		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0046888

Facility Name: Calhoun Nsg Rehab Center

Address: 1 Myrtle Lane (Number) Hardin (City) 62047 (Zip Code)

County: Calhoun

Telephone Number: (618) 576-2278 **Fax #** (618) 576-2487

HFS ID Number:

Date of Initial License for Current Owners: January 1, 2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Renee Klawon **Telephone Number:** (716) 972-2305
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) 6/29/2021 (Date)
(Type or Print Name) Ashley Wilson
(Title) Executive Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,280	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	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,136	9,289	3,227	24,652	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,136	9,289	3,227	24,652	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.19%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
Outpatient Therapy

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 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 2,666

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 1/1 to 12/31/20 Fiscal Year: 1/1 to 12/31/20

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,795	17,715	16,187	234,697		234,697	(7,720)	226,977			1
2	Food Purchase		162,236		162,236		162,236	(16,725)	145,511			2
3	Housekeeping	112,469	21,407		133,876		133,876		133,876			3
4	Laundry	35,277	14,571	220	50,068		50,068		50,068			4
5	Heat and Other Utilities			84,289	84,289		84,289		84,289			5
6	Maintenance	31,509	30,964	32,040	94,513		94,513	(11,625)	82,888			6
7	Other (specify):* see trial balance			28,983	28,983		28,983		28,983			7
8	**TOTAL General Services**	380,050	246,893	161,719	788,662		788,662	(36,070)	752,592			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	1,840,609	173,292	16,080	2,029,981		2,029,981	(9,790)	2,020,191			10
10a	Therapy		4,459	769,186	773,645		773,645	(161,972)	611,673			10a
11	Activities	39,465	1,569	389	41,423		41,423		41,423			11
12	Social Services	29,309		309	29,618		29,618		29,618			12
13	CNA Training											13
14	Program Transportation			11,713	11,713		11,713	(53)	11,660			14
15	Other (specify):* see trial balance			10,934	10,934		10,934	(4,702)	6,232			15
16	**TOTAL Health Care and Programs**	1,909,383	179,320	829,011	2,917,714		2,917,714	(176,517)	2,741,197			16
	C. General Administration											
17	Administrative	253,035		202,584	455,619		455,619	12,818	468,437			17
18	Directors Fees											18
19	Professional Services			7,054	7,054		7,054	(2,617)	4,437			19
20	Dues, Fees, Subscriptions & Promotions			13,029	13,029		13,029	(4,153)	8,876			20
21	Clerical & General Office Expenses	31,148	34,854	50,168	116,170		116,170	(5,279)	110,891			21
22	Employee Benefits & Payroll Taxes			690,523	690,523		690,523	(667)	689,856			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,332	9,332		9,332		9,332			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,889	46,889		46,889	(2,600)	44,289			26
27	Other (specify):* see trial balance			345,678	345,678		345,678	(286,558)	59,120			27
28	**TOTAL General Administration**	284,183	34,854	1,365,257	1,684,294		1,684,294	(289,056)	1,395,238			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,573,616	461,067	2,355,987	5,390,670		5,390,670	(501,643)	4,889,027			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.

Facility Name & ID Number Calhoun Nsg Rehab Center #0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,487	25,487		25,487	26,886	52,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			74,102	74,102		74,102		74,102			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(312,000)				34
35	Rent-Equipment & Vehicles			38,499	38,499		38,499		38,499			35
36	Other (specify):* Off-site storage			1,762	1,762		1,762		1,762			36
37	TOTAL Ownership			451,850	451,850		451,850	(285,114)	166,736			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			4	4		4		4			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,660	177,660		177,660		177,660			42
43	Other (specify):* see trial balance			156,150	156,150		156,150	(59,146)	97,004			43
44	TOTAL Special Cost Centers			333,814	333,814		333,814	(59,146)	274,668			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,573,616	461,067	3,141,651	6,176,334		6,176,334	(845,903)	5,330,431			45

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(16,444)	2		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				10
11	Discounts, Allowances, Rebates & Refunds	(34)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(281)	2		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	(851)	21		18
19	Entertainment				19
20	Contributions	(920)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(294,117)	27		24
25	Fund Raising, Advertising and Promotional	(2,356)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(133,676)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (448,679)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(397,224)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (397,224)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (845,903)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Calhoun Nsg Rehab Center

ID# 0046888

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admiss-Other Supplies	$ (3,033)	21	1
2	Remove Non-allowable Admin - Prof Dues	(1,583)	20	2
3	Remove Non-allowable Dietary - Prof Dues	(99)	20	3
4	Remove Non-allowable Activities - Prof Dues	(175)	20	4
5	Remove Non-allow Human Res. EE Background Check	60	20	5
6	Remove Non-allow Admin-TaxCreditSvcs (WOTC)	(201)	21	6
7	Remove Non-allowable Insurance Costs	(2,600)	26	7
8	Remove Non-allowable Admin Finance Charges	(16)	21	8
9	Remove -Non-allowable Admin - Legal Fees	(97)	19	9
10	Remove Non Allowable - Tax prep Fees	(2,520)	19	10
11	Remove Non-Allowable Nrs Resident Transport	(53)	14	11
12	Remove Non-allow Nrs Admin Purch Service	(1,375)	15	12
13	Offset Misc. Revenue	(2,141)	10	13
14	Offset Misc. Revenue	(71)	10	14
15	Offset Misc. Revenue	(618)	10	15
16	Offset Misc. Revenue	(35)	10	16
17	Offset Misc. Revenue	(82)	21	17
18	Offset Misc. Revenue	(36)	6	18
19	Offset Misc. Revenue	(916)	10	19
20	Offset Misc. Revenue	(916)	1	20
21	Offset Misc. Revenue	(916)	6	21
22	Offset Misc. Revenue	(76)	10	22
23	Offset Interco Sold Services Revenue	(620)	10	23
24	Offset Interco Sold Services Revenue	(727)	10	24
25	Offset Interco Sold Services Revenue	(252)	10	25
26	Offset Interco Sold Services Revenue	(449)	10	26
27	Offset Interco Sold Services Revenue	(275)	10	27
28	Offset Interco Sold Services Revenue	(344)	22	28
29	Remove Non-allowable IV PrescriptionDrugsCosts	(9,695)	43	29
30	Remove Prior Year Costs	(5,631)	43	30
31	Offset Outpatient Physical Therapy Revenue	(84,600)	10a	31
32	Offset Outpatient Occupational Therapy Revenue	(5,886)	10a	32
33	Offset Outpatient Speech Therapy Revenue	(8,388)	10a	33
34	Capitalize repairs & maintenance & equipment	(2,653)	1	34
35	Capitalize repairs & maintenance & equipment	(2,951)	1	35
36	Capitalize repairs & maintenance & equipment	(10,673)	6	36
37	Depreciation/Amortization LHI	4,335	30	37
38	Depreciation/Amortization MME	12,974	30	38
39	Current Year Depreciation Audit Adjustments LHI	(342)	30	39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(133,676)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(6,520)	0	(1,200)	0	0	0	0	0	0	0	0	(7,720)	1
2	Food Purchase	(16,725)	0	0	0	0	0	0	0	0	0	0	(16,725)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(11,625)	0	0	0	0	0	0	0	0	0	0	(11,625)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(34,870)	0	(1,200)	0	0	0	0	0	0	0	0	(36,070)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,180)	(3,610)	0	0	0	0	0	0	0	0	0	(9,790)	10
10a	Therapy	(98,874)	(63,098)	0	0	0	0	0	0	0	0	0	(161,972)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(53)	0	0	0	0	0	0	0	0	0	0	(53)	14
15	Other (specify):*	(1,375)	(3,327)	0	0	0	0	0	0	0	0	0	(4,702)	15
16	TOTAL Health Care and Programs	(106,482)	(70,035)	0	0	0	0	0	0	0	0	0	(176,517)	16
	C. General Administration													
17	Administrative	0	12,818	0	0	0	0	0	0	0	0	0	12,818	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,617)	0	0	0	0	0	0	0	0	0	0	(2,617)	19
20	Fees, Subscriptions & Promotions	(4,153)	0	0	0	0	0	0	0	0	0	0	(4,153)	20
21	Clerical & General Office Expenses	(4,217)	(1,062)	0	0	0	0	0	0	0	0	0	(5,279)	21
22	Employee Benefits & Payroll Taxes	(344)	(323)	0	0	0	0	0	0	0	0	0	(667)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(295,037)	0	8,479	0	0	0	0	0	0	0	0	(286,558)	27
28	TOTAL General Administration	(308,968)	11,433	8,479	0	0	0	0	0	0	0	0	(289,056)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(450,320)	(58,602)	7,279	0	0	0	0	0	0	0	0	(501,643)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nsg Rehab Center **#** 0046888 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	16,967	0	9,919	0	0	0	0	0	0	0	0	26,886	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(312,000)	0	0	0	0	0	0	0	0	(312,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	16,967	0	(302,081)	0	0	0	0	0	0	0	0	(285,114)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,326)	(43,820)	0	0	0	0	0	0	0	0	0	(59,146)	43
44	**TOTAL Special Cost Centers**	(15,326)	(43,820)	0	0	0	0	0	0	0	0	0	(59,146)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(448,679)	(102,422)	(294,802)	0	0	0	0	0	0	0	0	(845,903)	45

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
DTD HC, LLC	50%	Granite Nursing and Rehabilitation Center,LLC	Granite City	Hardin Property Com	Hardin	Property Company
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Tara Pharmacy SE, LL	Birmingham	Pharmacy
		White Hall Nursing and Rehabilitation Center, LLC	White Hall	Tara Therapy, LLC	Orchard Park	Therapy
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Raimax Healthcare So	Orchard Park	Software
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 Associates, LLC	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Grou	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d/	Orchard Park	Support Office

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	$ 202,584	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 215,402	$ 12,818	1
2	V	15	Wireless Access Points License Fee	631	RAImax Healthcare Solutions Group, LLC	0.00%	613	(18)	2
3	V	15	Patient Care Software	3,600	RAImax Healthcare Solutions Group, LLC	0.00%	291	(3,309)	3
4	V	21	Wireless Access Points License Fee		RAImax Healthcare Solutions Group, LLC	0.00%	212	212	4
5	V	21	Carrier Comm Rev Offset		RAImax Healthcare Solutions Group, LLC	0.00%	(1,274)	(1,274)	5
6	V	10	Pharmacy Consulting Services	16,080	Tara Pharmacy SE, LLC	0.00%	12,470	(3,610)	6
7	V	43	Flu Vac/Prescription Drug- Residents	128,590	Tara Pharmacy SE, LLC	0.00%	84,770	(43,820)	7
8	V	22	Vaccines for Employees	2,574	Tara Pharmacy SE, LLC	0.00%	2,251	(323)	8
9	V	10a	Physical Therapy Fees	404,165	Tara Therapy, LLC	0.00%	349,946	(54,219)	9
10	V	10a	Occupational Therapy Fees	251,951	Tara Therapy, LLC	0.00%	210,824	(41,127)	10
11	V	10a	Speech Therapy Fees	113,070	Tara Therapy, LLC	0.00%	145,318	32,248	11
12	V								12
13	V								13
14	Total			$ 1,123,245			$ 1,020,823	$ * (102,422)	14

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 312,000	Hardin Property Company, LLC	0.00%	$	$ (312,000)	15
16	V	30	Depreciation Bldg & Improve		Hardin Property Company, LLC	0.00%	9,919	9,919	16
17	V	27	Amort Debt Acquisition Costs		Hardin Property Company, LLC	0.00%	8,479	8,479	17
18	V	1	Dietary Services	13,027	Stearns Nursing and Rehabilitation Center LCL	0.00%	11,827	(1,200)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 325,027			$ 30,225	$ * (294,802)	39

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Jonesboro Nursing and Rehabilitation Center, L	Jonesboro				1
2			Lake City Nursing and Rehabilitation Center, L	Lake City				2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile				3
4			Florence Nursing and Rehabilitation Center, LL	Florence				4
5			Birmingham Nrs&Rehab Center East, LLC	Birmingham				5
6			Birmingham Nursing and Rehabilitation Center	Birmingham				6
7			Eight Mile Nursing and Rehabilitation Center, I	Eight Mile				7
8			North Hill Nursing and Rehabilitation Center, L	North Hill				8
9			Elba Nursing and Rehabilitation Center, LLC	Elba				9
10			Quince Nursing and Rehabilitation Center, LLC	Memphis				10
11			Allenbrooke Nursing and Rehabilitation Center,	Memphis				11
12			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo				12
13			Brandon Nursing and Rehabilitation Center, LL	Brandon				13
14			Lakeland Nursing and Rehabilitation Center, Ll	Jackson				14
15			McComb Nursing and Rehabilitation Center, LI	McComb				15
16			Cleveland Nursing and Rehabilitation Center, L	Cleveland				16
17			Chadwick Nursing and Rehabilitation Center, L	Jackson				17
18			Manhattan Nursing and Rehabilitation Center,]	Jackson				18
19			Ruleville Nursing and Rehabilitation Center, LI	Ruleville				19
20			Farmerville Nursing and Rehabilitation Center,	Farmerville				20
21			Bernice Nursing and Rehabilitation Center, LL(	Bernice				21
22			Ruston Nursing and Rehabilitation Center, LLC	Ruston				22
23			Natchitoches Nursing and Rehabilitation Center	Natchitoches				23
24			Winnfield Nursing and Rehabilitation Center, L	Winnfield				24
25			Ringgold Nursing and Rehabilitation Center, LI	Ringgold				25
26			Arcadia Nursing and Rehabilitation Center, LL(	Arcadia				26
27			Jena Nursing and Rehabilitation Center, LLC	Jena				27
28								28
29			** The above listed facilites are related by					29
30			common ownership					30

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00		0	0.00		$ 0	17	1
2	D & N, LLC	Owner		50.00		0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.55	1.38	Fin/ Adm. of TC	4,511	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CoCEO	Finance/ Admin	0.00	***	0.55	1.38	Fin/ Adm. of TC	4,511	17	5
6		for Tara Cares	of Tara Cares								6
7	Suzette Wilson	Vice President	Admin	0.00	***	0.55	1.38	VP of TC	3,547	17	7
8			of Tara Cares								8
9	Christopher Denz	Vice President	Tara Cares	0.00	***	0.55	1.38	VP of TC	1,074	17	9
10											10
11	*** Compensation paid only through Support Office and allocated share reported in column 7.										11
12											12
13								TOTAL	$ 13,643		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.

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 [X] NO [ ]

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

Name of Related Organization: Aurora Cares, LLC d/b/a Tara Cares
Street Address: PO Box 428
City / State / Zip Code: Orchard Park, NY 14127
Phone Number: (716)662 4955
Fax Number: (716)662-2629

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Administrative Services Costs	Total Costs	408,328,735	39	$ 387,083	$ 294,025	5,973,668	$ 5,667	1
2	3	Administrative Services Costs	Days	1,475,555	36	1,807	0	24,644	30	2
3	5	Administrative Services Costs	Days	1,475,555	36	28,542	0	24,644	477	3
4	6	Administrative Services Costs	Days	1,475,555	36	231,425	103,937	24,644	3,865	4
5	10	Administrative Services Costs	Total Costs	408,328,735	39	2,939,493	2,298,115	5,973,668	42,993	5
6	17	Administrative Services Costs	Days	1,475,555	36	7,181,342	7,181,342	24,644	119,946	6
7	19	Administrative Services Costs	Days	1,475,555	36	106,116	0	24,644	1,772	7
8	20	Administrative Services Costs	Days	1,475,555	36	152,019	0	24,644	2,539	8
9	21	Administrative Services Costs	Days	1,475,555	36	461,972	0	24,644	7,715	9
10	22	Administrative Services Costs	Days	1,475,555	36	1,411,377	0	24,644	23,573	10
11	24	Administrative Services Costs	Days	1,475,555	36	31,941	0	24,644	532	11
12	26	Administrative Services Costs	Days	1,475,555	36	5,217	0	24,644	87	12
13	27	Administrative Services Costs	Days	1,475,555	36	133,240	0	24,644	2,226	13
14	30	Administrative Services Costs	Days	1,475,555	36	96,883	0	24,644	1,618	14
15	33	Administrative Services Costs	Days	1,475,555	36	35,384	0	24,644	591	15
16	34	Administrative Services Costs	Days	1,475,555	36	103,471	0	24,644	1,728	16
17	35	Administrative Services Costs	Days	1,475,555	36	2,577	0	24,644	43	17
18										18
19		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								19
20		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								20
21		considered a Home Office by CMS and as defined in 42CFR 421.404.								21
22										22
23										23
24										24
25	TOTALS					$ 13,309,889	$ 9,877,419		$ 215,402	25

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 81,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 75,662	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,338)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 79,440	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 74,102	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	87,511	8
	2016	83,544	9
	2017	77,164	10
	2018	77,101	11
	2019	75,662	12

The 2020 assessment was estimated to be a 5% increase over the 2019 assessment.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calhoun Nsg Rehab Center COUNTY Calhoun

FACILITY IDPH LICENSE NUMBER 0046888

CONTACT PERSON REGARDING THIS REPORT Renee Klawon

TELEPHONE (716) 972-2305 FAX #: (972) 972-0338

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-08-27-200-108	PT NE 1/4-S27 T10S R2W	$ 75,661.86	$ 75,661.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,661.86	$ 75,661.86

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,969 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	199,940	2011	$ 19,577	1
2					2
3	TOTALS	199,940		$ 19,577	3

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		2011	1996	$ 396,764	$ 9,919	40	$ 9,919	$	$ 94,231	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	696		10			696	9
10	Blinds			2006	10,270		5			10,270	10
11	Plumbing and Mechanical repairs capitalized for Medicaid			2006	9,738		3			9,738	11
12	Plumbing and Mechanical repairs capitalized for Medicaid			2007	3,009		3			3,009	12
13	Carpeting			2007	3,360		5			3,360	13
14	Carpet Flooring			2007	7,038		5			7,038	14
15	Air Conditioning Unit (10 ton)			2007	4,650		10			4,650	15
16	2 Doors			2007	3,319		11			3,319	16
17	Cilcomm Phone System - Reduced on Audit			2007	9,716		10			9,716	17
18	Nurse Station			2008	40,675		10			40,675	18
19	Roof Replacement			2009	73,323		9			73,323	19
20	Front Doors (2)			2009	3,457		9			3,457	20
21											21
22											22
23											23
24	Air Compressor			2010	3,000		8			3,000	24
25	A/C Unit Rooftop 5 Ton			2010	4,900		8			4,900	25
26	Panic Bars (for Fire Door - 2)			2010	3,730		8			3,730	26
27	Repairs to Generator - Capitalized for Medicaid			2010	3,061		3			3,061	27
28	Sprinkler System Repair - Capitalized for Medicaid			2010	6,836		3			6,836	28
29	Fire Alarm Panel Repair-Capitalized for Medicaid			2010	3,021		3			3,021	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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sprinkler System Conversion	2011	$ 3,000	$	7	$	$	$ 3,000	37
38	Sprinkler System	2011	334,136		7			334,136	38
39									39
40									40
41									41
42	A/C Unit (10 ton Central NRS Station)	2011	10,000	667	15	667		6,335	42
43	Heaters (9 w/panel Attic)	2011	21,000		5			21,000	43
44									44
45									45
46	Walk in Freezer and water line repair - Capitalized for Medicaid	2012	4,800		3			4,800	46
47									47
48									48
49									49
50	Smoke Detectors (4, required additional)	2012	4,717	472	10	472		4,010	50
51									51
52									52
53									53
54									54
55	(3) Rooftop A/C Units	2013	38,000	2,533	15	2,533		18,999	55
56	Repairs fo AC -compressor, recharge freon-Cap for Medicaid	2013	3,860		3			3,860	56
57	Water Heater 100 Gallon for Showers	2014	12,500	1,250	10	1,250		8,125	57
58	A/C Unit (5 ton rooftop)	2014	14,000	1,400	10	1,400		9,100	58
59	Water Heater 100 Gallon for Laundry - Capitalized for Medicaid	2014	4,884	488	10	488		3,173	59
60	Shower Room Renovation - East hall install tile,cabinetry	2014	60,570	3,028	20	3,028		19,685	60
61	drywall, paint,framing, electric and plumbing								61
62	Storage Shed	2015	6,719	336	20	336		1,848	62
63	Kitchen Floor (Quarry Tile)	2015	16,717	836	20	836		4,597	63
64	Fire Panel	2015	26,181	2,618	10	2,618		14,399	64
65	Labor and materials to tie in two commercial water heaters - Capitalized	2015	2,940	118	25	118		648	65
66	Labor and materials to replace kitchen water lines & shut-offs - Capitaliz	2015	2,804	112	25	112		616	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,157,391	$ 23,777		$ 23,777	$	$ 746,361	70

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,157,391	$ 23,777		$ 23,777	$	$ 746,361	1
2	A/C Unit (5 ton rooftop) Capitalized for Medicaid	2016	3,825	383	10	383		1,722	2
3	Water Heater - Kitchen	2016	8,496	849	10	849		3,822	3
4	Repairs to Frozen Fire Suppression System for the building Capit	2016	2,633	376	7	376		1,692	4
5	Parking lot repair	2017	16,840	1,123	15	1,123		3,930	5
6	Parking lot striping	2017	9,700		2			9,700	6
7	Walk-in freezer door installed	2017	3,879	388	10	388		1,358	7
8	Repairs of dishwasher temperature probe and heater element	2017	2,894	192	15	192		674	8
9	Water Conditioning System Capitalized for Medicaid	2018	3,820	382	10	382		955	9
10	Install 5-Ton AC Unit Capitalized for Medicaid	2018	4,231	423	10	423		1,057	10
11	Water Heater (AO Smith 400-A)	2018	21,352	2,134	10	2,134		5,336	11
12	Water Heater (100GL A O Smith)	2019	7,800	780	10	780		1,170	12
13	AC Unit (4 ton)	2020	4,200	210	10	210		210	13
14	Comprssor (3 ton)	2020	2,800	140	10	140		140	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Note: See additional building improvements made by former		59,713					59,713	26
27	property owner Healthcare REIT, Inc. on supplemental								27
28	schedule included as page 23 of the cost report.								28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,309,574	$ 31,157		$ 31,157	$	$ 837,840	34

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 172,156	$ 19,635	$ 19,635	$	Various	$ 102,817	71
72	Current Year Purchases	27,027	1,536	1,536		Various	1,536	72
73	Fully Depreciated Assets	241,004	45	45		Various	241,004	73
74								74
75	TOTALS	$ 440,187	$ 21,216	$ 21,216	$		$ 345,357	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	Long Term Care	2009 Ford E250 Extended	2009	$ 36,998	$	$	$	5	$ 36,998	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			$ 36,998	$	$	$		$ 36,998	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,806,336	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 52,373	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,373	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,220,195	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	None	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 40,247 Description: see separate schedule
(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

* 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.

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] 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)	$			

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	

(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.
(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.

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 794,102	$	1
2	Cash-Patient Deposits	13,218		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	150,163		3
4	Supply Inventory (priced at)	7,232		4
5	Short-Term Investments			5
6	Prepaid Insurance	6,492		6
7	Other Prepaid Expenses	3,686		7
8	Accounts Receivable (owners or related parties)	(77,294)		8
9	Other(specify): Non-resident A/R-see TB	176,258		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,073,857	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	257,530		15
16	Equipment, at Historical Cost	170,118		16
17	Accumulated Depreciation (book methods)	(258,475)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deposits-Long Term	2,600		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 171,773	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,245,630	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,261	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,189		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	267,216		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,020		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,440		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	94,019		36
37	Accrued Expenses	153,672		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 674,817	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 674,817	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 570,813	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,245,630	$	48

***(See instructions.)**

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (158,871)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (158,871)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	799,628	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	(69,944)	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)**	$ 729,684	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)**	$ 570,813	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,198,210	1
2	Discounts and Allowances for all Levels	955,588	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,153,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	98,874	5
6	Therapy	641,430	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 740,304	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	16,444	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,720	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,448	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,635	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	64	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 64	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Prior Year Net Revenue**	(3,703)	28
28a	**Federal & State COVID Funds / Misc Revenues**	1,061,864	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,058,161	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,975,962	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	788,662	31
32	Health Care	2,917,714	32
33	General Administration	1,684,294	33
	B. Capital Expense		
34	Ownership	451,850	34
	C. Ancillary Expense		
35	Special Cost Centers	156,154	35
36	Provider Participation Fee	177,660	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,176,334	40
41	**Income before Income Taxes (line 30 minus line 40)****	799,628	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 799,628	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,008,648	44
45	Private Pay - Net Inpatient Revenue	1,588,688	45
46	Medicare - Net Inpatient Revenue	1,372,072	46
47	Other-(specify)		47
48	Other-(specify) **Medicare HMO**	184,390	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,153,798	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** see Pg 19 note **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,597	2,101	$ 92,730	$ 44.14	1
2	Assistant Director of Nursing	1,828	2,028	67,039	33.06	2
3	Registered Nurses	11,098	12,564	357,807	28.48	3
4	Licensed Practical Nurses	18,177	19,564	526,685	26.92	4
5	CNAs & Orderlies	47,648	50,436	767,890	15.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,503	1,711	27,292	15.95	9
10	Activity Assistants	1,220	1,300	12,173	9.36	10
11	Social Service Workers	1,654	1,830	29,309	16.02	11
12	Dietician					12
13	Food Service Supervisor	1,841	2,065	44,957	21.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,325	7,051	76,372	10.83	15
16	Dishwashers	6,577	6,969	79,466	11.40	16
17	Maintenance Workers	1,972	2,116	31,509	14.89	17
18	Housekeepers	8,296	9,341	112,469	12.04	18
19	Laundry	3,030	3,038	35,277	11.61	19
20	Administrator	2,048	2,792	141,241	50.59	20
21	Assistant Administrator	120	144	1,941	13.48	21
22	Other Administrative	1,925	2,037	43,084	21.15	22
23	Office Manager	1,886	2,064	40,448	19.60	23
24	Clerical	3,623	3,866	57,469	14.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,812	2,084	28,458	13.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,180	135,101	$ 2,573,616 *	$ 19.05	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	106	20,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	18	16,080	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	389	11-3	44
45	Social Service Consultant	5	309	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	135	$ 37,178		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Ledder	Administrator	0	$ 64,470
Ashley Wilson	Administrator	0	76,771
Ashley Wilson	Asst Administrator	0	1,941
Catherine Clowers	Bus Off Mgr	0	40,448
Amanda Kaufman	Bus Off Asst	0	26,321
Maggie Vinson	Admiss Director	0	43,084
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 253,035

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 202,584
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 202,584

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,772
Freed, Maxick & Battaglia	Tax Fees	2,520
Various Legal Fees - See attached detailed listing		1,762
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 7,054

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,916
Unemployment Compensation Insurance	9,161
FICA Taxes	192,452
Employee Health Insurance	447,774
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Worker Compensation Safety Rec. Program	2,216
Employee Benefit - Holiday/Recognition	19,595
Employee Benefit - Short Term Disability	593
Employee Benefit - Employee Vaccinations	2,251
Employee Benefit - HSA ER/Tuition Reimb	6,137
Employee Benefit - Life Insurance (ER)	0
Employee Benefit - Dental/Vission Ins (ER)	1,761
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,856

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

Description	Line #	Amount
None in allowable cost		$
(column 8) of Schedule V		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	912
Health Care Worker Background Check	802
(Indicate # of checks performed 82)	
Patient Background Checks 82	820
Facility Advertising	2,356
IHCA,AHCA,Diet&ActDues/Renew	6,034
NonAllowIHCA,AHCA,DietActDues	(1,857)
Administrator Cert/Exam	175
Less: Public Relations Expense	( )
Non-allowable advertising	(2,356)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,876

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,711
Seminar Expense	621
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,332

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Calhoun Nsg Rehab Center # 0046888 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,177 net of non-allowables**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,507** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **177,660**
This amount is to be recorded on line 42 of Schedule V.

(12) 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.

(13) 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**

(14) 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? **Yes, outpatient svcs** 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.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **16,444**

(16) 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? **N/A**
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? **No, Personal Use**
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**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) 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.

Facility Name & ID Number Calhoun Nursing and Rehabilitation Center, LLC # 0046888 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Made by Healthcare REIT (covered by rent at outset										9
10	of Change of Ownership):										10
11											11
12	A/C Units & Ductwork			2005	6,400		5			6,400	12
13	Maglocks (7), Keypads (6)			2005	4,560		10			4,560	13
14											14
15	Dining Room Lights (62)			2006	6,470		10			6,470	15
16	Nurse Station			2006	3,691		12			3,691	16
17	Metal Storage Building			2006	525		10			525	17
18	Window Treatments/Valances			2006	3,942		5			3,942	18
19	Windows (2)			2006	34,125		12			34,125	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					59,713					59,713	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

#REF!

XVII. INCOME STATEMENT Page 19 Note

Line 41 Income before Income Taxes 799,628 **
Does this agree with taxable income(loss) per Federal Income Tax Return?

** The Tax Return has been extended with a due date after the cost report filing date. It is expected that the cost report income and tax return income will agree.