

		FOR BHF USE					

LL1

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

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: 0046870

Facility Name: Stearns Nsg Rehab Center

Address: 3900 Stearns Avenue Granite City 62040
Number City Zip Code

County: Madison

Telephone Number: (618) 931-3900 Fax # (618) 931-0766

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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) Sherri Witmer

(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 Stearns Nsg Rehab Center

0046870 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,894</u>	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	<u>109</u>	TOTALS	<u>109</u>	<u>39,894</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,571</u>	<u>2,585</u>	<u>7,124</u>	<u>31,280</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,571</u>	<u>2,585</u>	<u>7,124</u>	<u>31,280</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.41%

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)

N/A

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

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 ☒ Date 01/01/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 109 and days of care provided 4,476

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 Stearns Nsg Rehab Center # 0046870 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	296,414	24,791	22,708	343,913		343,913	(33,011)	310,902			1
2	Food Purchase		194,806		194,806		194,806	(90)	194,716			2
3	Housekeeping	160,071	33,494	4,121	197,686		197,686		197,686			3
4	Laundry	41,925	25,606	2,013	69,544		69,544		69,544			4
5	Heat and Other Utilities			116,064	116,064		116,064		116,064			5
6	Maintenance	80,614	28,924	60,807	170,345		170,345	(4,778)	165,567			6
7	Other (specify):* see trial balance			21,865	21,865		21,865		21,865			7
8	TOTAL General Services	579,024	307,621	227,578	1,114,223		1,114,223	(37,879)	1,076,344			8
	B. Health Care and Programs											
9	Medical Director			22,541	22,541		22,541		22,541			9
10	Nursing and Medical Records	2,061,647	252,899	332,900	2,647,446		2,647,446	(24,983)	2,622,463			10
10a	Therapy		3,340	679,996	683,336		683,336	21,396	704,732			10a
11	Activities	76,441	4,483	5,424	86,348		86,348		86,348			11
12	Social Services	49,736	83	1,932	51,751		51,751		51,751			12
13	CNA Training											13
14	Program Transportation			40,311	40,311		40,311	(494)	39,817			14
15	Other (specify):* see trial balance			9,414	9,414		9,414	(3,336)	6,078			15
16	TOTAL Health Care and Programs	2,187,824	260,805	1,092,518	3,541,147		3,541,147	(7,417)	3,533,730			16
	C. General Administration											
17	Administrative	261,947		247,128	509,075		509,075	27,263	536,338			17
18	Directors Fees											18
19	Professional Services			80,532	80,532		80,532	(2,704)	77,828			19
20	Dues, Fees, Subscriptions & Promotions			53,420	53,420		53,420	(10,066)	43,354			20
21	Clerical & General Office Expenses	28,379	34,649	246,587	309,615		309,615	(186,385)	123,230			21
22	Employee Benefits & Payroll Taxes			875,111	875,111		875,111	(5,513)	869,598			22
23	Inservice Training & Education											23
24	Travel and Seminar			38,734	38,734		38,734		38,734			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,851	48,851		48,851	(2,600)	46,251			26
27	Other (specify):* see trial balance			399,683	399,683		399,683	(288,150)	111,533			27
28	TOTAL General Administration	290,326	34,649	1,990,046	2,315,021		2,315,021	(468,155)	1,846,866			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,057,174	603,075	3,310,142	6,970,391		6,970,391	(513,451)	6,456,940			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			19,478	19,478		19,478	142,488	161,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							106,574	106,574			32
33	Real Estate Taxes			105,379	105,379		105,379		105,379			33
34	Rent-Facility & Grounds			255,528	255,528		255,528	(236,153)	19,375			34
35	Rent-Equipment & Vehicles			82,722	82,722		82,722	(496)	82,226			35
36	Other (specify):* Off-site storage			3,607	3,607		3,607		3,607			36
37	TOTAL Ownership			466,714	466,714		466,714	12,413	479,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,584	222,584		222,584		222,584			42
43	Other (specify):* see trial balance			313,601	313,601		313,601	(127,139)	186,462			43
44	TOTAL Special Cost Centers			536,185	536,185		536,185	(127,139)	409,046			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,057,174	603,075	4,313,041	7,973,290		7,973,290	(628,177)	7,345,113			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21)	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	(3)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	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	(174,595)	21		18
19	Entertainment				19
20	Contributions	(545)	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	(292,829)	27		24
25	Fund Raising, Advertising and Promotional	(8,174)	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	(94,902)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (571,138)		\$	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)	(57,039)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (57,039)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (628,177)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues & Subscriptions	\$ (2,157)	20	1
2	Remove Non-allowable Admin Other Direct	(17)	21	2
3	Remove Non-allowable Finance Charges	(243)	21	3
4	Remove Non-allowable Insurance Costs	(2,600)	26	4
5	Remove Non-allow Nrs Admin-Res Transportation	(494)	14	5
6	Remove Admiss- Other Supplies	(2,332)	21	6
7	Remove Non-allowable Admin Other Supplies	(253)	21	7
8	Remove Non Allowable - Tax Prep Fees	(2,556)	19	8
9	Remove Non-Allowable Admin - Legal Fees	(148)	19	9
10	Remove Non-Allowable Nrs Admin-Rental/Lease	2,100	35	10
11	Remove Non-allowable IV Prescription Drug costs	(30,752)	43	11
12	Remove Non-allowable Prior Year costs	(7,675)	43	12
13	Offset Misc. Revenue	(2,863)	10	13
14	Offset Misc. Revenue	(158)	10	14
15	Offset Misc. Revenue	(876)	10	15
16	Offset Misc. Revenue	(9)	10	16
17	Offset Misc. Revenue	(41)	21	17
18	Offset Misc. Revenue	(34)	6	18
19	Offset Misc. Revenue	(1,300)	10	19
20	Offset Misc. Revenue	(1,300)	1	20
21	Offset Misc. Revenue	(1,300)	6	21
22	Offset Misc. Revenue	(1,028)	10	22
23	Offset Interco Sold Services Revenue	(605)	6	23
24	Offset Interco Sold Services Revenue	(31,708)	1	24
25	Offset Interco Sold Services Revenue	(5,395)	22	25
26	Capitalize repairs & maintenance & equipment	(4,359)	10	26
27	Capitalize repairs & maintenance & equipment	(2,839)	6	27
28	Capitalize repairs & maintenance & equipment	(5,093)	21	28
29	Capitalize repairs & maintenance & equipment	(197)	21	29
30	Depreciation/Amortization LHI	5,602	30	30
31	Depreciation/Amortization MME	8,357	30	31
32	Current Year Depreciation Audit Adjustment LHI	(286)	30	32
33	Remove Non-allow HR-EE Background Check	265	20	33
34	Remove Non-allow Nrs Admin Specialized Med Equip R	(2,596)	35	34
35	Discounts, Allowances, Rebates & Refunds	(12)	21	35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(94,902)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stearns Nsg Rehab Center# 0046870

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(33,011)	0	0	0	0	0	0	0	0	0	0	(33,011)	1
2	Food Purchase	(90)	0	0	0	0	0	0	0	0	0	0	(90)	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	(4,778)	0	0	0	0	0	0	0	0	0	0	(4,778)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(37,879)	0	0	0	0	0	0	0	0	0	0	(37,879)	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	(10,593)	(14,390)	0	0	0	0	0	0	0	0	0	(24,983)	10
10a	Therapy	0	21,396	0	0	0	0	0	0	0	0	0	21,396	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	(494)	0	0	0	0	0	0	0	0	0	0	(494)	14
15	Other (specify):*	0	(3,336)	0	0	0	0	0	0	0	0	0	(3,336)	15
16	TOTAL Health Care and Programs	(11,087)	3,670	0	0	0	0	0	0	0	0	0	(7,417)	16
	C. General Administration													
17	Administrative	0	27,263	0	0	0	0	0	0	0	0	0	27,263	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,704)	0	0	0	0	0	0	0	0	0	0	(2,704)	19
20	Fees, Subscriptions & Promotions	(10,066)	0	0	0	0	0	0	0	0	0	0	(10,066)	20
21	Clerical & General Office Expenses	(182,783)	(3,601)	(1)	0	0	0	0	0	0	0	0	(186,385)	21
22	Employee Benefits & Payroll Taxes	(5,395)	(118)	0	0	0	0	0	0	0	0	0	(5,513)	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):*	(293,374)	0	5,224	0	0	0	0	0	0	0	0	(288,150)	27
28	TOTAL General Administration	(496,922)	23,544	5,223	0	0	0	0	0	0	0	0	(468,155)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(545,888)	27,214	5,223	0	0	0	0	0	0	0	0	(513,451)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nsg Rehab Center # 0046870 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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	13,673	0	128,815	0	0	0	0	0	0	0	0	142,488	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	106,574	0	0	0	0	0	0	0	0	106,574	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(236,153)	0	0	0	0	0	0	0	0	(236,153)	34
35	Rent-Equipment & Vehicles	(496)	0	0	0	0	0	0	0	0	0	0	(496)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	13,177	0	(764)	0	0	0	0	0	0	0	0	12,413	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):*	(38,427)	(88,712)	0	0	0	0	0	0	0	0	0	(127,139)	43
44	TOTAL Special Cost Centers	(38,427)	(88,712)	0	0	0	0	0	0	0	0	0	(127,139)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(571,138)	(61,498)	4,459	0	0	0	0	0	0	0	0	(628,177)	45

Facility Name & ID Number Stearns Nsg Rehab Center # 0046870 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	Tara Pharmacy SE, LI	Birmingham	Pharmacy
D & N, LLC	50%	White Hall Nursing and Rehabilitation Center, LLC	White Hall	Tara Therapy, LLC	Orchard Park	Therapy
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Raimax Healthcare Sol	Orchard Park	Software
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Stearns Property Com	Granite City	Property Company
		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. ☒ 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	\$ 247,128	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 274,391	\$ 27,263	1
2	V	15	Patient Care Software	902	RAImax Healthcare Solutions Group, LLC	0.00%	875	(27)	2
3	V	15	Wireless Access Points License Fee	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%	303	303	4
5	V	21	Carrier Comm Rev Offset		RAImax Healthcare Solutions Group, LLC	0.00%	(3,904)	(3,904)	5
6	V	10	Pharmacy Consulting Services	21,909	Tara Pharmacy SE, LLC	0.00%	7,519	(14,390)	6
7	V	43	Flu Vac/Prescription Drugs-Residents	253,828	Tara Pharmacy SE, LLC	0.00%	165,116	(88,712)	7
8	V	22	Vaccines for Employees	1,682	Tara Pharmacy SE, LLC	0.00%	1,564	(118)	8
9	V	10a	Physical Therapy Fees	219,344	Tara Therapy, LLC	0.00%	209,128	(10,216)	9
10	V	10a	Occupational Therapy Fees	269,641	Tara Therapy, LLC	0.00%	241,428	(28,213)	10
11	V	10a	Occupational Therapy Fees	191,011	Tara Therapy, LLC	0.00%	250,836	59,825	11
12	V								12
13	V								13
14	Total			\$ 1,209,045			\$ 1,147,547	\$ * (61,498)	14

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

Facility Name & ID Number Stearns Nsg Rehab Center# 0046870Report 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. ☒ YES ☐ NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	<u>34 Rent</u>	\$ 255,528	<u>Stearns Property Company, LLC</u>	0.00%	\$	(255,528)	15
16	V	<u>30 Depreciation Leasehold Imp</u>		<u>Stearns Property Company, LLC</u>	0.00%	21,637	21,637	16
17	V	<u>30 Depreciation Bldg & Improve</u>		<u>Stearns Property Company, LLC</u>	0.00%	107,178	107,178	17
18	V	<u>27 Amort Loan Acquisition Costs</u>		<u>Stearns Property Company, LLC</u>	0.00%	5,224	5,224	18
19	V	<u>32 Interest-Capital/Long-Term Debt</u>		<u>Stearns Property Company, LLC</u>	0.00%	106,574	106,574	19
20	V	<u>34 Mortgage Insurance Premium</u>		<u>Stearns Property Company, LLC</u>	0.00%	19,375	19,375	20
21	V	<u>10 Central Supply Services</u>	3,116	<u>Birmingham Nrs & Rehab Center East, LLC</u>	0.00%	3,116		21
22	V	<u>11 Activities</u>	3,890	<u>Birmingham Nrs & Rehab Center East, LLC</u>	0.00%	3,890		22
23	V	<u>1 Dietary Services</u>	965	<u>Scenic Nursing and Rehabilitation Center, LLC</u>	0.00%	965		23
24	V	<u>1 Dietary Services</u>	423	<u>Jefferson City Nursing and Rehabilitation Center, LLC</u>	0.00%	423		24
25	V	<u>12 Social Services</u>	811	<u>Jefferson City Nursing and Rehabilitation Center, LLC</u>	0.00%	811		25
26	V	<u>21 Admissions Services</u>	1,185	<u>Jefferson City Nursing and Rehabilitation Center, LLC</u>	0.00%	1,185		26
27	V	<u>10 Nurses Aides Services</u>	563	<u>Jefferson City Nursing and Rehabilitation Center, LLC</u>	0.00%	563		27
28	V	<u>6 Plant Operations</u>	1,100	<u>Jefferson City Nursing and Rehabilitation Center, LLC</u>	0.00%	1,100		28
29	V	<u>10 Nursing RN Services</u>	17,796	<u>Granite Nursing and Rehabilitation Center LLC</u>	0.00%	17,796		29
30	V	<u>10 Medical Records Services</u>	286	<u>Granite Nursing and Rehabilitation Center LLC</u>	0.00%	286		30
31	V	<u>6 Plant Operations</u>	2,393	<u>Granite Nursing and Rehabilitation Center LLC</u>	0.00%	2,393		31
32	V	<u>21 Human Resource Services</u>	2,463	<u>Granite Nursing and Rehabilitation Center LLC</u>	0.00%	2,462	(1)	32
33	V	<u>21 Admissions Services</u>	608	<u>Granite Nursing and Rehabilitation Center LLC</u>	0.00%	608		33
34	V	<u>21 Business Office Services</u>	88	<u>Granite Nursing and Rehabilitation Center LLC</u>	0.00%	88		34
35	V	<u>10 Nursing LPN Services</u>	573	<u>Calhoun Nursing and Rehabilitation Center LLC</u>	0.00%	573		35
36	V	<u>10 Asst Director of Nursing Services</u>	289	<u>Calhoun Nursing and Rehabilitation Center LLC</u>	0.00%	289		36
37	V							37
38	V							38
39	Total		\$ 292,077			\$ 296,536	\$ * 4,459	39

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

Facility Name & ID Number

Stearns Nsg Rehab Center

0046870

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, I	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, LI	Brandon				13
14			Lakeland Nursing and Rehabilitation Center, LI	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, LLC	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 Stearns Nsg Rehab Center # 0046870 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 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	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	***	0.7	1.75	Fin/ Adm. of TC	5,721	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CoCEO	Finance/ Admin	0.00	***	0.7	1.75	Fin/ Adm. of TC	5,721	17	5
6		for Tara Cares	of Tara Cares								6
7	Suzette Wilson	Vice President	Admin of	0.00	***	0.7	1.75	VP of TC	4,499	17	7
8			Tara Cares								8
9	Christopher Denz	Vice President	Tara Cares	0.00	***	0.7	1.75	VP of TC	1,362	17	9
10											10
11	*** Compensation paid only through Support Office and allocated share reported in column 7.										11
12											12
13								TOTAL	\$ 17,303		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 Stearns Nsg Rehab Center# 0046870

Report Period Beginning:

01/01/2020Ending: 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 ☒ 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)662-2529

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	1	Administrative Services Costs	Total Costs	39	\$ 387,083	\$ 294,025	7,723,701	\$ 7,322	1
2	3	Administrative Services Costs	Days	36	1,807	0	31,256	38	2
3	5	Administrative Services Costs	Days	36	28,542	0	31,256	605	3
4	6	Administrative Services Costs	Days	36	231,425	103,937	31,256	4,904	4
5	10	Administrative Services Costs	Total Costs	39	2,939,493	2,298,115	7,723,701	55,593	5
6	17	Administrative Services Costs	Days	36	7,181,342	7,181,342	31,256	152,124	6
7	19	Administrative Services Costs	Days	36	106,116	0	31,256	2,247	7
8	20	Administrative Services Costs	Days	36	152,019	0	31,256	3,220	8
9	21	Administrative Services Costs	Days	36	461,972	0	31,256	9,785	9
10	22	Administrative Services Costs	Days	36	1,411,377	0	31,256	29,898	10
11	24	Administrative Services Costs	Days	36	31,941	0	31,256	676	11
12	26	Administrative Services Costs	Days	36	5,217	0	31,256	110	12
13	27	Administrative Services Costs	Days	36	133,240	0	31,256	2,821	13
14	30	Administrative Services Costs	Days	36	96,883	0	31,256	2,052	14
15	33	Administrative Services Costs	Days	36	35,384	0	31,256	750	15
16	34	Administrative Services Costs	Days	36	103,471	0	31,256	2,191	16
17	35	Administrative Services Costs	Days	36	2,577	0	31,256	55	17
18									18
19									19
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.							20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not							21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.							22
23									23
24									24
25	TOTALS				\$ 13,309,889	\$ 9,877,419		\$ 274,391	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	ORIX Real Estate Capital LLC		X	Land and Building	\$16,942.18	6/20/12	\$ 4,566,200	\$ 3,830,953	7/1/2047	0.0275	\$ 106,574	1	
2	dba Lument Capital											2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$16,942.18		\$ 4,566,200	\$ 3,830,953			\$ 106,574	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,566,200	\$ 3,830,953			\$ 106,574	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,375 Line # 34

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	<u>105,300</u>	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.)			\$	<u>102,769</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(2,531)</u>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>107,910</u>	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.			\$	<u>105,379</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	<u>100,696</u>	8	
		2016	<u>100,328</u>	9	
		2017	<u>98,398</u>	10	
		2018	<u>100,293</u>	11	
		2019	<u>102,769</u>	12	
<u>The 2020 assessment was estimated to be a 5% increase over the 2019 assessment.</u>					

		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 Stearns Nsg Rehab Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046870

CONTACT PERSON REGARDING THIS REPORT Renee Klawon

TELEPHONE (716) 972-2305 FAX #: (716) 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)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>22-1-20-09-07-201-013</u>	<u>3900 Stearns Avenue</u>	\$ <u>102,768.92</u>	\$ <u>102,768.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>102,768.92</u></u>	\$ <u><u>102,768.92</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,578 B. General Construction Type: Exterior Masonry Frame Steel Reinforcement Number of Stories One

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 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 ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long Term Care	195,584	2011	\$ 191,114	1
2					2
3	TOTALS	195,584		\$ 191,114	3

Facility Name & ID Number Stearns Nsg Rehab Center

0046870

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	109		2011	1972	\$ 4,287,120	\$ 107,178	40	\$ 107,178	\$	\$ 1,018,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Front Sign			2005	515		10			515	9
10	Sign			2005	800		10			800	10
11	Electrical and Mechanical Repairs capitalized for Medicaid			2005	11,308		3			11,308	11
12	Cabinetry Install for Therapy Room			2006	10,980		12			10,980	12
13	Emergency Lights (outside)			2006	1,621		12			1,621	13
14	Painting - Back Railings			2006	3,780		5			3,780	14
15	Outside Lights			2006	1,419		12			1,419	15
16											16
17	Roof Disposal 3/29/17			2006							17
18	Cabinetry - Therapy Room			2006	2,433		12			2,433	18
19	Plumbing and Mechanical Repairs capitalized for Medicaid			2006	3,808		3			3,808	19
20	Plumbing and Mechanical Repairs capitalized for Medicaid			2007	9,163		3			9,163	20
21	Air Conditioners (10)			2006	10,033		10			10,033	21
22	Closet Doors			2007	7,675		11			7,675	22
23	Kitchen Hoods and Sprinklers			2007	11,130		11			11,130	23
24	Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, paint			2007	85,475		10			85,475	24
25	1 Resident Shower Room- tile, mirrors, drains, fixtures, shut offs			2007	50,679		11			50,679	25
26	Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling			2008	7,820		10			7,820	26
27	3 Shower Rooms - tile, drains, shut offs, paint, faucets			2008	61,673		10			61,673	27
28	Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs			2008	54,775		10			54,775	28
29	Electrical & Floor Repair capitalized for Medicaid			2008	4,710		3			4,710	29
30							5				30
31	Fire Alarm Motherboard			2008	3,165		10			3,165	31
32	Nurses Stations (North & South)			2008	34,900		10			34,900	32
33	Kitchen Upgrade-waste/water line, metal studs, interior partition, new electrical			2008	44,605		10			44,605	33
34	Facility Sign			2008	11,365		10			11,365	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 Stearns Nsg Rehab Center

0046870

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	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		\$	\$		\$	\$	\$	37
38	Floor Installation	2009	40,021		9		40,021	38
39								39
40	Water Heater 100 Gallon & Pump	2009	8,225		9		8,225	40
41								41
42	Water Heater	2010	6,800		8		6,800	42
43	Water Heater (100 gallon)	2010	8,200		8		8,200	43
44								44
45	Back Door / frame replacement	2010	3,409		8		3,409	45
46	Lighting & Room Signage capitalized for Medicaid	2010	13,829		3		13,829	46
47	TCU Wing Renovation	2011	630,780		7		630,780	47
48	Ceiling & Door Replacement	2011	80,229		7		80,229	48
49	Locks (6 coded/keyed)	2011	3,352	335	10	335	3,114	49
50	Electrical (Dining/NRS)	2011	4,466	298	15	298	2,767	50
51								51
52	Utility Room Renovation Drywall/plumbing/electric/cabinets	2011	16,150	1,077	15	1,077	10,005	52
53	Landscaping	2011	7,890	526	15	526	4,888	53
54								54
55	Installation of 61 overbed lights-Capitalized for Medicaid	2011	12,272		5		12,272	55
56	Addtl TCU Wing Renovation - generator/flooring	2011	23,658		7		23,658	56
57	Ceiling, Smoke Door & Door Replacement	2011	19,522		7		19,522	57
58	Replace 41 Windows - Capitalized for Medicaid	2011	6,070		5		6,070	58
59	Dining Room Wall Repair - Capitalized for Medicaid	2011	3,220		5		3,220	59
60	Laundry Room Ceiling/Lighting/Drywall/Painting-Cap for MCD	2011	5,769		5		5,769	60
61	Apoxoy Coating Front Porch Floor	2011	5,005		5		5,005	61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 5,619,819	\$ 109,414		\$ 109,414	\$ 2,339,806	70

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

Facility Name & ID Number Stearns Nsg Rehab Center

0046870

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	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	
1	Totals from Page 12A, Carried Forward		\$ 5,619,819	\$ 109,414		\$ 109,414	\$	\$ 2,339,806	1
2	<u>Kitchen Sewer Line</u>	2012	28,671	1,434	20	1,434		12,185	2
3									3
4	<u>MagLock System Courtyard Gate</u>	2012	4,800	480	10	480		3,927	4
5	<u>Dietary Mixer Repair Capitalized for Medicaid</u>	2012	2,873		3			2,873	5
6	<u>Lobby/Lounge Door Hardware Capitalized for Medicaid</u>	2012	4,360		3			4,360	6
7	<u>Burnisher Repair Capitalized for Medicaid</u>	2012	2,628		3			2,628	7
8	<u>Sewer&DrainCleaning/Cableing,WaterLines-Cap for Medicaid</u>	2012	4,698		3			4,698	8
9									9
10	<u>81 gal Water Heater</u>	2013	6,577	658	10	658		4,932	10
11	<u>Cabling Installation for Wireless Access Point</u>	2013	2,589	129	20	129		970	11
12	<u>Asphalt parking lot</u>	2013	49,183	6,148	8	6,148		46,109	12
13	<u>Plumbing,Sprinkler,Wall&Burnisher Repairs - Cap for MCD</u>	2013	31,755		3			31,755	13
14	<u>Remove/Replace sidewalks to tie to existing 2 exit doors</u>	2014	7,500	500	15	500		3,250	14
15	<u>Seal Parking Lot - Capitalized for Medicaid</u>	2014	2,900		2			2,900	15
16	<u>Pave Walkway Capitalized for Medicaid</u>	2015	2,500	312	8	312		1,718	16
17	<u>Repair Cooler Floor - Capitalized for Medicaid</u>	2016	3,483	233	15	233		1,047	17
18	<u>Repair Air Conditioner - Roof Top Unit Capitalized for Medicaid</u>	2016	2,954	295	10	295		1,330	18
19	<u>Sewer&DrainCleaning/Cableing,WaterLines-Cap for Medicaid</u>	2016	2,708	452	3	452		3,160	19
20	<u>Facility Roof</u>	2017	216,366	21,637	10	21,637		75,728	20
21	<u>Facility Roof</u>	2017	9,916	991	10	991		3,470	21
22	<u>Paint - All Hallways,Lounges,Dining,Kitchen,Memory Unit Capita</u>	2017	18,963	3,793	5	3,793		13,274	22
23	<u>Rooftop HVAC unit (York)</u>	2018	5,985	399	15	399		997	23
24	<u>Replace & Install Walk-In Freezer Door Capitalized for MCD</u>	2018	3,441	229	15	229		574	24
25									25
26	<u>A/C Units (2)</u>	2019	12,623	842	15	842		1,262	26
27	<u>Exhaust Fan</u>	2019	2,876	288	10	288		431	27
28									28
29	<u>Note: See additional building improvements made by former</u>		507,266					507,266	29
30	<u>property owner Healthcare REIT, Inc. on supplemental</u>								30
31	<u>schedule included as page 23 and 24 of the cost report.</u>								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,557,434	\$ 148,234		\$ 148,234	\$	\$ 3,070,650	34

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

Facility Name & ID Number Stearns Nsg Rehab Center

0046870

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 12B, Carried Forward		\$ 6,557,434	\$ 148,234		\$ 148,234	\$	\$ 3,070,650	1
2	Water Heater	2020	6,750	338	10	338		338	2
3	AC Unit	2020	713	71	5	71		71	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,564,897	\$ 148,643		\$ 148,643	\$	\$ 3,071,059	34

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

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	\$ 75,143	\$ 9,515	\$ 9,515	\$	Various	\$ 49,032	71
72	Current Year Purchases	13,056	2,275	2,275		Various	2,275	72
73	Fully Depreciated Assets	442,126	1,533	1,533		Various	442,126	73
74								74
75	TOTALS	\$ 530,325	\$ 13,323	\$ 13,323	\$		\$ 493,433	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	2013 Champion Bus	2014	\$ 54,596	\$	\$	\$	4	\$ 54,596
77									77
78									78
79									79
80	TOTALS			\$ 54,596	\$	\$	\$		\$ 54,596

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	7,340,932
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	161,966
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	161,966
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,619,088

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	None	\$
93		
94		
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:

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?

☐ YES
☒ NO

16. Rental Amount for movable equipment: \$ 92,587 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

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 \$

* 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)	\$			

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.

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.

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,297,553	\$	1
2	Cash-Patient Deposits	47,228		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	411,794		3
4	Supply Inventory (priced at)	9,105		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,086		6
7	Other Prepaid Expenses	6,399		7
8	Accounts Receivable (owners or related parties)	(107,986)		8
9	Other(specify): <u>Non-resident A/R-see TB</u>	13,243		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,682,422	\$	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	177,586		15
16	Equipment, at Historical Cost	131,391		16
17	Accumulated Depreciation (book methods)	(228,192)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(654)		21
22	Other Long-Term Assets (specify) <u>Deposits-Long Term</u>	2,100		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 82,231	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,764,653	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 269,984	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,228		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,649		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,058		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(24,314)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Employee Benefits Payable</u>	73,776		36
37	<u>Accrued Expenses</u>	376,603		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 962,984	\$	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)	\$ 962,984	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 801,669	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,764,653	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 262,334	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 262,334	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,171,216	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	37,063	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(668,944)	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)	\$ 539,335	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)	\$ 801,669	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Stearns Nsg Rehab Center

