

		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: 0039644

Facility Name: Caseyville Nursing Rehab Ctr

Address: 601 West Lincoln Ave Caseyville 62232
Number City Zip Code

County: Saint Clair

Telephone Number: (618) 345-3072 Fax # (847) 345-3170

HFS ID Number:

Date of Initial License for Current Owners: 6/01/94

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

X"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: Amanda Springborn Telephone Number: (314) 925-3838

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 01/01/2025 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) (Date)

(Print Name and Title)

(Firm Name & Address) RSM US LLP 1450 American Way Suite 1400 Schaumburg, IL 60173-6084

(Telephone) (847) 517-7070 Fax # (847)517-7067

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

Caseyville Nursing Rehab Ctr

0039644

Report Period Beginning: 01/01/2025

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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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	12,045	20,973	1,106	45	2,055	2,517	353	39,094	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	12,045	20,973	1,106	45	2,055	2,517	353	39,094	14

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

71.40%

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

None (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ NO ☐

Note : 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 06/01/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/01/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐

If YES, enter certified beds.

number of certified beds 150

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number		Caseyville Nursing Rehab Ctr		STATE OF ILLINOIS		#	0039644	Report Period Beginning:		01/01/2025		Ending:	Page 3		12/31/2025	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)																
	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY						
		Salary/Wage	Supplies	Other	Total					9	10					
	A. General Services	1	2	3	4	5	6	7	8	9	10					
1	Dietary	400,527	33,736	9,490	443,753		443,753		443,753			1				
2	Food Purchase		299,181		299,181		299,181		299,181			2				
3	Housekeeping	263,509	45,635		309,144		309,144		309,144			3				
4	Laundry	98,360	20,364		118,724		118,724		118,724			4				
5	Heat and Other Utilities			179,525	179,525		179,525		179,525			5				
6	Maintenance	129,975		221,112	351,087		351,087		351,087			6				
7	Other (specify):*											7				
8	TOTAL General Services	892,371	398,916	410,127	1,701,415		1,701,415		1,701,415			8				
	B. Health Care and Programs															
9	Medical Director			24,457	24,457		24,457		24,457			9				
10	Nursing and Medical Records	3,459,597	175,415	343,505	3,978,517		3,978,517	37,942	4,016,459			10				
10a	Therapy											10a				
11	Activities	108,931			108,931		108,931		108,931			11				
12	Social Services	62,017			62,017		62,017		62,017			12				
13	CNA Training											13				
14	Program Transportation											14				
15	Other (specify):*											15				
16	TOTAL Health Care and Programs	3,630,545	175,415	367,962	4,173,922		4,173,922	37,942	4,211,864			16				
	C. General Administration															
17	Administrative	132,049		120,000	252,049		252,049	(27,500)	224,549			17				
18	Directors Fees											18				
19	Professional Services			1,131,561	1,131,561		1,131,561	(323,135)	808,426			19				
20	Dues, Fees, Subscriptions & Promotions			88,963	88,963		88,963	(13,025)	75,938			20				
21	Clerical & General Office Expenses	440,118	26,989	17,796	484,903		484,903	1	484,904			21				
22	Employee Benefits & Payroll Taxes			642,045	642,045		642,045		642,045			22				
23	Inservice Training & Education											23				
24	Travel and Seminar			10,981	10,981		10,981		10,981			24				
25	Other Admin. Staff Transportation			14,984	14,984		14,984		14,984			25				
26	Insurance-Prop.Liab.Malpractice			210,849	210,849		210,849	44,237	255,086			26				
27	Other (specify):*											27				
28	TOTAL General Administration	572,167	26,989	2,237,180	2,836,335		2,836,335	(319,422)	2,516,913			28				
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,095,083	601,320	3,015,269	8,711,672		8,711,672	(281,480)	8,430,192			29				

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
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 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	
	D. Ownership											
30	Depreciation			19,267	19,267		19,267	177,861	197,128			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,610)	(1,610)		(1,610)	137,137	135,527			32
33	Real Estate Taxes							90,117	90,117			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)				34
35	Rent-Equipment & Vehicles			41,697	41,697		41,697		41,697			35
36	Other (specify):* Mortgage Insurance							18,051	18,051			36
37	TOTAL Ownership			623,354	623,354		623,354	(140,834)	482,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			100	100		100		100			38
39	Ancillary Service Centers		131,792	714,732	846,524		846,524		846,524			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			793,946	793,946		793,946		793,946			42
43	Other (specify):* Non-Allowable Cos			289,623	289,623		289,623	(289,623)				43
44	TOTAL Special Cost Centers		131,792	1,798,401	1,930,193		1,930,193	(289,623)	1,640,570			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,095,083	733,112	5,437,024	11,265,219		11,265,219	(711,937)	10,553,282			45

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

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	(12,044)	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	(629)	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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,993)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(331,538)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(256,344)	43		24
25	Fund Raising, Advertising and Promotional	(4,441)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	22,000	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(76,351)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (662,340)		\$	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)	(49,597)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (49,597)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (711,937)		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

ID#0039644

Report Period Beginning:01/01/2025

Ending:12/31/2025

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Political Action Committee Payments	\$ (13,050)	20	1
2	Labs - Part A	(14,537)	43	2
3	X-Rays - Part A	(8,406)	43	3
4	Damage Loss	(291)	43	4
5	Travel and Entertainment	(12,567)	43	5
6	Disallow Management fees	(27,500)	17	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				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	(76,351)		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		See PG6-Supp		See PG6-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 Services	\$	Caseyville Property LLC		\$ 46,630	\$ 46,630	1
2	V	26	Insurance-Prop.Liab.Malpractice		Caseyville Property LLC		43,977	43,977	2
3	V	30	Depreciation		Caseyville Property LLC		178,490	178,490	3
4	V	32	Interest	18	Caseyville Property LLC		133,238	133,220	4
5	V	33	Real Estate Taxes		Caseyville Property LLC		90,117	90,117	5
6	V	34	Rent	564,000	Caseyville Property LLC			(564,000)	6
7	V	36	Mortgage Insurance		Caseyville Property LLC		18,051	18,051	7
8	V	21	Misc Expense		Caseyville Property LLC		1	1	8
9	V	32	Amortization		Caseyville Property LLC		3,917	3,917	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 564,018			\$ 514,421	\$ * (49,597)	14

* 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	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
	Line	Item							
15	V		N/A	\$			\$		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			\$			\$ 0	\$ *	0 39

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

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			Cahokia Nursing & Rehab	Cahokia	Prairie Crossing Supp	Shabbona	Supportive Living	1
2					Living Center, LLC		Facility	2
3								3
4			Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	Cahokia Building LLC	Cahokia	Real Estate	4
5			Oregon Living & Rehabilitation, LLC	Oregon	Caseyville Property LI	Caseyville	Real Estate	5
6			Prairie Crossing Living & Rehab Center	Shabbona	Green Acres	Amboy	Real Estate	6
7					Property LLC			7
8								8
9			Tower Hill Rehabilitation LLC	South Elgin	FOM Property LLC	Franklin Grove	Real Estate	9
10								10
11					Oregon Property LLC	Oregon	Real Estate	11
12					Prairie Crossing	Shabbona	Real Estate	12
13					Property LLC			13
14								14
15					Tower Hill Property L	South Elgin	Real Estate	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

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	Elly Bachrach		Administrative	23.67	92,500	20	50.00	Guar Pmt	\$ 92,500	17(3,7)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,500		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 Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/2025 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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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		N/A				\$	\$			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					\$	\$		\$	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	Heartland Bank		X	Mortgage	\$38,896.00	11/27/2001	\$ 6,814,000	\$ 3,494,105	12/1/2036	6.35%	\$ 133,220	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$38,896.00		\$ 6,814,000	\$ 3,494,105			\$ 133,220	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income			(1,610)	11	
12								Amortization			3,917	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 2,307	14	
15	TOTALS (line 9+line14)						\$ 6,814,000	\$ 3,494,105			\$ 135,527	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,051 Line # 36

* 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.)

B. Real Estate Taxes

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.

FACILITY NAME	Caseyville Nursing Rehab Ctr	COUNTY	Saint Clair
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CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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

D. Does the Operating Entity? (X) (a) Own the Equipment (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? Y
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 X NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Resident Care		2001	\$ 350,000	1
2					2
3	TOTALS			\$ 350,000	3

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	150		2001		\$ 5,265,179	\$	39	\$ 135,005	\$ 135,005	\$ 3,395,955
5										
6										
7										
8										
	Improvement Type**									
9	Various		1994		22,304		20			22,304
10	Various		1995		52,604		20			52,604
11	Various		1996		2,492		20			2,492
12	Various		1997		11,349		20			11,349
13	Various		1998		14,511		20			14,511
14	Various		1999		83,394		20			83,394
15	Parking Lot		2000		2,830		20			2,830
16	Sprinkler System		2000		3,385		20			3,385
17	Sprinkler System		2000		5,820		20			5,820
18	A/C Repairs		2000		1,018		10			1,018
19	Ac Repairs		2000		1,102		20			1,102
20	Draperies		2000		1,052		20			1,052
21	Carpeting		2000		1,578		20			1,578
22	Air Handler		2000		1,786		20			1,786
23	Air Conditioner		2000		1,963		7			1,963
24	Air Handler		2000		1,241		20			1,241
25	Air Conditioner		2000		1,029		20			1,029
26	Compressor		2000		1,800		20			1,800
27	Booster Heater		2000		1,675		20			1,675
28	Air Conditioner		2000		5,821		20			5,821
29	Air Conditioner		2000		17,320		20			17,320
30	Air Conditioner		2001		3,630		20			3,630
31	Air Conditioner		2001		3,630		20			3,630
32	Air Conditioner		2001		3,111		20			3,111
33	Blinds		2001		1,212		20			1,212
34	Sprinkler Repair		2001		1,609		20			1,609
35	Sprinkler Heads		2001		2,145		20			2,145
36	Pipes Repair		2001		1,903		20			1,903

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Caseyville Nursing Rehab Ctr

0039644

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room Wall	2002	\$ 10,650	\$	10	\$	\$	\$ 10,650	37
38	Water Heater	2002	4,900		12			4,900	38
39	Circuit Breaker	2002	1,390		10			1,390	39
40	Air Conditioners	2002	2,890		7			2,890	40
41	Air Conditioners	2002	4,284		7			4,284	41
42	Water Heater	2002	2,249		12			2,249	42
43	Doors	2003	9,995		20			9,995	43
44	Dry Value System	2003	5,623		20			5,623	44
45	Landscaping	2003	8,800		20			8,800	45
46	Nursing Stations	2003	35,000		20			35,000	46
47	Repair Fire Protection Equipment	2003	1,694		20			1,694	47
48	P.A. Amplifier	2003	713		20			713	48
49	Security Systems	2004	23,268		20			23,268	49
50	16 Transmitters	2004	1,517		20			1,517	50
51	Nurses Stations	2004	35,000		20			35,000	51
52	Wardrobe units w/ Installation	2004	46,731		20			46,731	52
53	Cabinets and Countertops	2005	85,938		20	2,148	2,148	85,938	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	52	52	2,100	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545		20	140	140	5,545	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensors	2005	6,270		20	153	153	6,270	59
60	Vinyl Flooring	2005	5,009		5			5,009	60
61	Paving and Sealing Sidewalks	2005	7,000		15			7,000	61
62	Metal Doors	2005	1,926		20	51	51	1,926	62
63	Kitchen Floor	2006	10,300		20	515	515	10,043	63
64	Sprinkler System	2006	9,529		20	476	476	9,288	64
65	Door Monitors & Paging System	2006	811		20	41	41	794	65
66	Exterior Security Lighting	2006	4,180		20	209	209	4,076	66
67	6 A/C Units	2006	2,576		20	129	129	2,513	67
68	6 A/C Units	2006	2,576		20	129	129	2,513	68
69	Fuel Pump & Injectors	2006	4,719		20	236	236	4,602	69
70	TOTAL (lines 4 thru 69)		\$ 5,937,002	\$		\$ 139,283	\$ 139,283	\$ 4,066,915	70

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr

0039644

Report Period Beginning:

01/01/2025

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	
1	Totals from Page 12A, Carried Forward		\$ 5,937,002	\$		\$ 139,283	\$ 139,283	\$ 4,066,915	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	3,609	2
3	Duct Heater	2006	1,349	49	20	67	18	1,312	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	8,984	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,018	20	2,895	877	53,558	5
6	4 Hot Water Heaters	2007	13,462	367	20	673	306	12,451	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	36,499	7
8	Repair Sprinkler System	2007	3,957		20	198	198	3,663	8
9	Oak flooring	2008	15,571	566	20	778	212	13,625	9
10	Fire alarm system	2008	8,858	322	20	443	121	7,751	10
11	Street and parking lot paving	2008	43,360	1,280	20	2,168	888	37,940	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	4,128	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	34,565	13
14	Replace pipe and fitting	2009	4,232	154	20	211	57	3,491	14
15	Air Handling Equipment	2010	22,154	806	20	1,108	302	17,174	15
16	Plumbing Value	2011	4,600	167	20	230	63	3,335	16
17	Hot water system	2011	6,900	251	20	345	94	5,003	17
18	Sprinkler Work	2011	20,035	729	20	1,002	273	14,943	18
19	Direct TV system Installation	2011	7,000		20	350	350	5,075	19
20	Handicap shower stall	2011	2,955	107	20	148	41	2,143	20
21									21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3,388	123	20	169	46	2,288	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4,917	179	20	246	67	3,319	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9,975	363	20	499	136	6,733	24
25	Fire Alarm: Whole Facility	2012	6,434	234	20	322	88	4,316	25
26									26
27	81 Gallon Hot Water Heater	2013	4,624		7			4,624	27
28	New Door	2013	3,094		7			3,094	28
29	100 Gallon Hot Water Heater:	2013	6,236		7			6,236	29
30									30
31									31
32	Belt Drive Rooftop Ventilator	2014	3,197		10			3,197	32
33	Countertop and Back Splash	2014	5,593		10			5,593	33
34	TOTAL (lines 1 thru 33)		\$ 6,293,375	\$ 11,227		\$ 155,964	\$ 144,737	\$ 4,375,562	34

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr

0039644

Report Period Beginning:

01/01/2025

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	
1	Totals from Page 12B, Carried Forward		\$ 6,293,375	\$ 11,227		\$ 155,964	\$ 144,737	\$ 4,375,562	1
2	7 Electric Door Holder/Closers	2015	10,102		20	505	505	5,304	2
3	Walk Path Improvements	2015	15,875		20	794	794	8,334	3
4	Hot Water Heater	2015	3,569		5			3,569	4
5									5
6	Siding for Cupola	2016	3,677	134	20	184	50	1,747	6
7	Clinic Service Sink Replacement	2016	3,909	142	20	195	53	1,857	7
8	2 Hot Water Heaters - Mechanical Room	2016	12,531		5			12,531	8
9	Hot Water Heater - Nurses Station	2016	7,050		5			7,050	9
10	Time Clock - 400 Hall in back of building by break room	2016	9,277		5			9,277	10
11	4 Custom Duct Heaters 200, 300, 400 & 600 halls	2016	3,650		5			3,650	11
12									12
13	Walk-In Cooler - Kitchen	2017	18,495	673	20	925	252	7,708	13
14	Install Fire Alarm	2017	3,430	125	20	172	47	1,458	14
15	98 gallon Water heater	2017	13,801		5			13,801	15
16	Install Sprinkler System - Entire Building	2017	250,800		20	12,540	12,540	106,590	16
17	Plan Submission Fee for Sprinklers - Entire Building	2017	3,010	109	5		(109)	3,010	17
18									18
19	Furnish & Install Building Front Doors - Main Exterior Entrance	2018	4,822	175	20	241	66	1,808	19
20									20
21	RE Install new water heater and associate piping	2019	4,925		20	246	246	1,601	21
22	RE Replace Lennox Condenser model ELS090S4S- Kitchen AC unit	2019	4,783		20	239	239	1,554	22
23	RE Fire alarm installation charges	2019	4,966		20	248	248	1,614	23
24	RE Security system and installation	2019	3,205		20	160	160	1,042	24
25	RE Replacement of fire alarm	2019	10,000		20	500	500	3,250	25
26									26
27	Install 2 water heaters	2020	26,876		20	1,344	1,344	7,391	27
28	Install accutech system - throughout facility	2020	9,238		20	462	462	2,541	28
29	Install Lightning Protection System - Entire facility	2020	17,623		20	881	881	4,848	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,738,989	\$ 12,585		\$ 175,601	\$ 163,016	\$ 4,587,095	34

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr

0039644

Report Period Beginning:

01/01/2025 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	
1	Totals from Page 12C, Carried Forward		\$ 6,738,989	\$ 12,585		\$ 175,601	\$ 163,016	\$ 4,587,095	1
2									2
3	Patio concrete- LED Lights, pergola, granite countertop, outdoor	2021	50,739		15	3,383	3,383	15,221	3
4	kitchen, outdoor kitchen & grill, fence, outdoor seating wall								4
5	Water heater	2021	9,200		30	307	307	1,380	5
6	Install 4 PTAC units	2021	2,725		5	545	545	2,452	6
7	CCTV Cameras	2021	2,610		5	522	522	2,349	7
8	4 door lock systems	2022	8,231	274	30	274		960	8
9	Replace Walk In Freezer Condenser	2022	6,098	1,220	5	1,220		4,269	9
10									10
11	Electrical work to move panel and circuit in kitchen	2023	3,450	183	15	230	47	643	11
12									12
13	Install float switches in drain pans 8 air handlers.	2023	3,785	74	15	252	179	578	13
14	Stormfront Roofing Inc-Roof repair & Tune up	2023	7,450	135	15	497	361	1,129	14
15	Interior, paint cove base and water line addition	2023	24,775	1,652	15	1,652		4,955	15
16	Season 12k Ptac 265 volt	2023	2,742	183	15	183		548	16
17									17
18	Exhaust fan motors and belts on 8 bathrooms	2024	3,600	120	15	240	120	360	18
19	replaced along with wiring replaced from motor to switches.								19
20	6 Front entry door locks replaced	2024	4,980	332	15	332	(0)	498	20
21	Inspection and maintenance of PIV tamper switch	2024	7,164	478	15	478	(0)	716	21
22	2 Boiler water heater repair	2024	7,162	477	15	477	0	716	22
23	Replace 2 water heaters	2024	37,050	2,470	15	2,470		3,707	23
24	Replace pipe and mixing valves	2024	2,949	197	15	197	(0)	453	24
25	Cooling compressor replacement	2025	3,400	67	15	67		67	25
26	Alarm smoke detector	2025	6,578	121	15	121		121	26
27	Emergency repair to pipe	2025	10,886	72	15	72		72	27
28	RE Heater compressor replacement	2025	8,683		15	302	302	302	28
29	RE Water heater replacement	2025	43,417		15	1,223	1,223	1,223	29
30	RE repair 12 shower bases	2025	41,265		15	703	703	703	30
31									31
32	Tie to financials			(7,154)			7,154		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,037,928	\$ 13,485		\$ 191,346	\$ 177,861	\$ 4,630,517	34

**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	\$26,153	\$3,408	\$3,408	\$	5-10	\$8,859	71
72	Current Year Purchases	29,235	2,374	2,374			2,374	72
73	Fully Depreciated Assets	1,569,672				5-10	1,569,672	73
74								74
75	TOTALS	\$1,625,060	\$5,782	\$5,782	\$		\$1,580,905	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	Facility Use	2011 Chevy Express Van	2011	\$40,007	\$	\$	\$		\$40,007	76
77										77
78										78
79										79
80	TOTALS			\$40,007	\$	\$	\$		\$40,007	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)	\$9,052,995	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$19,267	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$197,128	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$177,861	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,251,429	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				N/A			4
5								5
6								6
7	TOTAL				\$			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
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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: \$41,697Description: See SCH 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

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:

Caseyville Nursing & Rehabilitation Center, Inc.

IDPH License ID Number:

0039644

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

	Rental Description	Amount
500112-MAID	Medical Equipment Rental-Medicaid	13,398
500112-MEDA	Medical Equipment Rental-Medicaid	3,402
500112-MNGD	Medical Equipment Rental-Managed Care	2,097
500112-PRVT	Medical Equipment Rental-Private	694
520104-NURS	Nursing Equipment Rental-Clinical - Nursing	16,242
560108-MNTC	Building & Facility Equipment Rental-Environmental	125
700112-GADM	Office Equipment Rental-Administrative	5,739
	Total - Line 16	41,697

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	3,949	\$ 284,295	\$	3,949	\$ 284,295	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,845	132,859		1,845	132,859	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,619	260,578		3,619	260,578	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				131,792		131,792	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy	39(3)								12
13	Other (specify): Oxygen	39(2)				37,000			37,000	13
14	TOTAL			\$	9,413	\$ 714,732	\$ 131,792	9,413	\$ 846,524	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 320,790	\$ 339,513	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 199,368)	1,829,637	1,829,637	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,381	32,267	6
7	Other Prepaid Expenses	24,091	24,091	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	934,638	1,187,982	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,118,537	\$ 3,413,490	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,265,179	14
15	Leasehold Improvements, at Historical Cost	925,009	1,772,749	15
16	Equipment, at Historical Cost	363,683	1,665,067	16
17	Accumulated Depreciation (book methods)	(830,880)	(6,251,429)	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 (specCapitalized Costs	2,871	27,282	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 460,683	\$ 2,828,848	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,579,220	\$ 6,242,338	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (576)	\$ (576)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,927	242,927	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,867	4,867	31
32	Accrued Real Estate Taxes(Sch.IX-B)		86,200	32
33	Accrued Interest Payable		10,744	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,771,715	1,595,775	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,018,933	\$ 1,939,937	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,494,105	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,494,105	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,018,933	\$ 5,434,042	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,560,287	\$ 808,296	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,579,220	\$ 6,242,338	48

*(See instructions.)

Facility Name:Caseyville Nursing Rehab Ctr

IDPH License ID Number:0039644

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
RE ESCROW - INSURANCE	-	10,200
RE ESCROW - MIP	-	72,892
RE ESCROW - REPL RESERVE	-	130,677
RE ESCROW - REAL ESTATE TAX	-	39,575
Miscellaneous Receivables	162,007	162,007
Accounts Receivable - Employee Loans	-	-
Due To/From - Cahokia Nursing And Rehab Center	747,631	747,631
Due To/From - Caseyveille Partners	25,000	25,000
Total - Line 9	934,638	1,187,982
	-	-

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due to (from) G.P	-	55,940
Due t/f Caseyville nursing	-	120,000
Due To/From - Maestro	-	-
Due To/From - Associated Propco	(175,940)	(175,940)
Due To/From - SW Financial	(2,390)	(2,390)
Accounts Payable - Trade	(998,772)	(998,772)
Accrued Payables	(67,598)	(67,598)
Accrued Payables - Professional Fees	1,091	1,091
Accrued Payables - Health Insurance	(42,312)	(42,312)
Accrued Payable - Dental Insurance	259	259
Accrued Payables - Short Term Disability	(1,546)	(1,546)
Accrued Payables - 401K Deductions	7,711	7,711
Accrued Payables - Garnishments	(271)	(271)
Fringe Benefits - Flow Through	(9,504)	(9,504)
Accrued Payables - Business Insurance	(6,248)	(6,248)
Accrued Payables - OIG Audit	(166,752)	(166,752)
Accrued Payables - Bed Taxes Add'l	(274,444)	(274,444)
Accrued Payables - Management Fees	(35,000)	(35,000)
Notes Payable - Related Parties	0	0
Total - Line 36	(1,771,715)	(1,595,775)
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,000,070	1
2	Restatements (describe):		2
3	Adjustment	(11)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,000,059	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(439,772)	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)	\$ (439,772)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,560,287	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Caseyville Nursing Rehab Ctr

0039644

Report Period Beginning: 01/01/2025

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	\$ 10,390,736	1
2	Discounts and Allowances for all Levels	(1,351,404)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,039,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,661,192	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,661,192	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	115,303	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,920	19
20	Radiology and X-Ray	1,856	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 124,079	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	<u>See Schedule 19A</u>	844	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 844	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,825,447	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,701,415	31
32	Health Care	4,173,922	32
33	General Administration	2,836,335	33
	B. Capital Expense		
34	Ownership	623,354	34
	C. Ancillary Expense		
35	Special Cost Centers	1,136,247	35
36	Provider Participation Fee	793,946	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,265,219	40
41	Income before Income Taxes (line 30 minus line 40)**	(439,772)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (439,772)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 2,612,045.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,548,146.00	45
46	MMAI-Medicaid is the Primary Payer	239,844.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	489,140.00	48
49	Medicare Part A	974,629.00	49
50	Other-(specify) <u>Medicare Part B</u>	-514,868.00	50
51	Other-(specify) <u>Hospice</u>	675,165.00	51
52	Other-(specify) <u>Managed Care</u>		52
53	Other-(specify) <u>MAIP</u>	15,231.00	53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,039,332	56

Facility Name:Caseyville Nursing Rehab Ctr

IDPH License ID Number:0039644

Fiscal Year End:12/31/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Other Services - Revenue-Managed Care	428
Other Income-Other	(1,565)
Quality Incentive Program-Other	
Sequestration Expense-Managed Care	293
Total - Line 28	(844)
	-

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	1,872	2,044	\$ 143,721	\$ 70.31	1
2	Assistant Director of Nursing	1,856	1,998	112,980	56.55	2
3	Registered Nurses	10,334	11,649	540,405	46.39	3
4	Licensed Practical Nurses	21,509	24,347	1,007,712	41.39	4
5	CNAs & Orderlies	70,963	76,644	1,611,399	21.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,876	5,342	108,931	20.39	10
11	Social Service Workers	2,400	2,576	62,017	24.07	11
12	Dietician					12
13	Food Service Supervisor	3,722	4,218	112,303	26.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,045	5,690	107,100	18.82	15
16	Dishwashers	10,704	11,415	181,124	15.87	16
17	Maintenance Workers	6,599	7,418	129,975	17.52	17
18	Housekeepers	15,177	16,143	263,509	16.32	18
19	Laundry	5,987	6,418	98,360	15.33	19
20	Administrator	1,976	2,080	132,049	63.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,608	1,700	50,242	29.55	23
24	Clerical	19,949	20,112	326,020	16.21	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	1,747	2,091	43,380	20.75	31
32	Other Health Care(specify)					32
33	Other(specify) Human Resource	1,935	2,165	63,856	29.49	33
34	TOTAL (lines 1 - 33)	188,259	204,050	\$ 5,095,083 *	\$ 24.97	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	Monthly	\$ 9,490	L1, C3	35
36	Medical Director	Monthly	24,457	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,830	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 46,777		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	537	\$ 18,093	10(3)	50
51	Licensed Practical Nurses	3,863	205,374	10(3)	51
52	Certified Nurse Assistants/Aides	1,986	99,328	10(3)	52
53	TOTAL (lines 50 - 52)	6,386	\$ 322,795		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Michelle Goode	Administrator		\$ 132,049
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 132,049
B. Administrative - Other			
Description			Amount
Elly Bachrach - Management Fees <u>(Eliminated on Sch V, Column 7)</u>			\$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 120,000
C. Professional Services			
Vendor/Payee	Type		Amount
See attached Schedule 21C			\$ 1,131,561
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,131,561
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 32,880
Unemployment Compensation Insurance			49,188
FICA Taxes			387,480
Employee Health Insurance			156,076
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Miscellaneous Employee Benefits			
Other Employee Benefits			16,421
TOTAL (agree to Schedule V, line 22, col.8)			\$ 642,045
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 4,083
Advertising: Employee Recruitment			43,297
Health Care Worker Background Check (Indicate # of checks performed)			2,058
Patient Background Checks	172	610	7,318
Association Dues (total from pg 22, #4)			26,100
Miscellaneous Inspections & Licenses			1,728
Miscellaneous Dues & Permits			4,404
Less: Public Relations Expense			()
PAC and Lobbying payments			(13,050)
All non-allowable advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 75,938
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			10,981
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 10,981

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Caseyville Nursing Rehab Ctr
IDPH License ID Number: 0039644
Fiscal Year End: 12/31/2025

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Approved Admissions, LLC	Admission Process Consulting	810
AT&T	Internet	827
Direct Supply Inc.	Supplies	1,197
Firewall	Internet	889
Inovalon Provider, Inc.	Medicare Claim Management	5,527
John Grawitch	Travel & expense	28
Mobilex USA	Mobile service	350
Pass Security	Security service	180
PointClickCare Technologies Inc.	Cloud based software and services	37,942
PRIME CARE TECHNOLOGIES	PBJ Reporting Module Access Fee	(500)
RADAR Apps LLC	PDPM subscription	1,996
Spectrum	Internet	3,327
WellSky Corporation	Data Analytics	5,289
RSM	Accounting	12,000
Marsh & McLennan Agency LLC	Surety bond	260
Bock and Clark Corporation	Land Survey	1,838
Illinois Secretary Of State	Change of registered agent	25
Mathis, Marifan, & Richter	Legal counsel	5,155
Polsinelli PC	Legal counsel	17,534
Sher, LLP	Change of Ownership	8,029
Stone, Pogrund & Korey LLC	Legal counsel	4,910
Bock and Clark Corporation	ALTA Survey	4,500
Bureau Veritas Technical Assessments LLC	Property Condition Assessment	2,550
AssuredPartners Cornerstone LL	Cobra benefit administration	174
Jackson Lewis P.C.	Employment consult	1,236
National Datacare Corporation	trust service charge	673
Symphony Fee/Ensemble	Management fees	421,564
	Reclass to RE	(20,000)
ADR Systems of America LLC	Mediation agreement	5,090
Ashman & Stein, P.C.	Professional Services	531,656
Dantenyle Beck	Professional Services	270,000
Gina Alessia	Professional Services	3,625
Gregg Davis MD MBA Ltd	Professional Services	1,205
INSPE Associates LLC	Retainer	3,600
JAMS, Inc	Professional Services	7,500
Kuehn Beasley	Agreement of services	450,000
Law Offices of Michael Z. Margolies	Lease and option of Caseyville	600
McCorkle Litigation Services,Inc	Professional Services	2,339
Melissa K. Mitchell	Infusion of 1M primarily lawsuits	125,000
Michael Todd Grendon, M.D.	Services rendered	22,275
National Healthcare Innovations	Last year balance to pay	2,240
Regina Wilson	Infusion of 1M primarily lawsuits	20,000
Reifers, Holmes & Peters, LLC	Legal services rendered	2,835
Rence Robinson	Infusion of 1M primarily lawsuits	165,000
Urbanski Reporting Company, Inc	Melissa M and Caseyville dep	286
infusion of \$1M primarily for lawsuits 10/31/20: Legal		(1,000,000)
Total (agree to Schedule V, line 19, column 3)		1,131,561
Allocated from Management Company	Legal Fees	
Allocated from Management Company	Professional Services	46,631
Less: Non-Allowable Legal Fees		(331,538)
Reclass Point Click Care		(37,942)
Reclass Marsh & McLennan Agency LLC	Surety bond	(260)
Reclass Illinois Secretary Of State	Change of registered agent	(25)
Total (agree to Schedule V, line 19, column 8)		808,426

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

Amount

HEALTH CARE COUNCIL OF IL (HCCI)

13,050

13,050

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)

13,050

13,050

Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

26,100

26,100

Total
- (5)

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

\$ 47,043 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.

\$ 793,946

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.

\$ No Has any meal income been offset against related costs? \$ 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?

N/A

d. Have vehicle usage logs been maintained?

Adequate records have been maintained

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?

Yes

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

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

\$ N/A No
- (13)

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

Firm Name: No

N/A
- (14)

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

N/A
- (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.