

		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>0049221</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Hillsboro 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>1300 East Tremont St</u> <u>Hillsboro</u> <u>62049</u> Number City Zip Code																											
County: <u>Montgomery</u>																											
Telephone Number: <u>(217) 532-6191</u> Fax # <u>(217) 532-6194</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>2/1/2008</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> 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																									
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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 NumberHillsboro Rehab HCC# 0049221Report 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

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	121	Skilled (SNF)	121	44,165	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	121	TOTALS	121	44,165	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	Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF	7,079	7,788	5,361		5,672	1,907	2,655	30,462	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,079	7,788	5,361		5,672	1,907	2,655	30,462	14

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

68.97%

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 2/1/2008

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

YES X Date 2/1/2008 NO

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

YES X NO If YES, enter certified beds. number of certified beds 121

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?

YES X 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	327,500	17,926	20,065	365,491		365,491	(4)	365,487		1
2	Food Purchase		263,047		263,047		263,047		263,047		2
3	Housekeeping		15,703	162,148	177,851		177,851		177,851		3
4	Laundry		13,535	108,098	121,633		121,633		121,633		4
5	Heat and Other Utilities			140,905	140,905		140,905		140,905		5
6	Maintenance	68,753	30,490	73,842	173,085		173,085		173,085		6
7	Other (specify):*										7
8	TOTAL General Services	396,253	340,701	505,058	1,242,012		1,242,012	(4)	1,242,008		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,481,155	127,828	1,187,967	3,796,950		3,796,950		3,796,950		10
10a	Therapy										10a
11	Activities	200,746	8,755	5,706	215,207		215,207		215,207		11
12	Social Services	90,418	95	2,932	93,445		93,445		93,445		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,772,319	136,678	1,226,605	4,135,602		4,135,602		4,135,602		16
	C. General Administration										
17	Administrative	114,669		368,759	483,428		483,428	54,077	537,505		17
18	Directors Fees										18
19	Professional Services			97,879	97,879		97,879	(27,001)	70,878		19
20	Dues, Fees, Subscriptions & Promotions			27,145	27,145		27,145	(4,503)	22,642		20
21	Clerical & General Office Expenses	132,638	20,320	707,453	860,411		860,411	(545,464)	314,947		21
22	Employee Benefits & Payroll Taxes			442,963	442,963		442,963		442,963		22
23	Inservice Training & Education			3,045	3,045		3,045		3,045		23
24	Travel and Seminar			43,758	43,758		43,758		43,758		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			108,195	108,195		108,195		108,195		26
27	Other (specify):*										27
28	TOTAL General Administration	247,307	20,320	1,799,197	2,066,824		2,066,824	(522,891)	1,543,933		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,415,879	497,699	3,530,860	7,444,438		7,444,438	(522,895)	6,921,543		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
30	D. Ownership			6,506	6,506		6,506	112,446	118,952		
31	Depreciation										30
32	Amortization of Pre-Op. & Org.										31
33	Interest			25,094	25,094		25,094	16,485	41,579		32
34	Real Estate Taxes			44,631	44,631		44,631		44,631		33
35	Rent-Facility & Grounds			164,544	164,544		164,544	(164,544)			34
36	Rent-Equipment & Vehicles			16,272	16,272		16,272		16,272		35
37	Other (specify):* Mortgage Ins							6,019	6,019		36
38	TOTAL Ownership			257,047	257,047		257,047	(29,594)	227,453		37
39	Ancillary Expense										
40	E. Special Cost Centers										
41	Medically Necessary Transportation										38
42	Ancillary Service Centers		170,718	539,101	709,819		709,819		709,819		39
43	Barber and Beauty Shops										40
44	Coffee and Gift Shops										41
45	Provider Participation Fee			651,661	651,661		651,661		651,661		42
46	Other (specify):* Marketing			85,854	85,854		85,854	(85,854)			43
47	TOTAL Special Cost Centers		170,718	1,276,616	1,447,334		1,447,334	(85,854)	1,361,480		44
48	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,415,879	668,417	5,064,523	9,148,819		9,148,819	(638,343)	8,510,476		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)	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	(69)	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	(32,288)	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	(528,669)	21		24
25	Fund Raising, Advertising and Promotional	(25,078)	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				29
29	Other-Attach Schedule	10,990			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (575,118)		\$	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)	(63,225)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,225)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (638,343)		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#0049221

1/1/2025

12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ (4,503)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc. Income	15,493	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	10,990		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 Ownership-1		See Ownership-1		

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	\$ 164,544	TI-Hillsboro, LLC	100.00%	\$	(164,544)	1
2	V	32	Interest		TI-Hillsboro, LLC	100.00%	34,904	34,904	2
3	V	19	Accounting, Legal, Prof Svcs		TI-Hillsboro, LLC	100.00%	10,249	10,249	3
4	V	36	Mortgage Insurance		TI-Hillsboro, LLC	100.00%	6,019	6,019	4
5	V	30	Depreciation		TI-Hillsboro, LLC	100.00%	99,266	99,266	5
6	V	32	Amortization of Fiancing Costs		TI-Hillsboro, LLC	100.00%	6,744	6,744	6
7	V	33	Real Estate Taxes	44,630	TI-Hillsboro, LLC	100.00%	44,630		7
8	V	26	Property Insurance	12,359	TI-Hillsboro, LLC	100.00%	12,359		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 221,533			\$ 214,171	\$ * (7,362)	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	\$ 368,759	Tutera Health Care Service		\$ 422,836	\$ 54,077	15
16	V	19 Management-Data Processing	37,250	Tutera Health Care Service			(37,250)	16
17	V	30 Management-Depreciation		Tutera Health Care Service		13,180	13,180	17
18	V	43 Management-Marketing	60,776	Tutera Health Care Service			(60,776)	18
19	V	26 Insurance	94,821	LTC Plus Insurance, Inc.		94,821		19
20	V	32 Interest	25,094	Tutera Investments			(25,094)	20
21	V	39 IV Therapy & Supplies	3,618	Critical Care RX LLC		3,618		21
22	V	39 Drugs	143,582	Critical Care RX LLC		143,582		22
23	V	10 Pharmacy Consultant	11,709	Critical Care RX LLC		11,709		23
24	V	10 Nursing Purchased Svcs	242,338	TeamWorkers LLC		242,338		24
25	V	10 Non-covered Drgus	5,446	Critical Care RX LLC		5,446		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		\$ 993,393			\$ 937,530	\$ * (55,863)	39

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

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	Belton, MO	IL/AL	2
3	Carnegie Village Rehab & Health Care Center	Belton, MO			Country Gardens Assisted	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	Prairie Village, KS	AL/IL	5
6	Crystal Pines Rehab & Health Care Center	Crystal Lake, IL			Oakley Court Assisted	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	Overland Park, KS	Memory Care	8
9	Fair Oaks Rehab & Health Care Center	South Beloit, IL			The Lodge at Manito	Manito, IL	AL	9
10	Grand Meadows Senior Living	Asbury, IA			Tiffany Springs SLC	Kansas City, MO	AL/IL	10
11	Highland Rehab & Health Care Center	Kansas City, MO			Wesley Court Assisted	Boling Springs, SC	AL	11
12	Lakeland Rehab & Health Care Center	Effingham, IL						12
13	Matton Rehab & Health Care Center	Mattoon II						13
14	Meridian Rehab & Health Care Center	Wichita, KS						14
15	Metropolis Rehab & Health Care Center	Metropolis, IL			LTC Plus Insurance LLC	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 LLC	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 LLC	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		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	8,898,768	422,835	1
2	30	Management Fee- Depreciation	Direct Costs	512,439,158	114	758,922		8,898,768	13,179	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		\$ 436,014	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				\$		\$	1,164,528						\$	34,904		1	
2	Amortize HUD Financing Costs		X														6,744		2	
3	Interest Income Offset																(69)		3	
4																			4	
5																			5	
	Working Capital																			
6	Tutera Investments	X						2,459,571		3,012,474			0.0100				25,094		6	
7	Related Party Offset																(25,094)		7	
8																			8	
9	TOTAL Facility Related						\$	2,459,571	\$	4,177,002						\$	41,579		9	
	B. Non-Facility Related*																			
10																			10	
11																			11	
12																			12	
13																			13	
14	TOTAL Non-Facility Related						\$		\$							\$			14	
15	TOTALS (line 9+line14)						\$	2,459,571	\$	4,177,002						\$	41,579		15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,019 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	38,683	8
Real Estate Tax Bill for Calendar Year:	2020	41,712	9
	2021	42,359	10
	2022	44,290	11
	2023	41,486	12
	2024	43,058	13

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

Hillsboro Rehab HCC

COUNTY

Montgomery

FACILITY IDPH LICENSE NUMBER

0049221

CONTACT PERSON REGARDING THIS REPORT

Fatima Sediqzad

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.	16-12-256-022	Long-Term Care	\$ 43,058.46	\$ 43,058.46
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 43,058.46	\$ 43,058.46

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 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: 16,819

B. General Construction Type: Exterior BrickFrame 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	16,819	2008	\$ 240,000	1
2					2
3	TOTALS	16,819		\$ 240,000	3

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121		2008	1975	\$ 2,460,000	\$ 63,076	39	\$ 63,076		\$ 1,130,128	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2008 IMPROVEMENTS		2008		12,130					12,130	9
10	2009 IMPROVEMENTS		2009		1,309					1,309	10
11	2010 IMPROVEMENTS		2010		2,042					2,042	11
12	2014 IMPROVEMENTS		2014		31,300					31,300	12
13	2015 IMPROVEMENTS		2015		79,417	2,300	10	2,300		79,417	13
14	Fence Replacement		2020		6,995	700	10	700		3,463	14
15	Roofs on Two Buildings		2023		5,951	397	15	397		893	15
16											16
17											17
18											18
19	2011 IMPROVEMENTS (TI HILLSBORO)		2011		250,521	9,685	Various	9,685		197,250	19
20	2012 IMPROVEMENTS (TI HILLSBORO)		2012		58,858	1,819	Various	1,819		34,290	20
21	REMODEL SHOWER ON 300 HALL - TORN DOWN TO STUDS, EN		2016		53,119	3,541	15	3,541		35,117	21
22	WITH NEW PLUMBING, DRY WALL, TILE & PAINT										22
23	LED Light Project		2022		16,701	1,670	10	1,670		5,428	23
24	Clean, Seal, and Patch Parking lot		2024		32,979	2,198	15	2,198		2,931	24
25	Asphalt Seal (TI HILLSBORO)		2025		15,800	267	15	267		267	25
26											26
27											27
28	Home Office Depreciation					13,179		13,179			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	
	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)		\$3,027,122	\$98,832		\$98,832	\$	\$1,535,965	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	\$	177,826	\$ 20,120	\$ 20,120	\$	Various	\$ 109,932	71
72	Current Year Purchases								72
73	Fully Depreciated Assets		377,597					377,249	73
74									74
75	TOTALS	\$	555,423	\$ 20,120	\$ 20,120	\$		\$ 487,181	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	Dodge Grand Caravan Conversion Van		\$ 17,410	\$	\$	\$	5	\$ 17,410	76
77	Patient Transport	Dodge Caravan SE Minivan		23,414				5	23,414	77
78										78
79										79
80	TOTALS			\$ 40,824	\$	\$	\$		\$ 40,824	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)			\$ 3,863,369	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 118,952	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 118,952	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)			\$ 2,063,970	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	WIP	\$ 50,008
93		
94		
95		\$ 50,008

* 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: \$ 16,272 Description: Nursing, Plant, & Copier (WTB)
- ☐ YES☒ NO
- (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 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.)

	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	2	3	
1	Licensed Occupational Therapist	V39-03	hrs	\$	2,633	\$ 224,639	\$	2,633	\$ 224,639	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		740	85,582		740	85,582	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-02,03	hrs		2,316	196,717	3,564	2,316	200,281	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			383	15,245		15,628	11
12	Other (specify): <u>Respiratory Therapy</u>	V39-03								12
13	Other (specify): <u>See WTB</u>	V39-02,03				31,780	151,909		183,689	13
14	TOTAL			\$	5,689	\$ 539,101	\$ 170,718	5,689	\$ 709,819	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	\$ (5,659)	\$ 3,791	1
2	Cash-Patient Deposits	100,183	100,183	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	628,675	628,675	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,122	7,512	6
7	Other Prepaid Expenses	317,706	318,205	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	61,855	209,936	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,103,882	\$ 1,268,302	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		240,000	13
14	Buildings, at Historical Cost		2,887,979	14
15	Leasehold Improvements, at Historical Cost	139,144	139,144	15
16	Equipment, at Historical Cost	73,901	596,246	16
17	Accumulated Depreciation (book methods)	(190,109)	(2,063,970)	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):	48,713	48,173	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 71,649	\$ 1,847,572	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,175,531	\$ 3,115,874	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 632,852	\$ 632,852	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	100,911	100,911	28
29	Short-Term Notes Payable	3,012,474	3,100,552	29
30	Accrued Salaries Payable	280,427	280,427	30
	Accrued Taxes Payable (excluding real estate taxes)	56,880	56,880	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,058	32
33	Accrued Interest Payable		2,814	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	19,821	19,821	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,103,365	\$ 4,237,315	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,020,537	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)	\$	\$ 1,020,537	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,103,365	\$ 5,257,852	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,957,671)	\$ (2,141,978)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,145,694	\$ 3,115,874	48

*(See instructions.)

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,780,285)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,780,285)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,177,386)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,177,386)	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)	\$ (2,957,671)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,619,083	1
2	Discounts and Allowances for all Levels	(994,378)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,624,705	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,963,746	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,963,746	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	4	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	241,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	82,093	19
20	Radiology and X-Ray	16,016	20
21	Other Medical Services	46,858	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 386,942	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	69	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 69	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	(4,029)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,029)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,971,433	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,242,012	31
32	Health Care	4,135,602	32
33	General Administration	2,066,824	33
B. Capital Expense			
34	Ownership	257,047	34
C. Ancillary Expense			
35	Special Cost Centers	795,673	35
36	Provider Participation Fee	651,661	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,148,819	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,177,386)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,177,386)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,516,610.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,668,507.00	45
46	MMAI-Medicaid is the Primary Payer	1,148,545.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,294,490.00	48
49	Medicare Part A	-388,026.00	49
50	Other-(specify) Managed Care	384,579.00	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)	\$ 5,624,705	56

		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	2,882	3,090	\$ 78,734	\$ 25.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,472	6,871	531,772	77.29	3
4	Licensed Practical Nurses	16,761	18,150	578,421	31.87	4
5	CNAs & Orderlies	47,099	51,406	1,259,525	24.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,494	1,598	36,689	22.96	9
10	Activity Assistants	6,919	7,569	164,057	21.67	10
11	Social Service Workers	3,833	4,158	90,418	21.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,524	17,437	327,500	18.78	15
16	Dishwashers					16
17	Maintenance Workers	2,495	2,659	68,753	25.86	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,816	2,032	114,669	56.43	20
21	Assistant Administrator					21
22	Other Administrative	819	819	13,886	16.95	22
23	Office Manager					23
24	Clerical	4,041	4,471	132,638	29.67	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	1,114	1,282	18,817	14.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,269	121,542	\$ 3,415,879 *	\$ 28.10	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	231	\$ 12,497	V01-3	35
36	Medical Director	Monthly	30,000	V09-3	36
37	Medical Records Consultant			V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,247	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	49	4,457	V11-3	44
45	Social Service Consultant	42	2,932	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	322	\$ 60,133		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,362	\$ 179,991	V10-3	50
51	Licensed Practical Nurses	10,289	616,723	V10-4	51
52	Certified Nurse Assistants/Aides	10,451	386,853	V10-5	52
53	TOTAL (lines 50 - 52)	24,102	\$ 1,183,567		53

Facility Name & ID NumberHillsboro Rehab HCC

STATE OF ILLINOIS

#0049221

Report Period Beginning:1/1/2025

Ending:12/31/2025

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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)

8,332

8,332Total

(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)

4,503

4,503Total

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

IL HEALTHCARE ASSOCIATION (IHCA)

12,835

12,835Total

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

\$42,561

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.

\$651,661

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?

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?

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?

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: