

		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: <u>0051870</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Dixon Rehab HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> 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.																									
Address: <u>800 Division Street</u> <u>Dixon</u> <u>61021</u> Number City Zip Code																											
County: <u>Lee</u>																											
Telephone Number: <u>(815) 284-3393</u> Fax # <u>(815) 284-2066</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>5/1/2008</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																									
☐ Charitable Corp.	☐ Individual	☐ State																									
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	☒ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																									

STATE OF ILLINOIS

Page 2

Facility Name & ID Number

Dixon Rehab HCC

#

0051870

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

N/A

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	97	Skilled (SNF)	97	35,405	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	97	TOTALS	97	35,405	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 Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total
8	SNF	4,085	6,740	7,238		4,606	2,946	3,744	29,359
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	4,085	6,740	7,238		4,606	2,946	3,744	29,359

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

82.92%

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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

5/1/2008

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

YES

X

Date

5/1/2008

NO

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

YES

X

NO

If YES, enter certified beds.

number of certified beds

97

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL

X

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

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

	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	334,818	27,507	14,221	376,546		376,546	(85)	376,461		1
2	Food Purchase		268,986		268,986		268,986		268,986		2
3	Housekeeping		16,257	159,220	175,477		175,477		175,477		3
4	Laundry			111,610	111,610		111,610		111,610		4
5	Heat and Other Utilities			157,150	157,150		157,150		157,150		5
6	Maintenance	63,247	18,598	78,599	160,444		160,444		160,444		6
7	Other (specify):*										7
8	TOTAL General Services	398,065	331,348	520,800	1,250,213		1,250,213	(85)	1,250,128		8
	B. Health Care and Programs										
9	Medical Director			17,518	17,518		17,518		17,518		9
10	Nursing and Medical Records	3,114,656	133,025	114,702	3,362,383		3,362,383		3,362,383		10
10a	Therapy										10a
11	Activities	84,584	5,713	4,447	94,744		94,744		94,744		11
12	Social Services	109,671		1,745	111,416		111,416		111,416		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,308,911	138,738	138,412	3,586,061		3,586,061		3,586,061		16
	C. General Administration										
17	Administrative	93,752		434,283	528,035		528,035	(45,533)	482,502		17
18	Directors Fees										18
19	Professional Services			137,401	137,401		137,401	(61,361)	76,040		19
20	Dues, Fees, Subscriptions & Promotions			25,692	25,692		25,692	(3,364)	22,328		20
21	Clerical & General Office Expenses	210,336	15,438	308,493	534,267		534,267	(121,484)	412,783		21
22	Employee Benefits & Payroll Taxes			486,184	486,184		486,184		486,184		22
23	Inservice Training & Education			6,185	6,185		6,185		6,185		23
24	Travel and Seminar			1,333	1,333		1,333		1,333		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,657	93,657		93,657		93,657		26
27	Other (specify):*										27
28	TOTAL General Administration	304,088	15,438	1,493,228	1,812,754		1,812,754	(231,742)	1,581,012		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,011,064	485,524	2,152,440	6,649,028		6,649,028	(231,827)	6,417,201		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
30	D. Ownership			81,157	81,157		81,157	32,824	113,981		30
31	Depreciation										31
32	Amortization of Pre-Op. & Org.										32
33	Interest			32,147	32,147		32,147	184,448	216,595		33
34	Real Estate Taxes			50,791	50,791		50,791		50,791		34
35	Rent-Facility & Grounds			326,295	326,295		326,295	(326,295)			35
36	Rent-Equipment & Vehicles			27,631	27,631		27,631		27,631		36
37	Other (specify):*										37
38	TOTAL Ownership			518,021	518,021		518,021	(109,023)	408,998		38
39	Ancillary Expense										39
40	E. Special Cost Centers										40
41	Medically Necessary Transportation										41
42	Ancillary Service Centers		240,005	554,349	794,354		794,354		794,354		42
43	Barber and Beauty Shops			731	731		731		731		43
44	Coffee and Gift Shops										44
45	Provider Participation Fee			598,166	598,166		598,166		598,166		45
46	Other (specify):* Marketing			86,871	86,871		86,871	(86,871)			46
47	TOTAL Special Cost Centers		240,005	1,240,117	1,480,122		1,480,122	(86,871)	1,393,251		47
48	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,011,064	725,529	3,910,578	8,647,171		8,647,171	(427,721)	8,219,450		48

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(85)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(273)	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	(45,359)	21		18
19	Entertainment				19
20	Contributions	(154)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,182)	21		24
25	Fund Raising, Advertising and Promotional	(30,279)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	80,770			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,562)		\$	30

BHF USE ONLY								
48		49		50		51		52

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	2	
		Amount	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)	(272,159)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (272,159)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (427,721)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Dixon Rehab HCC

ID# 0051870

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ (3,441)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc. Income	84,211	21	3
4				4
5				5
6				6
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47				47
48				48
49	Total	80,770		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-1		See PG6-Supp		See PG6-Supp		

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

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 326,295	Ti-Dixon Illinois, LLC	100.00%	\$	(326,295)	1
2	V	32	Interest		Ti-Dixon Illinois, LLC	100.00%	216,868	216,868	2
3	V	19	Legal Fees		Ti-Dixon Illinois, LLC	100.00%	200	200	3
4	V	30	Depreciation		Ti-Dixon Illinois, LLC	100.00%	20,707	20,707	4
5	V	20	Licenses		Ti-Dixon Illinois, LLC	100.00%	77	77	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			\$ 326,295			\$ 237,852	\$ * (88,443)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 Management-Operating	\$ 434,283	Tutera Health Care Service		\$ 388,750	\$ (45,533)	15
16	V	19 Management-Data Processing	61,561	Tutera Health Care Service			(61,561)	16
17	V	30 Management-Depreciation		Tutera Health Care Service		12,117	12,117	17
18	V	43 Marketing	56,592	Tutera Health Care Service			(56,592)	18
19	V	32 Interest	32,147	Tutera Investment			(32,147)	19
20	V	26 Insurance	74,922	LTC Plus Insurance, Inc.		74,922		20
21	V	39 Drugs	181,113	Critical Care Rx, LLC		181,113		21
22	V	39 IV Therapy & Supplies	16,651	Critical Care Rx, LLC		16,651		22
23	V	10 Pharmacy Consultant	11,394	Critical Care Rx, LLC		11,394		23
24	V	10 Pharmacy Supplies	1,324	Critical Care Rx, LLC		1,324		24
25	V	10 Contracted Nursing	147	Teamworkers LLC		147		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		\$ 870,134			\$ 686,418	\$ * (183,716)	39

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

Report Period Beginning:

Ending:

ID#

0051870

1/1/2025

12/31/2025

Walnut Creek Mgt Corr

TI - Dixon

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	Operator/Licensee		Building Co.		Management	
	Ownership		Ownership		Co. /Home Office	
	Percentage		Percentage		Ownership	
	First Name	M.I.	Last Name	City	State	Percentage
1	Joseph	C	Tutera, Sr.	Mission Hills	KS	73.26000
2	Marian	O	Tutera	Mission Hills	KS	10.10000
3	Laura	C	Tutera-Tomlinson	Kansas City	MO	4.16060
4	Hannah	M	Tutera	Mission Hills	KS	4.16060
5	Dominic	F	Tutera	Mission Hills	KS	4.16060
6	Joseph	C	Tutera, Jr.	Mission Hills	KS	4.16060
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Report Period Beginning:

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ID#

0051870

1/1/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Place of Residence

Operator/Licensee

Building Co.

Management Co./Home Office

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name	M.I.	Last Name	City	State	Ownership Percentage	Building Co. Ownership Percentage	Management Co./Home Office Ownership Percentage	
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VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Bethany Rehab & Health Care Center	Dekalb, IL			Antioch Valley	Overland Park, KS	AL	1
2	Carlinsville Rehab & Health Care Center	Carlinsville, IL			Carnegie Village Senior Living	Belton, MO	IL/AL	2
3	Carnegie Village Rehab & Health Care Center	Belton, MO			Country Gardens Assisted Living	Muskogee, OK	AL	3
4	Charlton Place Rehab & Health Care Center	Deatsville, AL			Laurel Assisted Living	Liberty, MO	AL	4
5	Coulterville Rehab & Health Care Center	Coulterville, IL			Missiona Chateaux Senior Living	Prairie Village, KS	AL/IL	5
6	Crystal Pines Rehab & Health Care Center	Crystal Lake, IL			Oakley Court Assisted Living	Freeport, IL	AL	6
7	Estoria Rehabilitation Center	Liberty, MO			Town Center	Overland Park, KS	AL	7
8	Fair Oaks Rehab & Health Care Center	South Beloit, IL			Stratford Commons Memory Care	Overland Park, KS	Memory Care	8
9	Grand Meadows Senior Living	Asbury, IA			The Lodge at Manito	Manito, IL	AL	9
10	Highland Rehab & Health Care Center	Kansas City, MO			Tiffany Springs SLC	Kansas City, MO	AL/IL	10
11	Hillsboro Rehab & Health Care Center	Hillsboro, IL			Wesley Court Assisted Living	Boling Springs, SC	AL	11
12	Lakeland Rehab & Health Care Center	Effingham, IL						12
13	Matton Rehab & Health Care Center	Mattoon II, IL						13
14	Meridian Rehab & Health Care Center	Wichita, KS						14
15	Metropolis Rehab & Health Care Center	Metropolis, IL			LTC Plus Insurance Agency	Kansas City, MO	Insurance Company	15
16	Monterey Park Rehab & Health Care Center	Independence, MO			JCT Capital, Inc.	Kansas City, MO	Mgmt Company	16
17	Montgomery Children's Specialty Center	Montgomery, AL			Tutera Group, Inc.	Kansas City, MO	Mgmt Company	17
18	Moweaqua Rehab & Health Care Center	Moweaqua, IL			Tutera Health Care Services	Kansas City, MO	Mgmt Company	18
19	Northland Rehab & Health Care Center	Kansas City, MO			Tutera Investments, LLC	Kansas City, MO	Mgmt Company	19
20	St. Paul's Senior Community	Belleville, IL			Walnut Creek Mgmt Co	Kansas City, MO	Mgmt Company	20
21	Stratford Rehab & Health Care Center	Overland Park, KS			Walnut Creek New Era	Kansas City, MO	Mgmt Company	21
22	The Village at Mission	Prairie Village, KS			IPM, Inc.	Kansas City, MO	Property Mgt	22
23	Tiffany Springs Rehab & Health Care Center	Kansas City, MO			Columbia 7611 LC	Kansas City, MO	Building Company	23
24	Westview of Derby Rehab & Health Care Center	Derby, KS			JCT FLP Auburn LLC	Aurora, IL	Building Company	24
25	Windsor Estates of St. Charles	St. Charles, MO			TeamWorkers LLC	Kansas City, MO	Agency Nursing	25
26	Holly Hill Rehab & Health Care Center	Sulphur, LA			Critical Care Rx, LLC	Kansas City, MO	Pharmacy Company	26
27	Rosewood Rehab & Health Care Center	Lake Charles, LA						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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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.

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 Tutera Health Care Services

Street Address 7611 State Line Road

City / State / Zip Code Kansas City, Missouri 64114

Phone Number (816) 444-0900

Fax Number (816) 822-0081

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Management Fee- Operating	Direct Costs	512,439,158	114	\$ 24,349,098	\$ 16,637,381	8,181,486	388,752	1
2	30	Management Fee- Depreciation	Direct Costs	512,439,158	114	758,922		8,181,486	12,117	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 25,108,020	\$ 16,637,381		\$ 400,869	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	Tutera Group Inc	x		Note Payable (T1 Dixon)			\$	3,315,573		0.0700	\$	216,868	1							
2	Interest Income Offset											(273)	2							
3													3							
4													4							
5													5							
	Working Capital																			
6	Tutera Investment	x		Note Payable			3,187,657	3,245,360		0.0100		32,147	6							
7	Related Party Interest Offset											(32,147)	7							
8													8							
9	TOTAL Facility Related						\$	3,187,657	\$	6,560,933			\$	216,595	9					
	B. Non-Facility Related*																			
10													10							
11													11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$		\$			\$		14						
15	TOTALS (line 9+line14)						\$	3,187,657	\$	6,560,933			\$	216,595	15					

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

* 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.)

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dixon Rehab HCC COUNTY Lee
FACILITY IDPH LICENSE NUMBER 0051870
CONTACT PERSON REGARDING THIS REPORT Kiley Brooks
TELEPHONE (816) 444-0900 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)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>07-08-04-376-011</u>	<u>Long-Term Care</u>	\$ <u>52,602.52</u>	\$ <u>52,602.52</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>52,602.52</u>	\$ <u>52,602.52</u>

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 provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

28,700

B. General Construction Type:

Exterior

Brick

Frame

Brick

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(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?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(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 ground (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.

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility.

IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Long-Term Care	28,700	2002	\$ 92,000	1
2					2
3	TOTALS	28,700		\$ 92,000	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	97		2002	1973	\$ 822,167	\$ 20,168	27	\$ 20,168		\$ 801,754	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Home Office Allocation					12,117		12,117			9
10											10
11	2014 Improvements			2014	45,704					45,704	11
12	2015 Improvements			2015	46,238	2,504	Various	2,504		26,151	12
13	2016 Improvements			2016	39,929	2,259	Various	2,259		22,079	13
14	2017 Improvements			2017	9,918	982	Various	982		8,425	14
15	2018 Improvements			2018	176,208	11,747	Various	11,747		87,125	15
16	Replace Water Softeners			2022	14,054	937	15	937		1,874	16
17	Replace walk-in Cooler Floor			2023	11,200	1,120	10	1,120		2,987	17
18	Carport			2023	14,070	937	39	937		2,811	18
19	New Freezer			2024	18,467	1,231	15	1,231		2,360	19
20	Parking Lot Paving			2024	52,500	5,250	10	5,250		8,313	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.

See Page 12A, Line 70 for total

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	N/A		\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,250,455	\$ 59,252		\$ 59,252	\$	\$ 1,009,583	70

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

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	\$415,537	\$48,629	\$48,629	\$	Various	\$269,900	71
72	Current Year Purchases	54,626	6,100	6,100		Various		72
73	Fully Depreciated Assets	105,958				Various	105,958	73
74								74
75	TOTALS	\$576,121	\$54,729	\$54,729	\$		\$375,858	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		Ford Van	2012	\$13,000	\$	\$	\$	4	\$13,000	76
77		Ford Transit 350 XL van	2018	55,185				5	55,178	77
78										78
79										79
80	TOTALS			\$68,185	\$	\$	\$		\$68,178	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)	\$1,986,761	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$113,981	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$113,981	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,453,619	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	WIP	\$30,188	92
93			93
94			94
95		\$30,188	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?

☐ 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: *

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: \$ 27,631 Description: Dishwasher, Nursing Equipment, Copier, (See WTB)
(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2026 \$

13. /2027 \$

14. /2028 \$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

1		2		3		4		5		6		7		8	
1	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	V39-02.03	hrs	\$	1,600	\$ 160,946	\$	1,600	\$ 160,946	1					
2	Licensed Speech and Language Development Therapist	V39-02.03	hrs		394	46,305		394	46,305	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	V39-02.03	hrs		2,941	306,590	477	2,941	307,067	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy	V39-02	# of prescripts				195,424		195,424	9					
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Other (specify):									12					
13	Other (specify): See WTB	V39-02.03				40,508	44,104		84,612	13					
14	TOTAL			\$	4,935	\$ 554,349	\$ 240,005	4,935	\$ 794,354	14					

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (61,592)	\$ 5,814	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	409,932	409,932	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,379	84,379	6
7	Other Prepaid Expenses	253,382	253,382	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	46,612	46,612	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 732,713	\$ 800,119	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		92,000	13
14	Buildings, at Historical Cost		822,167	14
15	Leasehold Improvements, at Historical Cost	440,651	440,651	15
16	Equipment, at Historical Cost	557,308	631,943	16
17	Accumulated Depreciation (book methods)	(577,230)	(1,453,619)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): WIP	(12,392)	(12,392)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 408,337	\$ 520,750	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,141,050	\$ 1,320,869	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 292,787	\$ 292,787	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,362	23,362	28
29	Short-Term Notes Payable	3,245,360	3,245,360	29
30	Accrued Salaries Payable	446,359	446,359	30
	Accrued Taxes Payable (excluding real estate taxes)	143,773	143,773	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,084	41,084	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to/from Related Party	28,461	54,756	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,221,186	\$ 4,247,481	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,315,573	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,315,573	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,221,186	\$ 7,563,054	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,080,136)	\$ (6,242,185)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,141,050	\$ 1,320,869	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,184,157)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,184,157)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	77,489	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) PY Adjustments	26,532	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 104,021	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)	\$ (3,080,136)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,614,012	1
2	Discounts and Allowances for all Levels	(1,185,009)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,429,003	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,821,513	6
7	Oxygen	5,120	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,826,633	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	85	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	348,187	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,474	19
20	Radiology and X-Ray	13,366	20
21	Other Medical Services	60,185	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 448,297	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	273	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 273	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Revenue	20,454	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,454	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,724,660	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,250,213	31
32	Health Care	3,586,061	32
33	General Administration	1,812,754	33
B. Capital Expense			
34	Ownership	518,021	34
C. Ancillary Expense			
35	Special Cost Centers	881,956	35
36	Provider Participation Fee	598,166	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,647,171	40
41	Income before Income Taxes (line 30 minus line 40)**	77,489	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 77,489	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 968,700.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,598,295.00	45
46	MMAI-Medicaid is the Primary Payer	1,716,389.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	694,372.00	48
49	Medicare Part A	879,792.00	49
50	Other-(specify) Managed Care	571,455.00	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)	\$ 6,429,003	56

(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	1,944	2,080	\$ 103,648	\$ 49.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,056	19,499	1,085,791	55.68	3
4	Licensed Practical Nurses	14,815	16,289	537,102	32.97	4
5	CNAs & Orderlies	58,297	62,247	1,388,115	22.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,563	1,635	33,290	20.36	9
10	Activity Assistants	3,002	3,126	51,294	16.41	10
11	Social Service Workers	4,410	4,826	109,671	22.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,007	20,137	334,818	16.63	15
16	Dishwashers					16
17	Maintenance Workers	2,063	2,330	63,247	27.14	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,828	2,080	93,752	45.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,376	8,058	210,336	26.10	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,361	142,307	\$ 4,011,064 *	\$ 28.19	34

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

** See instructions.

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	278	\$ 16,238	V01-3	35
36	Medical Director	Monthly	17,518	V09-3	36
37	Medical Records Consultant	Monthly	1,248	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,398	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,600	V11-3	44
45	Social Service Consultant	36	1,745	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	354	\$ 49,747		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	135	\$ 7,548	V10-3	50
51	Licensed Practical Nurses	1,641	92,047	V10-3	51
52	Certified Nurse Assistants/Aides	43	1,321	V10-3	52
53	TOTAL (lines 50 - 52)	1,819	\$ 100,916		53

XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Nicole Garner	Administrator	100	\$ 93,752	Workers' Compensation Insurance	\$ 72,015	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		7,348
				FICA Taxes	327,278	Health Care Worker Background Check (Indicate # of checks performed 15)		475
				Employee Health Insurance	94,280	Patient Background Checks	242	2,422
				Employee Meals		Association Dues (total from pg 22, #4)		9,809
				Illinois Municipal Retirement Fund (IMRF)*		Lee County Health Department		576
				Other Benefits	(7,389)	Other Dues and Subscriptions		1,020
						Other Licences		4,119
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	(	
			\$ 93,752			PAC and Lobbying payments		(3,441)
B. Administrative - Other						All non-allowable advertising	(	
Description			Amount					
Tutera Health Care Services - Management Fee			\$ 434,283					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 434,283					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal Fees		\$ 1,558	N/A			Out-of-State Travel	\$
CliftonLarsonAllen LLP	Cost Report/Taxes		6,269					
Aline Ops	CRM Software		1,882					
Consolidated Billing Services	Billing		398				In-State Travel	1,333
Walnut Creek Mgt Company	CBO, IT & DP Mgt Fee		61,561					
Managed Care Group	Managed Care Contracting		550					
Netsmart Technologies	E.H.R.		2,156					
PointClickCare Tech	Medical Records Software		15,299				Seminar Expense	
Proclaim Partners	Claims Mgt		1,090					
Wellsky Corporation	Data Processing		1,275					
Payroll	Payroll Processing		18,933					
Various	Data Processing/Software		26,430					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							Entertainment Expense	(
			\$ 137,401					
				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,333

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- 1) 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? No Indicate the amount. \$ _____
- (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%
- 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: