

		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: 3000621

Facility Name: Mascoutah Rehab and Nursing

Address: 201 South 10th St Mascoutah 62258

NumberCityZip Code

County: Saint Clair

Telephone Number: (618) 566-8000 Fax #

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2025

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 TemplinTelephone 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 4/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(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 Mascoutah Rehab and Nursing # 3000621 Report Period Beginning: 4/1/2025 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	76	Skilled (SNF)	76	20,900	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	76	TOTALS	76	20,900	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,072	177	1,249	8
9	SNF/PED									9
10	ICF	3,071	2,581	92		2,632			8,376	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,071	2,581	92		2,632	1,072	177	9,625	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 46.05%

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 4/1/25

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 4/1/25 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 76

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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	154,869	14,139	2,260	171,268		171,268	(7,024)	164,244			1
2	Food Purchase		73,894		73,894		73,894		73,894			2
3	Housekeeping	91,759	3,509		95,268		95,268		95,268			3
4	Laundry	75,076	2,871		77,947		77,947		77,947			4
5	Heat and Other Utilities			44,668	44,668		44,668	465	45,133			5
6	Maintenance		20,578	39,325	59,903		59,903	(14,158)	45,745			6
7	Other (specify):* Waste Disposal			4,498	4,498		4,498		4,498			7
8	TOTAL General Services	321,704	114,991	90,751	527,446		527,446	(20,717)	506,729			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	1,058,208	56,311	44,044	1,158,563		1,158,563	72,895	1,231,458			10
10a	Therapy											10a
11	Activities	61,328	3,380		64,708		64,708		64,708			11
12	Social Services	30,111			30,111		30,111		30,111			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Home Office Benefit							6,914	6,914			15
16	TOTAL Health Care and Programs	1,149,647	59,691	52,044	1,261,382		1,261,382	79,809	1,341,191			16
	C. General Administration											
17	Administrative	56,535		105,929	162,464		162,464	(100,561)	61,903			17
18	Directors Fees											18
19	Professional Services			37,489	37,489		37,489	47,160	84,649			19
20	Dues, Fees, Subscriptions & Promotions			2,548	2,548		2,548	2,818	5,366			20
21	Clerical & General Office Expenses	32,056	2,660	5,447	40,163		40,163	82,507	122,670			21
22	Employee Benefits & Payroll Taxes			320,205	320,205		320,205		320,205			22
23	Inservice Training & Education											23
24	Travel and Seminar			153	153		153	3,134	3,287			24
25	Other Admin. Staff Transportation			14,460	14,460		14,460	8,628	23,088			25
26	Insurance-Prop.Liab.Malpractice			79,652	79,652		79,652	1,189	80,841			26
27	Other (specify):* Allocated Home Office Benefit							11,415	11,415			27
28	TOTAL General Administration	88,591	2,660	565,883	657,134		657,134	56,290	713,424			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,559,942	177,342	708,678	2,445,962		2,445,962	115,382	2,561,344			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SEE ACCOUNTANTS' PREPARATION REPORT

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							29,751	29,751			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							822	822			32
33	Real Estate Taxes			65,486	65,486		65,486	(82,891)	(17,405)			33
34	Rent-Facility & Grounds			279,000	279,000		279,000	(279,000)				34
35	Rent-Equipment & Vehicles			1,480	1,480		1,480		1,480			35
36	Other (specify):* Loan Costs			2,500	2,500		2,500		2,500			36
37	TOTAL Ownership			348,466	348,466		348,466	(331,318)	17,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	150,354	40,852	2,824	194,030		194,030	78,313	272,343			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,991	156,991		156,991		156,991			42
43	Other (specify):* Disallowed Costs			164,038	164,038		164,038	(164,038)				43
44	TOTAL Special Cost Centers	150,354	40,852	323,853	515,059		515,059	(85,725)	429,334			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,710,296	218,194	1,380,997	3,309,487		3,309,487	(301,661)	3,007,826			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(743)	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	29,751	30		9
10	Interest and Other Investment Income	(94)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,495)	43		24
25	Fund Raising, Advertising and Promotional	(2,475)	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	(342,030)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (476,411)		\$	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)	174,750		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 174,750		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (301,661)		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	Non-Allowable Travel	(727)	25	3
4	Disallow Related Party Interest Expense	(274,958)	32	4
5	Capitalize Equipment/Repairs over \$2,500	(14,840)	6	5
6	Capitalize Equipment over \$2,500	(7,024)	1	6
7	Capitalize Large Allocated Repair-Home Office	(465)	6	7
8	Disallow Non Allowable Allocated Home Office Exp	(6,150)	21	8
9	Disallow Non Allowable Allocated Home Office Exp	(1,648)	25	9
10	Disallow Owner Wages	(33,448)	17	10
11	Disallow Owner Wages	(2,770)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(342,030)		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	32	Interest	\$	Mascoutah SNF Propco LLC		\$ 275,052	\$ 275,052	1
2	V	33	Real Estate Taxes	83,870	Mascoutah SNF Propco LLC			(83,870)	2
3	V	34	Rent	279,000	Mascoutah SNF Propco LLC			(279,000)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 362,870			\$ 275,052	\$ * (87,818)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number	Mascoutah Rehab and Nursing	#	3000621	Report Period Beginning:	4/1/2025	Ending:	12/31/2025
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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	105,929	Stern Therapy Consultants, LLC		33,448	(72,481)	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			\$ 105,929			\$ 371,967	\$ * 266,038	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subscriptions & Promotions	\$	CET Office Holdings, LLC		\$ 1	\$ 1	15
16	V	32	Interest Expense		CET Office Holdings, LLC		822	822	16
17	V	34	Rent	2,348	CET Office Holdings, LLC			(2,348)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,348			\$ 823	\$ * (1,525)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Pharmacy	\$ 40,852	Medwiz of Illinois, LLC		\$ 38,907	\$ (1,945)	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			\$ 40,852			\$ 38,907	\$ * (1,945)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS				Ownership Listing-1			
Mascoutah Rehab and Nursing							
ID#		3000621					
Report Period Beginning:		4/1/2025		Stern Therapy Consults			
Ending:		12/31/2025		Mascoutah SNF Propco LLC			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Management			
-Owners of companies must be listed instead of company names.				Operator/Licensee	Building Co.	Co./Home Office	
-Names of trust beneficiaries must be listed.				Ownership Percentage	Ownership Percentage	Ownership Percentage	
First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	Boruch	NG Sheps	Spring Valley	NY	10.00000	10.00000	1
2	Avraham	NG Erbllich	Pomona	NY	10.00000	2.50000	2
3	Chaim	O Millman as Trustee**	Pomona	NY	12.87750	12.62500	3
4	Lisa	NG Millman as Trustee**	Pomona	NY	12.62250	12.37500	4
5	Eric	NG Newhouse as Trustee*	Suffern	NY	12.87750	16.66500	22.72500
6	Temi	BG Newhouse as Trustee*	Suffern	NY	12.62250	16.33500	22.27500
7	Benjamin	NG Friedman as Trustee***	Pomona	NV	7.57500	3.78750	
8	Bezalel	NG Stern	Monsey	NV	4.50000	10.00000	55.00000
9	Shmuel	NG Cohn	Clifton	NJ	0.99000	0.99000	
10	Sarah	NG Cohn	Clifton	NJ	2.01000	2.01000	
11	Aharon	NG Wolf	Pomona	NY	1.00000	1.00000	
12	Dina	NG Hirsch	Pomona	NY	4.00000	2.00000	
13	Daniella	BG Unger	Pomona	NY	1.50000	1.50000	
14	Shana	BG Friedman as Trustee***	Pomona	NY	7.42500	3.71250	
15	Avraham	NG Sackton	Clifton	NJ		4.50000	
16							
17							
18							
19							
20							
21	*Trustee in ETN Family Holdings						
22							
23	**Trustee in TLCO Holdings						
24							
25	***Trustee in BSF Family Holdings LLC						
26							
27							
28							
29							
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74							
75							

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			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	Mascoutah SNF Prope	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			Marshall Rehabilitation and Nursing	Marshall, 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

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	7.58	See Att. Sch 7A	1.60	4.00	Alloc. Salary	\$ 5,368	17-7	1
2	Dina Hirsch	Controller	Administrative	4.00	See Att. Sch 7A	1.68	4.18	Alloc. Salary	8,197	21-7	2
3	Daniella Unger	Regional MDS Coord	Nursing	1.50	See Att. Sch 7A	1.68	4.18	Alloc. Salary	10,467	10-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 24,032		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 2/31/2025

(845) 517-4796

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2025

(845) 517-4796

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2025

(845) 624-8055

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	CBE Funding	X		Mortgage			\$	2,444,907			\$	275,052	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related						\$	2,444,907				\$	275,052	9
	B. Non-Facility Related*													
10								Interest Income Offset				(94)	10	
11								CET Office Holdings Alloc				822	11	
12								Disallow Related Party Interest Exp				(274,958)	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(274,230)	14
15	TOTALS (line 9+line14)						\$	2,444,907				\$	822	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024	\$	65,485	2
3. Under or (over) accrual (line 2 minus line 1).			\$	65,485	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.				(83,869)	
Credit on Closing				979	
Allocated from Home Office					
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.			\$	(17,405)	7
Assessed Value from Real Estate Tax Bill: 2024 806,805 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 65,485 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 Mascoutah Rehab and Nursing COUNTY Saint Clair

FACILITY IDPH LICENSE NUMBER 3000621

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. 10-31.0-114-007	Long Term Care Property	\$ 63,955.98	\$ 63,955.98
2. 10-31.0-114-044	Long Term Care Property	\$ 817.30	\$ 817.30
3. 10-31.0-114-045	Long Term Care Property	\$ 711.04	\$ 711.04
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 65,484.32	\$ 65,484.32

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,425B. General Construction Type: Exterior BrickFrame Steel ReinforceNumber 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	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1		Facility		2024	\$ 141,221	1	
2		Alloc CET Office Holdings, LLC		1989	2,609	2	
3		TOTALS			\$ 143,830	3	

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		2025	1986	\$ 1,270,977	\$	35	\$ 27,235	\$ 27,235	\$ 27,235	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install 32 Channel COM System			2025	14,840		20	371	371	371	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

Facility Name & ID Number Mascoutah Rehab and Nursing

3000621

Report Period Beginning:

4/1/2025

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2021	530		20	27	27	522	46
47	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2023	1,319		20	66	66	198	47
48	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2024	1,167		20	58	58	117	48
49	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2025	465		20	23	23	23	49
50	Allocated from CET Office Holdings, LLC - Building	1989	15,475		20	397	397	3,073	50
51	Allocated from CET Office Holdings, LLC-Leasehold Improvements	2018	4,457		20	223	223	1,709	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,309,230	\$		\$ 28,400	\$ 28,400	\$ 33,248	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	27,024		1,351	1,351	10 yrs	1,351	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 27,024	\$	\$ 1,351	\$ 1,351		\$ 1,351	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,480,084	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,751	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,751	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 34,599	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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
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: \$1,480
- Description: Copier \$1,339; Medical Equipment \$141
- (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				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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)	1357	hrs	\$ 48,453		\$	1,357	\$ 48,453	1
2	Licensed Speech and Language Development Therapist	39(1)	465	hrs	25,686			465	25,686	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	39(1)	1720	hrs	76,215			1,720	76,215	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			40,852		40,852	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): Lab/X-Ray	39(3)				2,824			2,824	12
13	Other (specify): Home Office Allocation	39(7)			80,258				80,258	13
14	TOTAL				\$ 230,612	\$ 2,824	\$ 40,852	3,542	\$ 274,288	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 254,292	\$ 262,342	1
2	Cash-Patient Deposits	50	50	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	693,826	693,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 948,168	\$ 956,218	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,830	13
14	Buildings, at Historical Cost		1,270,977	14
15	Leasehold Improvements, at Historical Cost		38,253	15
16	Equipment, at Historical Cost		27,024	16
17	Accumulated Depreciation (book methods)		(34,599)	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>Closing Costs</u>		5,438	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,450,923	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 948,168	\$ 2,407,141	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 388,903	\$ 109,903	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50	50	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		37,929	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		275,052	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany</u>	1,120,811		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,509,764	\$ 422,934	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,444,907	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)	\$	\$ 2,444,907	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,509,764	\$ 2,867,841	46
47	TOTAL EQUITY(page 18, line 24)	\$ (561,596)	\$ (460,700)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 948,168	\$ 2,407,141	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(561,596)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (561,596)	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)	\$ (561,596)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mascoutah Rehab and Nursing

3000621

Report Period Beginning: 4/1/2025

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	\$ 2,644,938	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,644,938	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,632	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 99,632	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,712	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,712	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	94	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 94	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	CNA Initiative	515	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 515	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,747,891	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	527,446	31
32	Health Care	1,261,382	32
33	General Administration	657,134	33
	B. Capital Expense		
34	Ownership	348,466	34
	C. Ancillary Expense		
35	Special Cost Centers	358,068	35
36	Provider Participation Fee	156,991	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,309,487	40
41	Income before Income Taxes (line 30 minus line 40)**	(561,596)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (561,596)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 638,229.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	551,827.00	45
46	MMAI-Medicaid is the Primary Payer	19,670.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	568,290.00	48
49	Medicare Part A	748,286.00	49
50	Other-(specify) Insurance/Managed Care	118,636.00	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)	\$ 2,644,938	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			\$	\$	1
2	Assistant Director of Nursing	1,107	1,123	38,732	34.49	2
3	Registered Nurses	4,426	4,742	211,058	44.51	3
4	Licensed Practical Nurses	7,116	7,361	274,096	37.24	4
5	CNAs & Orderlies	21,548	22,055	499,420	22.64	5
6	CNA Trainees					6
7	Licensed Therapist	3,417	3,542	150,354	42.45	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,939	2,995	61,328	20.48	10
11	Social Service Workers	1,318	1,360	30,111	22.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,788	9,020	154,869	17.17	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	5,650	5,770	91,759	15.90	18
19	Laundry	4,622	4,721	75,076	15.90	19
20	Administrator	1,338	1,408	56,535	40.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,104	1,112	32,056	28.83	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	949	965	34,902	36.17	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	64,322	66,174	\$ 1,710,296 *	\$ 25.85	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	39	\$ 2,260	L1, C3	35
36	Medical Director	Monthly	8,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	39	\$ 10,260		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	193	\$ 12,120	L10, C3	50
51	Licensed Practical Nurses	423	25,973	L10, C3	51
52	Certified Nurse Assistants/Aides	310	5,951	L10, C3	52
53	TOTAL (lines 50 - 52)	926	\$ 44,044		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberMascoutah Rehab and Nursing# 3000621Report Period Beginning:4/1/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nicole Snyder	Administrator	0	\$ 15,790
Alicia Emmerich	Administrator	0	40,745
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 56,535

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	\$ 105,929
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Direct Supply	Life Safety Compliance	\$ 889
IT Computing Services	Computer Service	1,529
Natl Datacare Corp	Fund Management	768
Pointclickcare	Computer Service	14,384
Streamline Verify LLC	Computer Service	484
Lucia Abreu	Billing Services	250
Avraham Lipman	Contract Consultant	3,300
Carolyn Tom	Contract Consultant	500
Radial Consulating	Website Creation	1,150
Gutnicki LLP	Legal Services	5,952
The Conner Law Firm LLC	Legal Services	6,963
Accurate Pay	Payroll Services	1,320
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 37,489

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 25,851
Unemployment Compensation Insurance	42,380
FICA Taxes	130,892
Employee Health Insurance	119,001
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,081
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 5)	106
Patient Background Checks 47	956
Association Dues (total from pg 22, #4)	
Licenses & Fees	1,486
Home Office/CET Office Holdings Alloc	2,818
Less: Public Relations Expense	()
PAC and Lobbying payments	()
All non-allowable advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	153
Home Office Allocation	3,134
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,287

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|------------------|--------------|
| | |
| | |
| | |
| | Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--|--------------|
| | |
| | |
| | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|--------------|
| | |
| | |
| | |
| | |
| | Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 8,920 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. \$ 156,991
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.