

		FOR BHF USE					

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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>0050963</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Fair Oaks 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>1515 Blackhawk</u> <u>South Beloit</u> <u>61080</u> Number City Zip Code																											
County: <u>Winnebago</u>																											
Telephone Number: <u>(815) 389-3911</u> Fax # <u>(815) 389-3911</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>7/1/2010</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> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☐ 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	_____																									
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: _____																											

STATE OF ILLINOIS

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Facility Name & ID NumberFair Oaks Rehab HCC# 0050963Report Period Beginning: 1/1/2025Ending: 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

1234

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	78	Skilled (SNF)	78	28,470	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	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

123456789

	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	2,766	5,187	3,490		4,559	2,300	4,167	22,469
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	2,766	5,187	3,490		4,559	2,300	4,167	22,469

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

78.92%

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?

YESNO

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

YESNO

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

Date started7/1/2010

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

YESDate7/1/2010NO

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

YESNO

If YES, enter certified beds.

number of certified beds78

Medicare IntermediaryWisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUALMODIFIED

ACCRAUCASH*CASH*

Is your fiscal year identical to your tax year?

YESNO

Tax Year:12/31/2025Fiscal 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	241,982	22,045	26,318	290,345		290,345		290,345		1
2	Food Purchase		190,025		190,025		190,025		190,025		2
3	Housekeeping		13,588	147,452	161,040		161,040		161,040		3
4	Laundry		5,760	97,547	103,307		103,307		103,307		4
5	Heat and Other Utilities			158,745	158,745		158,745		158,745		5
6	Maintenance	101,566	19,216	114,766	235,548		235,548		235,548		6
7	Other (specify):*										7
8	TOTAL General Services	343,548	250,634	544,828	1,139,010		1,139,010		1,139,010		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,386,334	96,282	591,933	3,074,549		3,074,549		3,074,549		10
10a	Therapy										10a
11	Activities	83,619	10,130	2,665	96,414		96,414		96,414		11
12	Social Services	125,840		7,198	133,038		133,038		133,038		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,595,793	106,412	625,796	3,328,001		3,328,001		3,328,001		16
	C. General Administration										
17	Administrative	115,528		341,641	457,169		457,169	11,990	469,159		17
18	Directors Fees										18
19	Professional Services			167,821	167,821		167,821	(39,852)	127,969		19
20	Dues, Fees, Subscriptions & Promotions			26,441	26,441		26,441	(3,537)	22,904		20
21	Clerical & General Office Expenses	190,360	34,555	560,887	785,802		785,802	(291,256)	494,546		21
22	Employee Benefits & Payroll Taxes			378,104	378,104		378,104		378,104		22
23	Inservic Training & Education			3,097	3,097		3,097		3,097		23
24	Travel and Seminar			2,899	2,899		2,899		2,899		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,792	77,792		77,792		77,792		26
27	Other (specify):*										27
28	TOTAL General Administration	305,888	34,555	1,558,682	1,899,125		1,899,125	(322,655)	1,576,470		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,245,229	391,601	2,729,306	6,366,136		6,366,136	(322,655)	6,043,481		29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			20,635	20,635		20,635	106,143	126,778		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,975	19,975		19,975	27,148	47,123		32
33	Real Estate Taxes			56,406	56,406		56,406		56,406		33
34	Rent-Facility & Grounds			196,681	196,681		196,681	(196,681)			34
35	Rent-Equipment & Vehicles			23,252	23,252		23,252		23,252		35
36	Other (specify):* Mortgage Ins							8,210	8,210		36
37	TOTAL Ownership			316,949	316,949		316,949	(55,180)	261,769		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		50,063	702,570	752,633		752,633		752,633		39
40	Barber and Beauty Shops			565	565		565		565		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			385,796	385,796		385,796		385,796		42
43	Other (specify):* Marketing			75,388	75,388		75,388	(75,388)			43
44	TOTAL Special Cost Centers		50,063	1,164,319	1,214,382		1,214,382	(75,388)	1,138,994		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,245,229	441,664	4,210,574	7,897,467		7,897,467	(453,223)	7,444,244		45

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

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

		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				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	(487)	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	(42,180)	21		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	(316,755)	21		24
25	Fund Raising, Advertising and Promotional	(24,475)	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	58,280			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (325,617)		\$	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)	(127,606)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (127,606)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (453,223)		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

Report Period Beginning:

Ending:

ID#

0050963

1/1/2025

12/31/2025

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (3,302)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc. Income	62,048	21	3
4	Chamber of Commerce Dues	(312)	20	4
5	Gifts	(154)	21	5
6				6
7				7
8				8
9				9
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40				40
41				41
42				42
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46				46
47				47
48				48
49	Total	58,280		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 PG6-Supp		See PG6-Supp			See PG6-Supp	

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 196,681	TI - South Beloit	100.00%	\$	(196,681)	1
2	V	32	Interest		TI - South Beloit	100.00%	47,610	47,610	2
3	V	19	Legal & Accounting		TI - South Beloit	100.00%	12,138	12,138	3
4	V	36	Mortgage Insurance		TI - South Beloit	100.00%	8,210	8,210	4
5	V	30	Depreciation		TI - South Beloit	100.00%	95,120	95,120	5
6	V	33	Real Estate Taxes	56,407	TI - South Beloit	100.00%	56,407		6
7	V	26	Insurance	12,595	TI - South Beloit	100.00%	12,595		7
8	V	20	Licenses		TI - South Beloit	100.00%	77	77	8
9	V	21	Taxes		TI - South Beloit	100.00%	5,785	5,785	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 265,683			\$ 237,942	\$ * (27,741)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1	2	3 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	\$ 341,641	Tutera Health Care Service		\$ 353,631	\$ 11,990	15
16	V	19 Management-Data Processing	51,990	Tutera Health Care Service			(51,990)	16
17	V	30 Management-Depreciation		Tutera Health Care Service		11,023	11,023	17
18	V	43 Management-Marketing	50,913	Tutera Health Care Service			(50,913)	18
19	V	32 Interest	19,975	Tutera Investments			(19,975)	19
20	V	26 Insurance	61,124	LTC Plus Insurance, Inc.		61,124		20
21	V	10 Pharmacy Consultant	7,383	Critical Care Rx, LLC		7,383		21
22	V	39 Supplies & Non-Covered Drugs	11,267	Critical Care Rx, LLC		11,267		22
23	V	39 Drugs	190,809	Critical Care Rx, LLC		190,809		23
24	V	39 OTC drugs	125	Critical Care Rx, LLC		125		24
25	V	10 Nursing Purchased Svcs	23,743	TeamWorkers, LLC		23,743		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		\$ 758,970			\$ 659,105	\$ * (99,865)	39

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

Report Period Beginning:

Ending:

ID#

0050963

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 Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage		City	State	Last Name	M.I.	First Name
76				76					
77				77					
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150				150					

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 Chateau 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	Dixon Rehab & Health Care Center	Dixon, IL			Town Center	Overland Park, KS	AL	7
8	Estoria Rehabilitation	Liberty, MO			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☒XNO☐

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related OrganizationTutera Health Care Services

Street Address7611 State Line Road

City / State / Zip CodeKansas City, Missouri 64114

Phone Number(816) 444-0900

Fax Number(816) 822-0081

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fee Operating	Direct Cost	512,439,158	114	\$ 24,349,098	\$ 16,637,381	7,442,254	353,627	1
2	30	Management Fee Depreciation	Direct Cost	512,439,158	114	758,922		7,442,254	11,022	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		\$ 364,649	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense									
		YES	NO				Original	Balance												
	A. Directly Facility Related Long-Term																			
1	HUD (Landlord WTB)		x	Mortgage			\$		\$	1,605,417						\$	47,610		1	
2	Interest Income Offset																(487)		2	
3																			3	
4																			4	
5																			5	
	Working Capital																			
6	TI Note	x		Operating				750,000		2,719,247					1.0000		19,975		6	
7	Related Party Interest Offset																(19,975)		7	
8																			8	
9	TOTAL Facility Related							\$	750,000	\$	4,324,664					\$	47,123		9	
	B. Non-Facility Related*																			
10																			10	
11																			11	
12																			12	
13																			13	
14	TOTAL Non-Facility Related							\$		\$						\$			14	
15	TOTALS (line 9+line14)							\$	750,000	\$	4,324,664					\$	47,123		15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,210 Line # 36

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

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

B. Real Estate Taxes

Assessed Value from Real Estate Tax Bill:	2024	37,899	8
Real Estate Tax Bill for Calendar Year:	2020	96,543	9
	2021	73,751	10
	2022	70,060	11
	2023	53,979	12
	2024	55,193	13

	FOR BHF USE ONLY		
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

Fair Oaks Rehab HCC

COUNTY

Winnebago

FACILITY IDPH LICENSE NUMBER

0050963

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.	04-07-258-002	Long-Term Care	\$ 55,192.74	\$ 55,192.74
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 55,192.74	\$ 55,192.74

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:

11,217

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long Term Care	11,217	2010	\$ 233,678	1
2					2
3	TOTALS	11,217		\$ 233,678	3

	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	78		2010	1975	\$ 2,249,148	\$ 88,603	27	\$ 88,603		\$ 1,267,701	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFTOP HVAC		2013		6,946					6,946	9
10	CEILING INSULATION		2013		6,625					6,625	10
11	ROOF REPLACEMENT		2018		75,365	2,749	27	2,749		19,700	11
12	REPLACE DRY WALL		2021		5,500	200	27	200		850	12
13	BLACKTOP REPAIR		2021		10,998	733	15	733		3,055	13
14	3" WATER MAIN VALVE		2024		6,542	1,308	5	1,308		2,508	14
15	WATER HEATER (TI - SOUTH BELOIT)		2012		5,886					5,866	15
16	FIRE SPRINKLER SYSTEM (TI - SOUTH BELOIT)		2013		6,071	34	15	34		4,891	16
17	WATER HEATER (TI - SOUTH BELOIT)		2014		5,243					5,243	17
18	2017 Improvements (TI-South Beloit)		2017		33,219	205	Various	205		22,172	18
19	Tile Flooring - Halls		2023		6,011	33	15	33		1,135	19
20	FIRE SYSTEMS PIPE REPLACEMENT (TI-South Beloit)		2024		9,595	114	7	114		1,828	20
21	Painting Project Hallways		2025		11,240	3,747		3,747		3,747	21
22	Sprinkler System (TI - SOUTH BELOIT)		2025		21,561						22
23											23
24											24
25											25
26											26
27											27
28	Home Office Depreciation					11,022		11,022			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)		\$2,459,950	\$108,748		\$108,748	\$	\$1,352,267	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	\$171,740	\$17,650	\$17,650	\$	Various	\$63,841	71
72	Current Year Purchases	3,857	380	380		Various	380	72
73	Fully Depreciated Assets	566,841				Various	566,841	73
74								74
75	TOTALS	\$742,438	\$18,030	\$18,030	\$		\$631,062	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	Patient Transport	Van	2012	\$ 57,910	\$	\$	\$	5	\$ 57,910	76
77										77
78										78
79										79
80	TOTALS			\$ 57,910	\$	\$	\$		\$ 57,910	80

E. Summary of Care-Related Assets		1	2	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,493,976	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,778	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,778	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)	\$ 2,041,239	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress			
	Description	Cost	
92	WIP - Reserves	\$ 34,466	92
93			93
94			94
95		\$ 34,466	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: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 23,252 Description: Nursing, Dishwasher, Housekeeping, & Copier (See WTB)
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

	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 EndingAnnual 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	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
							Units	Cost				
1	Licensed Occupational Therapist	V39-03		hrs	\$		1,399	\$ 162,584	\$	1,399	\$ 162,584	1
2	Licensed Speech and Language Development Therapist	V39-03		hrs			584	80,622		584	80,622	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	V39-02,03		hrs			1,424	187,596	347	1,424	187,943	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								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Other (specify): <u>Respiratory Therapy</u>	V39-03										12
13	Other (specify):	V39-02,03						271,768	49,716		321,484	13
14	TOTAL				\$		3,407	\$ 702,570	\$ 50,063	3,407	\$ 752,633	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 48,586	\$ 57,665	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	455,878	455,878	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,985	63,497	6
7	Other Prepaid Expenses	201,518	206,813	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	22,860	264,815	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 785,827	\$ 1,048,668	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		233,678	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	123,216	2,459,950	15
16	Equipment, at Historical Cost	117,567	800,348	16
17	Accumulated Depreciation (book methods)	(102,976)	(2,041,239)	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):	97,274	97,274	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 235,081	\$ 1,550,011	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,020,908	\$ 2,598,679	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 330,677	\$ 330,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,598	46,598	28
29	Short-Term Notes Payable	2,719,247	2,801,407	29
30	Accrued Salaries Payable	306,729	306,729	30
	Accrued Taxes Payable (excluding real estate taxes)	170,609	170,609	31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,193	32
33	Accrued Interest Payable		3,880	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(1,248)	(1,248)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,572,612	\$ 3,713,845	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,523,257	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)	\$	\$ 1,523,257	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,572,612	\$ 5,237,102	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,637,983)	\$ (2,638,423)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 934,629	\$ 2,598,679	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,670,732)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,670,732)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(880,971)	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) Prior Year Entries	(86,280)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (967,251)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,637,983)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,206,900	1
2	Discounts and Allowances for all Levels	(1,136,567)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,070,333	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,495,869	6
7	Oxygen	876	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,496,745	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	425,858	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,286	19
20	Radiology and X-Ray	9,459	20
21	Other Medical Services	18,488	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 480,091	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	487	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 487	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	(31,160)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (31,160)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,016,496	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,139,010	31
32	Health Care	3,328,001	32
33	General Administration	1,899,125	33
B. Capital Expense			
34	Ownership	316,949	34
C. Ancillary Expense			
35	Special Cost Centers	828,586	35
36	Provider Participation Fee	385,796	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,897,467	40
41	Income before Income Taxes (line 30 minus line 40)**	(880,971)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (880,971)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 699,703.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,312,132.00	45
46	MMAI-Medicaid is the Primary Payer	882,850.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,106,661.00	48
49	Medicare Part A	648,795.00	49
50	Other-(specify) Managed Care	420,192.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,070,333	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,872	2,043	\$ 115,795	\$ 56.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,392	13,214	670,872	50.77	3
4	Licensed Practical Nurses	12,689	13,314	583,722	43.84	4
5	CNAs & Orderlies	39,367	41,387	995,324	24.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,764	1,909	37,943	19.88	9
10	Activity Assistants	2,726	2,886	45,676	15.83	10
11	Social Service Workers	3,840	4,139	125,840	30.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,503	12,042	241,982	20.09	15
16	Dishwashers					16
17	Maintenance Workers	2,757	2,981	101,566	34.07	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,897	2,080	115,528	55.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,945	5,361	192,373	35.88	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	999	1,079	18,608	17.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,751	102,435	\$ 3,245,229 *	\$ 31.68	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	221	\$ 12,662	V01-3	35
36	Medical Director	Monthly	24,000	V09-3	36
37	Medical Records Consultant	Monthly	832	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,547	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	24	1,560	V11-3	44
45	Social Service Consultant	24	2,155	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	269	\$ 49,756		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,149	\$ 184,332	V10-3	50
51	Licensed Practical Nurses	2,708	151,986	V10-3	51
52	Certified Nurse Assistants/Aides	6,194	250,073	V10-3	52
53	TOTAL (lines 50 - 52)	11,051	\$ 586,391		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
Sherry Wheelchel	Administrator	0	\$ 115,528	Workers' Compensation Insurance	\$	57,128	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	11,165
				FICA Taxes		256,211	Health Care Worker Background Check	384
				Employee Health Insurance		67,899	(Indicate # of checks performed 12)	
				Employee Meals			Patient Background Checks	257
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	6,749
				Other Benefits		(3,134)	Roscoe Chamber of Commerce	312
							Other Licenses	4,947
							Other Dues	391
							Winnebago County Health	
							Less: Public Relations Expense	(312)
							PAC and Lobbying payments	(3,302)
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	115,528		TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				\$	378,104		\$	
							22,904	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	341,641			
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		\$ 50,782				Out-of-State Travel	\$
Clifton Larson Allen LLP	Cost Report/Taxes		6,261					
Aline Ops	CRM Software		1,882					
Consolidated Billing Services	Billing		398				In-State Travel	2,899
Enquire	Data Processing Fees		485					
Managed Care Group	Managed Care Contracting		1,100					
Netsmart Tech.	E.H.R.		2,156					
PointClickCare Tech	Medical Records Software		12,655				Seminar Expense	
Proclaiming Partners	Claims Mgt		2,630					
Payroll	Payroll Processing		18,374					
Walnut Creek Mgt Company	CBO, IT & DP Mgt Fee		51,990					
Various	Data Processing/Software		19,108					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$	167,821		Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,899

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID NumberFair Oaks Rehab HCC

STATE OF ILLINOIS

#0050963

Report Period Beginning:1/1/2025

Ending:12/31/2025

Page 22

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

IL HEALTHCARE ASSOCIATION (IHCA)

3,447

3,447Total

(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

IL HEALTHCARE ASSOCIATION (IHCA)

3,302

3,302Total

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

IL HEALTHCARE ASSOCIATION (IHCA)

6,749

6,749Total

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

\$34,020

Line10

(6)Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$385,796

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?

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 transportation
program during this reporting period.

\$N/A

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

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

No

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

\$N/A

(13)Has an audit been performed by an independent certified public accounting firm

Firm Name:

N/A

No

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

No

(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: