
Gutnicki LLP	Legal Services		7,367				Seminar Expense	1,168	
Livingston Barger	Legal Services		2,609						
Nova Group	PCNA Consultant		8,000				Home Office Allocation	3,134	
Parkwood Associates, Inc.	401K Consultant		750						
Accurate Pay	Payroll Services		7,717				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)			\$ 52,591					TOTAL	\$ 4,302

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

****See instructions.**

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.

\$18,641Line10

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YesIf 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.
This amount is to be recorded on line 42 of Schedule V.

\$209,531

(8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NoIf 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?

NoFor 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.

\$N/AHas any meal income been offset against related costs?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?

NoIf 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.