

		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>0050971</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Lakeland Rehab HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>800 W Temple Avenue</u> <u>Effingham</u> <u>62401</u> Number City Zip Code																											
County: <u>Effingham</u>																											
Telephone Number: <u>(217) 342-2171</u> Fax # <u>(217) 342-2258</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

Page 2

Facility Name & ID NumberLakeland Rehab HCC# 0050971Report 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

1156

Skilled (SNF)

156

56,940

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

156

TOTALS

156

56,940

7

B. Census-For the entire report period.

123456789

Level of Care

Medicaid Fee for Service

Medicaid MLTSS

MMAI

Medicaid Primary

Medicare Primary

Private Pay

Medicare Part A Only

Other

Total

8

SNF

4,989

5,756

8,577

10,263

6,593

4,037

40,215

8

9

SNF/PED

9

10

ICF

10

11

ICF/DD

11

12

SC

12

13

DD 16 OR LESS

13

14

TOTALS

4,989

5,756

8,577

10,263

6,593

4,037

40,215

14

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

70.63%

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 beds156

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	538,393	38,892	114,730	692,015		692,015	(202)	691,813		1
2	Food Purchase		332,244		332,244		332,244		332,244		2
3	Housekeeping		18,811	235,263	254,074		254,074		254,074		3
4	Laundry		7,243	156,842	164,085		164,085		164,085		4
5	Heat and Other Utilities			180,195	180,195		180,195		180,195		5
6	Maintenance	83,880	20,962	94,603	199,445		199,445		199,445		6
7	Other (specify):*										7
8	TOTAL General Services	622,273	418,152	781,633	1,822,058		1,822,058	(202)	1,821,856		8
	B. Health Care and Programs										
9	Medical Director			18,800	18,800		18,800		18,800		9
10	Nursing and Medical Records	4,258,929	185,893	713,714	5,158,536		5,158,536		5,158,536		10
10a	Therapy										10a
11	Activities	185,858	12,753	6,426	205,037		205,037		205,037		11
12	Social Services	146,477		2,851	149,328		149,328		149,328		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,591,264	198,646	741,791	5,531,701		5,531,701		5,531,701		16
	C. General Administration										
17	Administrative	110,559		630,648	741,207		741,207	(29,472)	711,735		17
18	Directors Fees										18
19	Professional Services			185,383	185,383		185,383	(69,165)	116,218		19
20	Dues, Fees, Subscriptions & Promotions			28,444	28,444		28,444	(5,824)	22,620		20
21	Clerical & General Office Expenses	481,162	41,236	535,200	1,057,598		1,057,598	(236,719)	820,879		21
22	Employee Benefits & Payroll Taxes			728,128	728,128		728,128		728,128		22
23	Inservic Training & Education			1,661	1,661		1,661		1,661		23
24	Travel and Seminar			12,347	12,347		12,347		12,347		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			149,479	149,479		149,479		149,479		26
27	Other (specify):*										27
28	TOTAL General Administration	591,721	41,236	2,271,290	2,904,247		2,904,247	(341,180)	2,563,067		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,805,258	658,034	3,794,714	10,258,006		10,258,006	(341,382)	9,916,624		29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			68,085	68,085		68,085	222,097	290,182		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			7,954	7,954		7,954	221,546	229,500		32
33	Real Estate Taxes			88,771	88,771		88,771		88,771		33
34	Rent-Facility & Grounds			505,441	505,441		505,441	(505,441)			34
35	Rent-Equipment & Vehicles			11,962	11,962		11,962		11,962		35
36	Other (specify):* Mortgage Ins							50,135	50,135		36
37	TOTAL Ownership			682,213	682,213		682,213	(11,663)	670,550		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		484,049	1,040,709	1,524,758		1,524,758		1,524,758		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			754,163	754,163		754,163		754,163		42
43	Other (specify):*			89,542	89,542		89,542	(89,542)			43
44	TOTAL Special Cost Centers		484,049	1,884,414	2,368,463		2,368,463	(89,542)	2,278,921		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,805,258	1,142,083	6,361,341	13,308,682		13,308,682	(442,587)	12,866,095		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	(202)	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	(611)	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	(46,248)	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	(186,492)	21		24
25	Fund Raising, Advertising and Promotional	(21,593)	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	(9,880)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (265,026)		\$	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)	(177,561)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (177,561)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (442,587)		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

Lakeland Rehab HCC

ID# 0050971

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ (5,901)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc. Income	(3,979)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,880)		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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 505,441	TI-Effingham, LLC	100.00%	\$	(505,441)	1
2	V	32	Interest		TI-Effingham, LLC	100.00%	223,672	223,672	2
3	V	19	A&G-Legal/Acctg/Bank Sv Chg		TI-Effingham, LLC	100.00%	12,102	12,102	3
4	V	36	Mortgage Insurance		TI-Effingham, LLC	100.00%	50,135	50,135	4
5	V	30	Depreciation		TI-Effingham, LLC	100.00%	203,360	203,360	5
6	V	32	Amortization of Financing Costs		TI-Effingham, LLC	100.00%	6,439	6,439	6
7	V	33	Real Estate Taxes	88,772	TI-Effingham, LLC	100.00%	88,772		7
8	V	26	Property Insurance	22,884	TI-Effingham, LLC	100.00%	22,884		8
9	V	20	Licenses		TI-Effingham, LLC	100.00%	77	77	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 617,097			\$ 607,441	\$ * (9,656)	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	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management-Operating	\$ 630,648	Tutera Health Care Service	\$ 601,176	29,472	15
16	V	19	Management-Data Processing	81,267	Tutera Health Care Service		81,267	16
17	V	30	Management-Depreciation		Tutera Health Care Service	18,737	18,737	17
18	V	43	Management-Marketing	67,949	Tutera Health Care Service		67,949	18
19	V	32	Interest	7,954	Tutera Investments		7,954	19
20	V	26	Insurance	120,493	LTC Plus Insurance, Inc.	120,493		20
21	V	10	Nursing Purchased Services	312,223	TeamWorkers LLC	312,223		21
22	V	10	Pharmacy Consultant	18,714	Critical Care Rx, LLC	18,714		22
23	V	39	Drugs	440,618	Critical Care Rx, LLC	440,618		23
24	V	39	IV Therapy & Supplies	48,179	Critical Care Rx, LLC	48,179		24
25	V	10	Over the counter drugs	9,330	Critical Care Rx, LLC	9,330		25
26	V	10	Nursing Admin	1,055	Critical Care Rx, LLC	1,055		26
27	V	39	Lab Supplies	1,477	Critical Care Rx, LLC	1,477		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		\$ 1,739,907			\$ 1,572,002	\$ * (167,905)	39

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

Report Period Beginning:

Ending:

ID#

0050971

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					
78				78					
79				79					
80				80					
81				81					
82				82					
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149				149					
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	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	Hillsboro Rehab & Health Care Center	Hillsboro, IL						12
13	Matton Rehab & Health Care Center	Mattoon IL						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 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 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 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	12,652,085	\$ 601,177	1
2	30	Management Fee- Depreciation	Direct Cost	512,439,158	114	758,922		12,652,085	18,738	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		\$ 619,915	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			\$		\$	7,627,166						\$	223,672		1	
2	HUD Amortize Financing Costs		X														6,439		2	
3	Interest Income Offset																(611)		3	
4																			4	
5																			5	
	Working Capital																			
6	Tutera Investments, LLC	X		Working Capital - Note				800,000		1,213,992					0.0100		7,954		6	
7	Related Party Offset																(7,954)		7	
8																			8	
9	TOTAL Facility Related						\$	800,000	\$	8,841,158						\$	229,500		9	
	B. Non-Facility Related*																			
10																			10	
11																			11	
12																			12	
13																			13	
14	TOTAL Non-Facility Related						\$		\$							\$			14	
15	TOTALS (line 9+line14)						\$	800,000	\$	8,841,158						\$	229,500		15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 50,135 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.)

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakeland Rehab HCC COUNTY Effingham
FACILITY IDPH LICENSE NUMBER 0050971
CONTACT PERSON REGARDING THIS REPORT 0050971
TELEPHONE (816) 444-0900 FAX #: Fatima Sediqzad

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>03-11-020-019</u>	<u>Long Term Care</u>	\$ <u>89,461.52</u>	\$ <u>89,461.52</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>89,461.52</u>	\$ <u>89,461.52</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:28,594

B. General Construction Type:ExteriorBrickFrameBrick

Number of Stories1

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)?

YESNOX

If YES, please indicate name of the facility.

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

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Long Term Care	28,594	2010	\$612,285	1
2					2
3	TOTALS	28,594		\$612,285	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	156		2010	1970	\$ 5,081,962	\$ 184,799	27	\$ 184,799		\$ 2,864,379	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
9	2011 Building Improvements		2011		102,049	5,102	20	5,102		72,285	9
10	2012 Building Improvements		2012		17,065					17,065	10
11	2013 Building Improvements		2013		195,075	13,089	15	13,089		162,523	11
12	2016 Building Improvements		2016		9,945					9,945	12
13	2017 Building Improvements		2017		266,244	9,661	Various	9,661		85,308	13
14	Fence Replacement		2020		18,097	1,206	15	1,206		6,535	14
15	Fence Install		2023		12,485	832	15	832		2,081	15
16	Employee Security Door		2025		6,700	149	15	149		149	16
17	Paint and Clean Building Exterior		2025		30,952	688	15	688		688	17
18	Parking Lot Lights		2025		9,600	213	15	213		213	18
19	2011 Building Improvements (TI Effingham)		2011		14,917					14,917	19
20	2012 Building Improvements (TI Effingham)		2012		157,941	5,743	27	5,743		76,578	20
21	2017 Building Improvements (TI Effingham)		2017		40,910	1,743	Various	1,743		14,532	21
22	Concrete Parking Lot (TI Effingham)		2018		13,357	890	15	890		6,091	22
23	Upgrade Parking Lot Drainage (TI Effingham)		2023		34,997	2,333	15	2,333		6,805	23
24	Entry Door Repair (TI Effingham)		2023		7,996	533	15	533		1,510	24
25	Shower 400 Hall (TI Effingham) - retile, expand, drywall, plumbing		2025		21,375	198	15	198		198	25
26											26
27											27
28	Home Office Depreciation					18,737		18,737			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)		\$6,041,667	\$245,916		\$245,916	\$	\$3,341,802	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	\$658,945	\$28,208	\$28,208	\$		\$603,121	71
72	Current Year Purchases	88,434	3,732	3,732			3,732	72
73	Fully Depreciated Assets	204,157					204,157	73
74								74
75	TOTALS	\$951,536	\$31,940	\$31,940	\$		\$811,010	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	2022	\$61,628	\$12,326	\$12,326	\$		\$39,031	76
77										77
78										78
79										79
80	TOTALS			\$61,628	\$12,326	\$12,326	\$		\$39,031	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$7,667,116	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$290,182	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$290,182	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)	\$4,191,843	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	WIP - Reserves	\$34,990	92
93			93
94			94
95		\$34,990	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: \$ 11,962 Description: Nursing, Dietary, & Copier (See 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.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	V39-03	hrs	\$		\$ 344,576	\$		\$	344,576	1				
2	Licensed Speech and Language Development Therapist	V39-03	hrs			74,822				74,822	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist	V39-02,03	hrs			521,613				521,613	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				443,304			443,304	9				
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
10	Academic Education		hrs								11				
12	Other (specify):										12				
13	Other (specify): See WTB	V39-02,03				99,698	40,745			140,443	13				
14	TOTAL			\$		\$ 1,040,709	\$ 484,049		\$	1,524,758	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	\$ 110,203	\$ 143,428	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,274,392	1,274,392	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,785	126,615	6
7	Other Prepaid Expenses	375,308	404,136	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		328,834	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,874,688	\$ 2,277,405	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		612,285	13
14	Buildings, at Historical Cost		5,373,455	14
15	Leasehold Improvements, at Historical Cost	668,212	668,212	15
16	Equipment, at Historical Cost	427,203	1,013,164	16
17	Accumulated Depreciation (book methods)	(637,844)	(4,191,843)	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):	22,032	22,032	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 479,603	\$ 3,497,305	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,354,291	\$ 5,774,710	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 651,987	\$ 651,987	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,617	25,617	28
29	Short-Term Notes Payable	1,213,992	1,407,270	29
30	Accrued Salaries Payable	523,569	523,569	30
	Accrued Taxes Payable (excluding real estate taxes)	238,559	238,559	31
32	Accrued Real Estate Taxes(Sch.IX-B)		89,467	32
33	Accrued Interest Payable		18,432	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to/from Related Party	23,395	23,395	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,677,119	\$ 2,978,296	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,433,888	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)	\$	\$ 7,433,888	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,677,119	\$ 10,412,184	46
47	TOTAL EQUITY(page 18, line 24)	\$ (322,828)	\$ (4,637,474)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,354,291	\$ 5,774,710	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 250,953	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 250,953	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(573,788)	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) Rounding	7	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (573,781)	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)	\$ (322,828)	24

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,952,779	1
2	Discounts and Allowances for all Levels	(2,408,471)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,544,308	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,053,374	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,053,374	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	202	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	854,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,060	19
20	Radiology and X-Ray	15,143	20
21	Other Medical Services	223,219	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,121,493	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	611	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 611	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Revenue	15,108	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,108	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,734,894	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,822,058	31
32	Health Care	5,531,701	32
33	General Administration	2,904,247	33
B. Capital Expense			
34	Ownership	682,213	34
C. Ancillary Expense			
35	Special Cost Centers	1,614,300	35
36	Provider Participation Fee	754,163	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,308,682	40
41	Income before Income Taxes (line 30 minus line 40)**	(573,788)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (573,788)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,070,442.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,372,569.00	45
46	MMAI-Medicaid is the Primary Payer	2,045,261.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,749,445.00	48
49	Medicare Part A	1,797,261.00	49
50	Other-(specify) Managed	509,330.00	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)	\$ 8,544,308	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	2,074	2,270	\$ 122,446	\$ 53.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,958	12,767	613,022	48.02	3
4	Licensed Practical Nurses	35,467	37,966	1,401,114	36.90	4
5	CNAs & Orderlies	75,625	80,909	2,088,831	25.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	1,991	36,164	18.16	9
10	Activity Assistants	6,852	7,272	149,694	20.58	10
11	Social Service Workers	6,014	6,338	146,477	23.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,918	24,829	538,393	21.68	15
16	Dishwashers					16
17	Maintenance Workers	3,356	3,690	83,880	22.73	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,836	2,080	110,559	53.15	20
21	Assistant Administrator					21
22	Other Administrative	815	815	14,474	17.76	22
23	Office Manager					23
24	Clerical	9,151	9,822	481,162	48.99	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	1,102	1,262	19,042	15.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,067	192,011	\$ 5,805,258 *	\$ 30.23	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	3,289	\$ 20,208	V10-3	35
36	Medical Director	Monthly	18,800	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	18,714	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	41	2,851	V11-3	44
45	Social Service Consultant	34	2,405	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,364	\$ 62,978		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,029	\$ 154,860	V10-3	50
51	Licensed Practical Nurses	5,086	304,450	V10-3	51
52	Certified Nurse Assistants/Aides	5,575	211,656	V10-3	52
53	TOTAL (lines 50 - 52)	12,690	\$ 670,966		53

Facility Name & ID Number

Lakeland Rehab HCC

STATE OF ILLINOIS

#0050971

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)

10,921

10,921Total

(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)

5,901

5,901Total

(4)

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

IL HEALTHCARE ASSOCIATION (IHCA)

16,822

16,822Total

(5)

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

\$59,210

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.

\$754,163

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 a
program during this reporting period.

\$N/A

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

100%

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$N/A

(13)

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

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: