

		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: 0055913

Facility Name: Marshall Rehab Nursing

Address: 410 North Second St Marshall 62441
Number City Zip Code

County: Clark

Telephone Number: (217) 826-2358 Fax # (217) 826-2367

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2019

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 Marshall Rehab Nursing # 0055913 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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	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				15		2,737	372	3,124	8
9	SNF/PED									9
10	ICF	5,233	7,912	53		1,884			15,082	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,233	7,912	53	15	1,884	2,737	372	18,206	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 66.51%

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) None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 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 08/01/2019

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 08/01/2019 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 75

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	194,364	2,217	4,775	201,356		201,356		201,356			1
2	Food Purchase		119,865		119,865		119,865	(1,345)	118,520			2
3	Housekeeping	123,168	6,087		129,255		129,255		129,255			3
4	Laundry	100,773	4,980		105,753		105,753		105,753			4
5	Heat and Other Utilities			135,442	135,442		135,442	465	135,907			5
6	Maintenance	75,136	15,955	74,330	165,421		165,421	(44,777)	120,644			6
7	Other (specify):* Waste Disposal			4,814	4,814		4,814		4,814			7
8	TOTAL General Services	493,441	149,104	219,361	861,906		861,906	(45,657)	816,249			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,027,479	84,966	4,861	2,117,306		2,117,306	72,895	2,190,201			10
10a	Therapy											10a
11	Activities	78,427	3,865	650	82,942		82,942		82,942			11
12	Social Services	40,609			40,609		40,609		40,609			12
13	CNA Training			595	595		595		595			13
14	Program Transportation											14
15	Other (specify):* Allocated Home Office Benefit							6,914	6,914			15
16	TOTAL Health Care and Programs	2,146,515	88,831	18,106	2,253,452		2,253,452	79,809	2,333,261			16
	C. General Administration											
17	Administrative	136,003		351,163	487,166		487,166	(345,795)	141,371			17
18	Directors Fees											18
19	Professional Services			138,950	138,950		138,950	(13,033)	125,917			19
20	Dues, Fees, Subscriptions & Promotions			7,540	7,540		7,540	2,818	10,358			20
21	Clerical & General Office Expenses	61,065	6,046	12,239	79,350		79,350	82,371	161,721			21
22	Employee Benefits & Payroll Taxes			510,958	510,958		510,958		510,958			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,012	1,012		1,012	3,134	4,146			24
25	Other Admin. Staff Transportation			8,112	8,112		8,112	5,673	13,785			25
26	Insurance-Prop.Liab.Malpractice			107,481	107,481		107,481	20,544	128,025			26
27	Other (specify):* Allocated Home Office Benefit							11,415	11,415			27
28	TOTAL General Administration	197,068	6,046	1,137,455	1,340,569		1,340,569	(232,873)	1,107,696			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,837,024	243,981	1,374,922	4,455,927		4,455,927	(198,721)	4,257,206			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			31,839	31,839		31,839	41,296	73,135			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							485,665	485,665			32
33	Real Estate Taxes							27,576	27,576			33
34	Rent-Facility & Grounds			812,246	812,246		812,246	(812,246)				34
35	Rent-Equipment & Vehicles			3,971	3,971		3,971		3,971			35
36	Other (specify):* Goodwill Amort/MIP			10,000	10,000		10,000	48,802	58,802			36
37	TOTAL Ownership			858,056	858,056		858,056	(208,907)	649,149			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			50	50		50		50			38
39	Ancillary Service Centers	277,629	109,898	65,865	453,392		453,392	75,025	528,417			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			292,128	292,128		292,128		292,128			42
43	Other (specify):* Disallowed Costs			169,369	169,369		169,369	(169,369)				43
44	TOTAL Special Cost Centers	277,629	109,898	527,412	914,939		914,939	(94,344)	820,595			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,114,653	353,879	2,760,390	6,228,922		6,228,922	(501,972)	5,726,950			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	(1,345)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,896)	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	18,124	30		9
10	Interest and Other Investment Income	(53,388)	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	(325)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(60,193)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(153,699)	43		24
25	Fund Raising, Advertising and Promotional	(10,449)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(83,669)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (349,840)		\$	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)	(152,132)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (152,132)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (501,972)		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	(136)	21	3
4	Disallow Goodwill Amortization	(10,000)	36	4
5	Non-Allowable Travel	(3,682)	25	5
6	Disallow Propco Income Taxes	(93)	43	6
7	Record Entry Made on Propco To Book Insurance	(74,561)	26	7
8	Record Entry Made on Propco To Adjust Rent	102,666	34	8
9	Record Entry Made on Propco-Book Acct Fees	(7,500)	19	9
10	Nonallowable Property Taxes	(423)	33	10
11	Reclassify Roofing Work Deposit to Balance Sheet	(28,300)	06	11
12	Capitalized Improvements over \$2,500	(17,159)	06	12
13	Capitalize Large Allocated Repair-Home Office	(465)	6	13
14	Disallow Non Allowable Allocated Home Office Exp	(6,150)	21	14
15	Disallow Non Allowable Allocated Home Office Exp	(1,648)	25	15
16	Disallow Owner Wages	(33,448)	17	16
17	Disallow Owner Wages	(2,770)	21	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	(83,669)		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	\$	SMN Holdings LLC		\$ 7,500	\$ 7,500	1
2	V	26	Property Insurance		SMN Holdings LLC		93,916	93,916	2
3	V	30	Depreciation		SMN Holdings LLC		23,172	23,172	3
4	V	32	Interest	1,074	SMN Holdings LLC		535,457	534,383	4
5	V	32	Loan Cost Amortization		SMN Holdings LLC		3,848	3,848	5
6	V	33	Real Estate Taxes		SMN Holdings LLC		27,020	27,020	6
7	V	34	Rent	914,912	SMN Holdings LLC			(914,912)	7
8	V	36	Mortgage Insurance		SMN Holdings LLC		58,802	58,802	8
9	V	43	Income Taxes		SMN Holdings LLC		93	93	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 915,986			\$ 749,808	\$ * (166,178)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	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	351,163	Stern Therapy Consultants, LLC		33,448	(317,715)	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			\$ 351,163			\$ 371,967	\$ * 20,804	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	\$ 109,898	Medwiz of Illinois, LLC		\$ 104,665	\$ (5,233)	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			\$ 109,898			\$ 104,665	\$ * (5,233)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS				Ownership Listing-1				
Marshall Rehab Nursing								
ID#		0055913						
Report Period Beginning:		1/1/2025			Stern Therapy Consult			
Ending:		12/31/2025			SMN Holdings LLC			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Operator/Licensee		Management		
-Owners of companies must be listed instead of company names.				Building Co.		Co./Home Office		
-Names of trust beneficiaries must be listed.				Ownership Percentage		Ownership Percentage		
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	Chaim	O	Millman	Pomona	NY	26.00000	25.00000	1
2	Boruch	NG	Sheps	Spring Valley	NY	20.00000	20.00000	2
3	Benjamin	NG	Friedman	Pomona	NY	13.00000		3
4	Avraham	NG	Erblich	Pomona	NY	11.00000		4
5	Bezael	NG	Stern	Monsey	NY	10.00000		5
6	Eric	NG	Newhouse as Trustee*	Pomona	NY	10.10000	22.72500	6
7	Temi	NG	Newhouse as Trustee*	Pomona	NY	9.90000	22.27500	7
8	Avraham	NG	Sackton	Clifton	NJ		10.00000	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	*Trustee in ETN Family Holdings							21
22								22
23								23
24								24
25								25
26								26
27								27
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62								62
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69								69
70								70
71								71
72								72
73								73
74								74
75								75

Facility Name & ID Number

Marshall Rehab Nursing

0055913

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	SMN Holdings LLC	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	HCIT LLC	Bardonia, NY	IT Consulting	5
6			Lacon Rehab and Nursing	Lacon, IL	Medwiz of Illinois, LL	Bardonia, NY	Pharmacy	6
7			Macomb Post Acute Care Center	Macomb, 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

Ending: 2/31/2025

(845) 517-4796

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Marshall Rehab Nursing # 0055913 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 Marshall Rehab Nursing # 0055913 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	104,665	1	\$ 104,665	\$	104,665	\$ 104,665	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					\$ 104,665	\$		\$ 104,665	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	\$64,464.00	12/21/23	\$ 8,758,000	\$ 8,614,729	1/1/59	0.0619	\$ 535,457	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$64,464.00		\$ 8,758,000	\$ 8,614,729			\$ 535,457	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(54,462)	10	
11								CET Office Holdings Alloc			822	11	
12								Loan Fee Amortization			3,848	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (49,792)	14	
15	TOTALS (line 9+line14)						\$ 8,758,000	\$ 8,614,729			\$ 485,665	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 58,802 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.) SEE ACCOUNTANTS' PREPARATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024	\$	27,020	2
3. Under or (over) accrual (line 2 minus line 1).			\$	27,020	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Nonallowable RE Taxes		(423)	
		Allocated from Home Office		979	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	27,576	7
Assessed Value from Real Estate Tax Bill: 2024 417,278 8					
Real Estate Tax Bill for Calendar Year: 2020 26,086 9					
2021 25,871 10					
2022 25,713 11					
2023 26,672 12					
2024 27,020 13					
Facility does not accrue for real estate taxes.					
			14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
			15	PLUS APPEAL COST FROM LINE 5 \$	15
			16	LESS REFUND FROM LINE 6 \$	16
			17	AMOUNT TO USE FOR RATE CALCULATION \$	17

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marshall Rehab Nursing COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0055913

CONTACT PERSON REGARDING THIS REPORT Larry Templin

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-08-14-00-400-015	Long Term Care Property	\$ 26,102.86	\$ 26,102.86
2. 08-08-13-17-302-002	Long Term Care Property	\$ 494.86	\$ 494.86
3. 08-08-13-17-302-001	Vacant Lot	\$ 422.58	
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 27,020.30	\$ 26,597.72

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,819 B. General Construction Type: Exterior Limestone Frame Wood 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).
Independent Living Facility - 16 Units
This facility has its own accounting records and shares no common costs with Marshall Rehab & Nursing

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:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2019	\$ 50,000	1
2	Alloc CET Office Holdings, LLC			2,609	2
3	TOTALS			\$ 52,609	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Marshall Rehab Nursing

0055913

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	75		2019	1963	\$ 950,000	\$	35	\$ 27,143	\$ 27,143	\$ 165,120	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Installation Of Door			2020	3,000		20	150	150	750	9
10	Replaced Fire Control Panel			2020	8,300		20	415	415	2,490	10
11	A-Wing Replacement Devices-28 Smokes, 4 Pull Stations			2020	3,360		20	168	168	840	11
12	Nursing Stations For Infection Control			2020	44,782		20	2,239	2,239	11,195	12
13	Pipe Replacement			2020	3,390		20	170	170	850	13
14	Hvac Repairs			2020	4,600		20	230	230	1,150	14
15	Walk In Freezer			2020	6,733		20	337	337	1,685	15
16	Sprinkler System-Repair Dry System Leaks			2021	5,067		20	253	253	1,265	16
17	Sprinkler System-Rehab Wing Replacement			2021	143,890		20	7,195	7,195	35,975	17
18	Sprinkler System-Repair Piping Leaks			2021	4,920		20	246	246	1,230	18
19	Phone Conference System			2021	6,119		20	306	306	1,530	19
20	New Boiler			2021	5,229		20	261	261	1,305	20
21	Install New Access Control System			2022	100,140		20	5,007	5,007	17,525	21
22	Install New Flooring-Front of Building by Administrator Office			2022	10,801		20	540	540	1,890	22
23	Install 9 New Awnings			2022	5,183		20	259	259	907	23
24	Install New Boiler			2022	15,400		20	770	770	2,695	24
25	Install Lockable Covers/Disconnects for Boilers & Water Heaters			2023	4,610		20	231	231	577	25
26	Install Cable and Conduit to Tie In Relays to Door Lock Control			2023	2,906		20	145	145	363	26
27	Replace Transfer Switch on Generator			2023	3,023		20	151	151	378	27
28	Install New Air Conditioner			2023	3,000		20	150	150	375	28
29	Install Solar Energy System			2023	262,275		20	13,114	13,114	32,785	29
30	Replace Windows in Halls A/B/C/D/E and Chapel			2023	70,778		20	3,539	3,539	8,847	30
31	Resurface Front Parking Lot/Driveway			2024	50,070		20	2,504	2,504	3,756	31
32	Upgrade Smoke Detectors to Addressable Devices			2024	2,970		20	149	149	223	32
33	Repair and Replace Damaged Areas of Soffits/Metal Facia/Gutters			2024	6,858		20	343	343	514	33
34	AC Repair - Replace Contactors and Sensors			2024	2,979		20	149	149	223	34
35	Remove ACM Pipe Insulation			2024	3,200		20	160	160	240	35
36											36

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

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

Facility Name & ID Number Marshall Rehab Nursing

0055913

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Repair Leaking Backflow Device	2025	\$ 5,200	\$	20	\$ 130	\$ 130	\$ 130	37
38	Replace Sprinkler System Accelerator	2025	5,200		20	130	130	130	38
39	Replace Cracked Sprinkler Pipe/Replace 56 Heads Throughout	2025	6,759		20	169	169	130	39
40									40
41									41
42									42
43									43
44									44
45									45
46	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2021	530		20	27	27	522	46
47	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2023	1,319		20	66	66	198	47
48	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2024	1,167		20	58	58	117	48
49	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2025	465		20	23	23	23	49
50	Allocated from CET Office Holdings, LLC - Building	1989	15,475		20	397	397	3,073	50
51	Allocated from CET Office Holdings, LLC-Leasehold Improvements	2018	4,457		20	223	223	1,709	51
52									52
53									53
54	Financial Statement Depreciation			31,839			(31,839)		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)		\$ 1,774,155	\$ 31,839		\$ 67,547	\$ 35,708	\$ 302,715	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	\$ 55,875	\$	\$ 5,588	\$ 5,588	10 yrs	\$ 31,887	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 55,875	\$	\$ 5,588	\$ 5,588		\$ 31,887	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	Vehicle	2019	\$ 17,761	\$	\$	\$	5	\$ 17,761	76
77										77
78										78
79										79
80	TOTALS			\$ 17,761	\$	\$	\$		\$ 17,761	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)	\$ 1,900,400	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,839	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,135	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,296	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 352,363	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: \$ 3,971 Description: Copier \$3,900; Medical Equipment \$71
(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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		595		595
9	TOTALS	\$	\$ 595	\$	\$ 595
10	SUM OF line 9, col. 1 and 2 (e)	\$ 595			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8							
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist	39(1)	2597	hrs	\$	101,383		2,597	\$	101,383	1					
2	Licensed Speech and Language Development Therapist	39(1)	1041	hrs		50,684		1,041		50,684	2					
3	Licensed Recreational Therapist			hrs							3					
4	Licensed Physical Therapist	39(1), (3)	3691	hrs		125,562		3,691		186,615	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			109,898			109,898	9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10					
11	Academic Education			hrs							11					
12	Other (specify): <u>Lab/X-Ray</u>	39(3)				4,812				4,812	12					
13	Other (specify): <u>Home Office Allocation</u>	39(7)				80,258				80,258	13					
14	TOTAL				\$	357,887		\$	65,865	\$	109,898		7,329	\$	533,650	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number	Marshall Rehab Nursing
--------------------------------------	-------------------------------

0055913

Report Period Beginning: 1/1/2025

Ending:

12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2025**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,379	\$ 148,228	1
2	Cash-Patient Deposits	18,970	18,970	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,439,991	1,439,991	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	699,102	699,102	5
6	Prepaid Insurance		32,893	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	63,984	63,984	8
9	Other(specify): <u>Loan</u>	42,030	42,030	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,269,456	\$ 2,445,198	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		52,609	13
14	Buildings, at Historical Cost		950,000	14
15	Leasehold Improvements, at Historical Cost	1,090,111	824,155	15
16	Equipment, at Historical Cost	72,990	73,636	16
17	Accumulated Depreciation (book methods)	(832,403)	(352,363)	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): <u>See Attached Schedule 17A</u>	85,833	718,297	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 416,531	\$ 2,266,334	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,685,987	\$ 4,711,532	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 167,566	\$ 194,238	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,850	18,850	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		44,438	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Security Deposit</u>	4,950	4,950	36
37	<u>Intercompany</u>	231,519	231,519	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 422,885	\$ 493,995	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,614,729	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u></u>			43
44	<u></u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,614,729	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 422,885	\$ 9,108,724	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,263,102	\$ (4,397,192)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,685,987	\$ 4,711,532	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name:

Marshall Rehab Nursing

IDPH License ID Number:

0055913

Fiscal Year End:

12/31/2025

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Leasehold Deposit		28,300
Loan Costs		345,242
Real Estate Tax Escrow		8,860
Insurance Escrow		5,508
MIP Escrow		51,702
Replacement Reserve Escrow		192,852
Goodwill	85,833	85,833
Total - Line 23	85,833	718,297

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,506,263	1
2	Restatements (describe):		2
3	Prior Period Adjustments	1,480	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,507,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	262,645	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	(507,286)	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)	\$ (244,641)	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)	\$ 2,263,102	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Marshall Rehab Nursing

0055913

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,034,256	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,034,256	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	242,517	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 242,517	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	1,345	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,790	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,809	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 21,944	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53,388	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,388	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule 19A</u>	16,872	28
28a	<u>CNA Initiative</u>	122,590	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 139,462	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,491,567	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	861,906	31
32	Health Care	2,253,452	32
33	General Administration	1,340,569	33
	B. Capital Expense		
34	Ownership	858,056	34
	C. Ancillary Expense		
35	Special Cost Centers	622,811	35
36	Provider Participation Fee	292,128	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,228,922	40
41	Income before Income Taxes (line 30 minus line 40)**	262,645	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 262,645	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,480,310.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,108,583.00	45
46	MMAI-Medicaid is the Primary Payer	14,125.00	46
47	MMAI-Medicare is the Primary Payer	8,437.00	47
48	Private Pay	424,495.00	48
49	Medicare Part A	1,789,056.00	49
50	Other-(specify) <u>Insurance/Managed Care</u>	209,250.00	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)	\$ 6,034,256	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Marshall Rehab Nursing

IDPH License ID Number:

0055913

Fiscal Year End:

12/31/2025

Schedule 19A

Amount

XVII. INCOME STATEMENT

Line 28a- Other Income

Awards	40
Miscellaneous Income	136
Income Tax Refunds	16,696
Total	16,872

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	4,946	5,879	\$ 269,157	\$ 45.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,584	5,865	245,445	41.85	3
4	Licensed Practical Nurses	12,750	13,415	478,420	35.66	4
5	CNAs & Orderlies	40,880	43,168	919,495	21.30	5
6	CNA Trainees					6
7	Licensed Therapist	6,841	7,329	277,629	37.88	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,314	4,844	78,427	16.19	10
11	Social Service Workers	1,921	2,144	40,609	18.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,714	12,141	194,364	16.01	15
16	Dishwashers					16
17	Maintenance Workers	3,762	4,068	75,136	18.47	17
18	Housekeepers	7,874	8,167	123,168	15.08	18
19	Laundry	6,443	6,682	100,773	15.08	19
20	Administrator	2,532	2,600	136,003	52.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,686	2,874	61,065	21.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: MDS Coord	2,355	2,702	114,962	42.55	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,602	121,878	\$ 3,114,653 *	\$ 25.56	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	87	\$ 4,775	L1, C3	35
36	Medical Director	Monthly	12,000	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	1	100	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	88	\$ 20,375		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Amanda Yoder	Administrator	0	\$ 98,504	Workers' Compensation Insurance		\$ 25,213	IDPH License Fee	\$ 2,035	
James McGill	Regional Admin	0	37,499	Unemployment Compensation Insurance		23,496	Advertising: Employee Recruitment		
				FICA Taxes		238,110	Health Care Worker Background Check		
				Employee Health Insurance		214,466	(Indicate # of checks performed 21)	366	
				Employee Meals			Patient Background Checks	189 3,296	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				Other Employee Benefits		9,673			
TOTAL (agree to Schedule V, line 17, col. 1)							Licenses & Fees	1,843	
(List each licensed administrator separately.)			\$ 136,003				CET Office Holdings Allocation	1	
B. Administrative - Other							Home Office Allocation	2,817	
Description			Amount				Less: Public Relations Expense	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 351,163				PAC and Lobbying payments	()	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 351,163	TOTAL (agree to Schedule V, line 22, col.8)			\$ 510,958	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,358
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Ark Inovations	Computer Services		\$ 2,367			\$	Out-of-State Travel	\$	
Direct Supply	Life Safety Compliance		3,084						
IT Computing Services	Computer Service		2,559						
Natl Datacare Corp	Fund Management		1,544				In-State Travel		
Pointclickcare	Computer Service		13,423						
Streamline Verify LLC	Computer Service		394						
uattend.com	Employee Attendance Software		210						
Whentowork	Employee Scheduling Software		640				Seminar Expense	1,012	
HCIT	Computer Services		10,584						
							Home Office Allocation	3,134	
See Attached Schedule 21A			104,145				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 138,950					TOTAL	\$ 4,146

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

****See instructions.**

Facility Name:

Marshall Rehab Nursing

IDPH License ID Number:

0055913

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	7,237
Compliance Consulting Group	Healthcare Compliance	7,200
Gutnicki LLP	Legal Services	64,413
Livingston Barger	Legal Services	5,542
Accurate Pay	Payroll Services	10,173
Total		104,145

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.

\$ 24,607 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.

\$ 292,128

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. \$ 1,345
- (12)

Travel and Transportation

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

No If YES, attach a complete explanation.

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

No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$ N/A
- (13)

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

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

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