

		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: 0056648

Facility Name: Lacon Rehab and Nursing

Address: 401 9th Street Lacon 61540
Number City Zip Code

County: Marshall

Telephone Number: 309-246-2175 Fax #: 309-246-2299

HFS ID Number:

Date of Initial License for Current Owners: 7/15/2020

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lacon Rehab and Nursing # 0056648 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>93</u>	Skilled (SNF)	<u>93</u>	<u>33,945</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>93</u>	TOTALS	<u>93</u>	<u>33,945</u>	7

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 61.48%

SEE ACCOUNTANTS' PREPARATION REPORT

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)
Sheriff's Department Meals

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 7/15/2020

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/15/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 93

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Lacon Rehab and Nursing

0056648

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	270,594	9,228	5,484	285,306		285,306		285,306			1
2	Food Purchase		149,749		149,749		149,749	(8,368)	141,381			2
3	Housekeeping	106,839	11,306		118,145		118,145		118,145			3
4	Laundry	87,413	9,250		96,663		96,663		96,663			4
5	Heat and Other Utilities			182,414	182,414		182,414	465	182,879			5
6	Maintenance	60,090	46,064	43,604	149,758		149,758	(21,598)	128,160			6
7	Other (specify):* Waste Disposal			10,402	10,402		10,402		10,402			7
8	TOTAL General Services	524,936	225,597	241,904	992,437		992,437	(29,501)	962,936			8
	B. Health Care and Programs											
9	Medical Director			11,871	11,871		11,871		11,871			9
10	Nursing and Medical Records	2,036,123	85,690	97,113	2,218,926		2,218,926	57,350	2,276,276			10
10a	Therapy											10a
11	Activities	48,215	5,815		54,030		54,030		54,030			11
12	Social Services	79,076			79,076		79,076		79,076			12
13	CNA Training			170	170		170		170			13
14	Program Transportation											14
15	Other (specify):* Allocated Home Office Benefit							6,914	6,914			15
16	TOTAL Health Care and Programs	2,163,414	91,505	109,154	2,364,073		2,364,073	64,264	2,428,337			16
	C. General Administration											
17	Administrative	115,228		341,669	456,897		456,897	(336,301)	120,596			17
18	Directors Fees											18
19	Professional Services			70,871	70,871		70,871	47,160	118,031			19
20	Dues, Fees, Subscriptions & Promotions			3,697	3,697		3,697	2,818	6,515			20
21	Clerical & General Office Expenses	46,206	19,112	10,482	75,800		75,800	72,956	148,756			21
22	Employee Benefits & Payroll Taxes			489,039	489,039		489,039		489,039			22
23	Inservice Training & Education											23
24	Travel and Seminar			466	466		466	3,134	3,600			24
25	Other Admin. Staff Transportation			9,162	9,162		9,162	2,901	12,063			25
26	Insurance-Prop.Liab.Malpractice			118,153	118,153		118,153	1,998	120,151			26
27	Other (specify):* Allocated Home Office Benefit							11,415	11,415			27
28	TOTAL General Administration	161,434	19,112	1,043,539	1,224,085		1,224,085	(193,919)	1,030,166			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,849,784	336,214	1,394,597	4,580,595		4,580,595	(159,156)	4,421,439			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			13,952	13,952		13,952	208,625	222,577			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							79,420	79,420			32
33	Real Estate Taxes							47,549	47,549			33
34	Rent-Facility & Grounds			567,451	567,451		567,451	(567,451)				34
35	Rent-Equipment & Vehicles			5,178	5,178		5,178		5,178			35
36	Other (specify):* Mortgage Ins							38,452	38,452			36
37	TOTAL Ownership			586,581	586,581		586,581	(193,405)	393,176			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	143,519	58,732	8,714	210,965		210,965	77,461	288,426			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			344,831	344,831		344,831		344,831			42
43	Other (specify):* Disallowed Costs			96,415	96,415		96,415	(96,415)				43
44	TOTAL Special Cost Centers	143,519	58,732	449,960	652,211		652,211	(18,954)	633,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,993,303	394,946	2,431,138	5,819,387		5,819,387	(371,515)	5,447,872			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	(8,368)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,049)	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	(64,120)	30		9
10	Interest and Other Investment Income	(132,248)	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	(2,882)	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	(37,121)	43		24
25	Fund Raising, Advertising and Promotional	(3,188)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(45,175)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(91,893)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (393,044)		\$	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)	21,529		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 21,529		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (371,515)		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 Miscellaneous Income	(30)	21	3
4	Disallow Lacon Propco Income Taxes	(1,473)	43	4
5	Non-Allowable Travel	(6,454)	25	5
6	Record Entry Made on Propco To Book Insurance	(102,056)	26	6
7	Record Entry Made on Propco To Adjust Rent	117,447	34	7
8	Record Entry Made on Propco-Book Acct Fees	(7,500)	19	8
9	Capitalized Repairs/Improvements over \$2,500	(22,280)	06	9
10	Capitalize Furniture over \$2,500	(9,521)	21	10
11	Capitalize Furniture over \$2,500	(15,545)	10	11
12	Capitalize Large Allocated Repair-Home Office	(465)	6	12
13	Disallow Non Allowable Allocated Home Office Exp	(6,150)	21	13
14	Disallow Non Allowable Allocated Home Office Exp	(1,648)	25	14
15	Disallow Owner Wages	(33,448)	17	15
16	Disallow Owner Wages	(2,770)	21	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	(91,893)		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	\$	Lacon Propco Two LLC		\$ 7,500	\$ 7,500	1
2	V	26	Property Insurance		Lacon Propco Two LLC		102,865	102,865	2
3	V	30	Depreciation		Lacon Propco Two LLC		272,745	272,745	3
4	V	32	Interest	36	Lacon Propco Two LLC		206,467	206,431	4
5	V	32	Loan Cost Amortization		Lacon Propco Two LLC		4,415	4,415	5
6	V	33	Real Estate Taxes		Lacon Propco Two LLC		46,570	46,570	6
7	V	34	Rent	684,898	Lacon Propco Two LLC			(684,898)	7
8	V	36	Mortgage Insurance		Lacon Propco Two LLC		38,452	38,452	8
9	V	43	Income Taxes		Lacon Propco Two LLC		1,473	1,473	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 684,934			\$ 680,487	\$ * (4,447)	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	341,669	Stern Therapy Consultants, LLC		33,448	(308,221)	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			\$ 341,669			\$ 371,967	\$ * 30,298	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

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	\$ 58,732	Medwiz of Illinois, LLC		\$ 55,935	\$ (2,797)	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			\$ 58,732			\$ 55,935	\$ * (2,797)	39

STATE OF ILLINOIS				Ownership Listing-1					
Lacon Rehab and Nursing									
ID#		0056648							
Report Period Beginning:		1/1/2025		Stern Therapy Consult:					
Ending:		12/31/2025		Lacon Propco Two LLC					
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Operator/Licensee	Building Co.	Co./Home Office	Management		
-Owners of companies must be listed instead of company names.				Ownership Percentage	Ownership Percentage	Ownership Percentage			
-Names of trust beneficiaries must be listed.									
First Name	M.I.	Last Name	Place of Residence City State	Ownership Percentage	Ownership Percentage	Ownership Percentage			
1	Chaim	O Millman	Pomona NY	26.00000	26.66500		1		
2	Boruch	NG Sheps	Spring Valley NY	20.00000	16.66500		2		
3	Benjamin	NG Friedman	Pomona NY	13.00000	5.00000		3		
4	Avraham	NG Erbllich	Pomona NY	10.00000			4		
5	Bezalel	NG Stern	Monsey NY	13.50000	22.50000	55.00000	5		
6	Shmuel	NG Cohn	Clifton NJ	2.68000	2.22311		6		
7	Sarah	NG Cohn	Clifton NJ	1.32000	4.44689		7		
8	Eric	NG Newhouse as Trustee*	Pomona NY	6.81750	11.36250	22.72500	8		
9	Temi	NG Newhouse as Trustee*	Pomona NY	6.68250	11.13750	22.27500	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	*Trustee in ETN Family Holdings						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							49		
50							50		
51							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							70		
71							71		
72							72		
73							73		
74							74		
75							75		

Facility Name & ID Number

Lacon Rehab and Nursing

0056648

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			Casey Rehab and Nursing	Casey, IL	Consultants, LLC		Therapy Mgmt	2
3			Countryside Care Center	Macomb, IL	Lacon Propco Two LL	Pomona, NY	Property Co.	3
4			Gallatin Manor	Ridgway, IL	CET Office Holdings I	Pomona, NY	Stern Building	4
5			Henry Rehab and Nursing	Henry, IL	Medwiz of Illinois, LL	Bardonia, NY	Pharmacy	5
6			Macomb Post Acute Care Center	Macomb, IL	HCIT LLC	Bardonia, NY	IT Consulting	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	13.00	See Att. Sch 7A	1.60	4.00	Alloc Salary	\$ 5,368	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 5,368		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lacon Rehab and Nursing # 0056648 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lacon Rehab and Nursing # 0056648 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 CET Office Holdings, 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 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	20	Dues, Fees, Subscriptions & Prom	Evenly Over Units	23	23	\$ 25	\$	1	\$ 1	1
2	32	Interest Expense	Evenly Over Units	23	23	18,902		1	822	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					\$ 18,927	\$		\$ 823	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lacon Rehab and Nursing # 0056648 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	55,935	1	\$ 55,935	\$	55,935	\$ 55,935	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					\$ 55,935	\$		\$ 55,935	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	HUD		X	Mortgage	\$39,629.32		\$ 6,215,800	\$ 5,869,335			\$ 206,467	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$39,629.32		\$ 6,215,800	\$ 5,869,335			\$ 206,467	9
	B. Non-Facility Related*											
10								Interest Income Offset			(132,284)	10
11								CET Office Holdings Alloc			822	11
12								Loan Cost Amortization			4,415	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (127,047)	14
15	TOTALS (line 9+line14)						\$ 6,215,800	\$ 5,869,335			\$ 79,420	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 38,452 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 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. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

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

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

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Facility	428,532	2020	\$ 27,000	1
2	Alloc CET Office Holdings, LLC			2,609	2
3	TOTALS	428,532		\$ 29,609	3

Facility Name & ID Number Lacon Rehab and Nursing

0056648

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	93		2020	1965	\$ 3,007,000	\$	35	\$ 85,914	\$ 85,914	\$ 468,948
5										
6										
7										
8										
	Improvement Type**									
9	Boiler Retube			2020	6,874		20	344	344	2,063
10	Solar Installation (Net Of Credits)			2021	125,335		20	6,267	6,267	31,335
11	Repair Chiller - New Hp Motor,Pulley & Sensor			2021	4,200		20	210	210	1,050
12	Replace Climate Control Compressor			2021	6,545		20	327	327	1,635
13	Install New Asphalt Pavement in Front/Back/Side Lots			2022	168,700		20	8,435	8,435	29,523
14	Repair Chiller - New Condenser Coil/Water Sensors/Drier			2022	12,953		20	648	648	2,268
15	Install One Post and Panel and One Dimensional Sign			2022	5,494		20	275	275	962
16	LRN Fire Alarm Replacement			2022	31,595		20	1,580	1,580	5,530
17	Cable/Satellite System for Entire Facility			2022	10,260		20	513	513	1,796
18	Power Wash/Scrape/Paint Fascia & Soffits - Replace Rotted Boards			2022	27,075		20	1,354	1,354	4,739
19	Replace Turbine Pumps in the Well			2023	2,648		20	132	132	330
20	Replace Isolation Valves to All Resident Wings			2023	9,153		20	458	458	1,145
21	Generator Repair - Rebuilt Starter/Replaced Relay			2024	5,116		20	256	256	384
22	Boiler Repair - Installed 5 Port Switch/Actuator			2024	3,765		20	188	188	282
23	Install new Water Heater			2024	2,525		20	126	126	189
24	AC Repair - Installed New TVX and added Refrigerant			2024	3,273		20	164	164	246
25	Repair Boiler #2 - Replaced 22 Heavy Gauge Around Furnace Tube			2024	13,750		20	688	688	1,032
26	New 75 Gallon Water Heater			2024	2,823		20	141	141	212
27	New 85 Gallon Water Heater			2024	10,187		20	509	509	764
28	New 91 Gallon Water Heater			2024	6,212		20	311	311	466
29	New 100 Gallon 199,000 BTU Water Heater			2025	7,437		20	186	186	186
30	New 100 Gallon 199,000 BTU Water Heater			2025	6,695		20	167	167	167
31	Install Boiler Main Gas Valves And Actuators			2025	2,898		20	72	72	72
32	Repair Cracks in Rear Furnace Chamber/Tube Sheet/Rear Water Wal			2025	5,250		20	131	131	131
33										
34										
35										

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	Financial Statement Depreciation		13,952			(13,952)		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)	\$ 3,511,176	\$ 13,952		\$ 110,190	\$ 96,238	\$ 561,097	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	\$ 1,016,842	\$	\$ 101,684	\$ 101,684	10 yrs	\$ 493,168	71
72	Current Year Purchases	25,066		2,507	2,507	10 yrs	2,507	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,041,908	\$	\$ 104,191	\$ 104,191		\$ 495,675	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	Dodge Caravan	2021	\$ 40,976	\$	\$ 8,196	\$ 8,196	5	\$ 40,976	76
77										77
78										78
79										79
80	TOTALS			\$ 40,976	\$	\$ 8,196	\$ 8,196		\$ 40,976	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,623,669	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,577	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 208,625	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,097,748	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								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
- 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: \$ 5,178
- Description: Copier \$4,208; Medical Equipment \$970
- (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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		170		170
9	TOTALS	\$	\$ 170	\$	\$ 170
10	SUM OF line 9, col. 1 and 2 (e)	\$ 170			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	39(1)	2111	hrs	\$ 64,560		\$	\$	2,111	\$ 64,560		1	
2	Licensed Speech and Language Development Therapist	39(1)	1047	hrs	48,868				1,047	48,868		2	
3	Licensed Recreational Therapist			hrs								3	
4	Licensed Physical Therapist	39(1), (3)	785	hrs	30,091		7,811		785	37,902		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				58,732		58,732		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10	
11	Academic Education			hrs								11	
12	Other (specify): Lab/X-Ray	39(3)					903			903		12	
13	Other (specify): Home Office Allocation	39(7)			80,258					80,258		13	
14	TOTAL				\$ 223,777		\$ 8,714	\$ 58,732	3,943	\$ 291,223		14	

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

SEE ACCOUNTANTS' PREPARATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 570,342	\$ 762,051	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	930,760	930,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		45,647	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,501,102	\$ 1,738,458	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		29,609	13
14	Buildings, at Historical Cost		3,007,000	14
15	Leasehold Improvements, at Historical Cost	1,140,145	504,176	15
16	Equipment, at Historical Cost	44,095	1,082,884	16
17	Accumulated Depreciation (book methods)	(857,501)	(1,097,748)	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): See Attached Schedule 17A		475,957	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,739	\$ 4,001,878	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,827,841	\$ 5,740,336	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,434	\$ 235,411	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		17,070	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 184,434	\$ 252,481	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,869,335	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)	\$	\$ 5,869,335	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 184,434	\$ 6,121,816	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,643,407	\$ (381,480)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,827,841	\$ 5,740,336	48

Facility Name:Lacon Rehab and Nursing

IDPH License ID Number:0056648

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		50,663
Insurance Escrow		43,458
MIP Escrow		22,793
Replacement Reserve		220,628
Unamortized Loan Costs		138,415
Total - Line 23	-	475,957

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,814,101	1
2	Restatements (describe):		2
3	Prior Period Adjustments-ERC Receivable	395,309	3
4	Prior Period Adjustments-Depreciation Exp/Copier Lease	(30,280)	4
5	Prior Period Adjustments-Capitalize Furniture	44,095	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,223,225	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	474,798	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	(1,054,616)	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)	\$ (579,818)	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)	\$ 1,643,407	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lacon Rehab and Nursing

0056648

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	\$ 5,936,662	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,936,662	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,566	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 55,566	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	1,118	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,368	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,454	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,123	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,063	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	132,248	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 132,248	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	30	28
28a	CNA Initiative	152,616	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 152,646	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,294,185	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	992,437	31
32	Health Care	2,364,073	32
33	General Administration	1,224,085	33
	B. Capital Expense		
34	Ownership	586,581	34
	C. Ancillary Expense		
35	Special Cost Centers	307,380	35
36	Provider Participation Fee	344,831	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,819,387	40
41	Income before Income Taxes (line 30 minus line 40)**	474,798	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 474,798	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,245,054.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,042,822.00	45
46	MMAI-Medicaid is the Primary Payer	67,386.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,424,392.00	48
49	Medicare Part A	690,728.00	49
50	Other-(specify) Insurance/Managed Care	466,280.00	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)	\$ 5,936,662	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	5,802	6,096	\$ 298,021	\$ 48.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,376	5,537	234,451	42.34	3
4	Licensed Practical Nurses	12,035	12,520	488,838	39.04	4
5	CNAs & Orderlies	39,762	41,674	877,370	21.05	5
6	CNA Trainees					6
7	Licensed Therapist	3,757	3,943	143,519	36.40	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,093	3,206	48,215	15.04	10
11	Social Service Workers	3,797	4,135	79,076	19.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,469	16,428	270,594	16.47	15
16	Dishwashers					16
17	Maintenance Workers	3,184	3,262	60,090	18.42	17
18	Housekeepers	6,520	6,789	106,839	15.74	18
19	Laundry	5,335	5,555	87,413	15.74	19
20	Administrator	2,056	2,284	115,228	50.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,980	2,104	46,206	21.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,909	3,053	70,261	23.01	31
32	Other Health C: MDS Coord	1,538	1,570	67,182	42.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,613	118,156	\$ 2,993,303 *	\$ 25.33	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	98	\$ 5,484	L1, C3	35
36	Medical Director	Monthly	11,871	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	3,500	L10, C3	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)	98	\$ 20,855		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	951	\$ 50,236	L10, C3	50
51	Licensed Practical Nurses	677	32,325	L10, C3	51
52	Certified Nurse Assistants/Aides	285	9,448	L10, C3	52
53	TOTAL (lines 50 - 52)	1,913	\$ 92,009		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Lacon Rehab and Nursing

0056648

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Roxanne Dorsey

Administrator

0

\$ 80,613

Tami Wacker

Administrator

0

34,615

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 115,228

B. Administrative - Other

Description

Amount

Management Fees-See Page 6, Eliminated on P 3, C 7

\$ 341,669

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 341,669

C. Professional Services

Vendor/Payee

Type

Amount

Ark Inovations

Computer Services

\$ 2,367

Direct Supply

Life Safety Compliance

1,524

IT Computing Services

Computer Service

3,169

Natl Datacare Corp

Fund Management

1,556

Pointclickcare

Computer Service

16,581

Streamline Verify LLC

Computer Service

182

uattend.com

Employee Attendance Software

211

Whentowork

Employee Scheduling Software

520

Ubiquiti

Computer Services

221

HCIT

Computer Services

9,960

See Attached Schedule 21A

34,580

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 70,871

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 25,213

Unemployment Compensation Insurance

41,213

FICA Taxes

226,852

Employee Health Insurance

186,530

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Employee Benefits

9,231

TOTAL (agree to Schedule V, line 22, col.8)

\$ 489,039

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

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed 11)

215

Patient Background Checks

103

Association Dues (total from pg 22, #4)

Licenses & Fees

1,546

CET Office Holdings/ Home Office Alloc

2,818

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 6,515

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

466

Home Office Allocation

3,134

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 3,600

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Lacon Rehab and Nursing

IDPH License ID Number:

0056648

Fiscal Year End:

12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Bernath and Rosenberg, P.C	Accounting	9,580
Templin Healthcare Accounting	Accounting	6,487
Compliance Consulting Group	Healthcare Compliance	7,200
Accurate Pay	Payroll Services	11,313
Total		34,580

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.

\$23,519

Line10
- (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.

\$344,831

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.

\$

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$8,368
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$N/A
- (13)

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

Firm Name:

N/A
- (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.

N/A

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