0046870

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.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,297,970	1
2	Discounts and Allowances for all Levels	1,590,306	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,888,276	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	597,690	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 597,690	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	21	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14	19
20	Radiology and X-Ray	86	20
21	Other Medical Services	1,446	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,826	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	149	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 149	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Prior Year Net Revenue</u>	(3,877)	28
28a	<u>Federal & State COVID Funds / Misc Revenues</u>	1,657,442	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,653,565	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,144,506	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,114,223	31
32	Health Care	3,541,147	32
33	General Administration	2,315,021	33
	B. Capital Expense		
34	Ownership	466,714	34
	C. Ancillary Expense		
35	Special Cost Centers	313,601	35
36	Provider Participation Fee	222,584	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,973,290	40
41	Income before Income Taxes (line 30 minus line 40)**	1,171,216	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,171,216	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,469,753	44
45	Private Pay - Net Inpatient Revenue	451,254	45
46	Medicare - Net Inpatient Revenue	2,466,996	46
47	Other-(specify) <u>Hospice</u>	374,493	47
48	Other-(specify) <u>Medicare HMO</u>	125,780	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,888,276	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,765	1,943	\$ 82,527	\$ 42.47	1
2	Assistant Director of Nursing	116	116	4,061	35.01	2
3	Registered Nurses	4,614	4,785	163,037	34.07	3
4	Licensed Practical Nurses	30,352	33,015	1,041,933	31.56	4
5	CNAs & Orderlies	49,735	52,203	746,763	14.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,004	2,179	35,974	16.51	9
10	Activity Assistants	3,978	4,323	40,467	9.36	10
11	Social Service Workers	1,955	2,168	49,736	22.94	11
12	Dietician	1,899	2,083	65,139	31.27	12
13	Food Service Supervisor	2,350	2,358	42,957	18.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,233	8,757	101,655	11.61	15
16	Dishwashers	7,452	8,087	86,663	10.72	16
17	Maintenance Workers	3,668	3,994	80,614	20.18	17
18	Housekeepers	12,111	13,400	160,071	11.95	18
19	Laundry	3,408	3,962	41,925	10.58	19
20	Administrator	2,008	2,174	117,859	54.21	20
21	Assistant Administrator					21
22	Other Administrative	2,995	3,699	92,879	25.11	22
23	Office Manager	457	457	8,633	18.89	23
24	Clerical	4,040	4,360	70,955	16.27	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	1,179	1,402	23,326	16.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,319	155,465	\$ 3,057,174 *	\$ 19.66	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	116	\$ 11,728	1-3	35
36	Medical Director	131	22,541	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	30	21,909	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	18	1,141	11-3	44
45	Social Service Consultant	18	1,121	12-3	45
46	Other(specify) Int Exec Director	412	45,713	27-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	725	\$ 104,153		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,445	\$ 79,360	10-3	50
51	Licensed Practical Nurses	978	46,095	10-3	51
52	Certified Nurse Assistants/Aides	4,742	162,580	10-3	52
53	TOTAL (lines 50 - 52)	7,165	\$ 288,035		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Gina Graham	Administrator	0	\$ 11,801
Karlene Dotson	Administrator	0	99,951
Pamela Owens	Administrator	0	6,107
Nicole Stockett	Bus Off Mgr	0	8,633
Lisa Schmidt/Kimberlin Simon/Julia Scroggin	Bus Off Asst	0	42,576
Lynde Carlisle/Dawn Vereeke/Miranda Willia	HR/Payroll	0	46,375
Miranda Malson	Admiss Director	0	46,504
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 261,947
B. Administrative - Other			
Description			Amount
Tara Cares Administrative Services Fee		\$	247,128
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 247,128
C. Professional Services			
Vendor/Payee	Type		Amount
Freed, Maxick & Battaglia	Accounting Fees	\$	2,772
Freed, Maxick & Battaglia	Tax Fees		2,556
Various Legal Fees - See attached detailed listing			75,204
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 80,532
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	209,084
Unemployment Compensation Insurance			14,600
FICA Taxes			230,862
Employee Health Insurance			395,811
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			0
Worker Compensation Safety Rec. Program			3,118
Employee Benefit - Holiday/Recognition			10,381
Employee Benefit - Short Term Disability			377
Employee Benefit - Employee Vaccinations			1,564
Employee Benefit - HSA ER/Tuition Reimb			1,026
Employee Benefit - Life Insurance (ER)			0
Employee Benefit - Dental/Vission Ins (ER)			2,775
TOTAL (agree to Schedule V, line 22, col.8)			\$ 869,598
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			33,581
Health Care Worker Background Check (Indicate # of checks performed 27)			682
Patient Background Checks	131		1,310
Facility Advertising			8,174
IHCA			7,848
Non-allow IHCA			(2,157)
Business License			100
Less: Public Relations Expense		(	)
Non-allowable advertising			(8,174)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 43,354
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			38,734
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	38,734

*** Attach copy of IMRF notifications**

****See instructions.**

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 \$5,691 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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,537 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. \$ 222,584
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? 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.
- (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. \$ 21
- (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 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 Stearns Nursing and Rehabilitation Center, LLC

0046870

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	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	Improvements Made by Healthcare REIT (covered by rent at outset		\$	\$		\$	\$	\$	37
38	of Change of Ownership):								38
39									39
40	Cove Base	2006	16,775		12			16,775	40
41	Sprinkler System Cost @ 6/30/06	2006	120,650		12			120,650	41
42	Sprinkler System Addl Cost Post 6/30/06	2006	4,750					4,750	42
43	Painting of Facility Cost @ 6/30/06	2006	117,665		5			117,665	43
44	Painting of Facility Addl Cost Post 6/30/06	2006							44
45	Exterior Siding Cost @ 6/30/06	2006	54,360		12			54,360	45
46	Exterior Siding Addl Cost Post 6/30/06	2006	(6,440)					(6,440)	46
47	Handrails and Chairrails	2006	12,705		12			12,705	47
48	Ducts & Fire Dampers for Fire Alarm System	2006	1,445		10			1,445	48
49	A/C Units (10)	2006	9,284		5			9,284	49
50	Carpeting	2006	3,894		5			3,894	50
51	Grease Trap	2005	8,421		13			8,421	51
52	Air Conditioning Units (6)	2005	3,818		5			3,818	52
53	Air Conditioning Units (5)	2005	2,600		13			2,600	53
54	Doors (2) Beauty Shop, Office	2005	2,044		13			2,044	54
55	Doors (2)	2005	3,997		13			3,997	55
56	Replacement Windows	2005	6,554		10			6,554	56
57	Sprinkler System	2005	56,150		13			56,150	57
58	Fire Alarm System	2005	22,294		10			22,294	58
59	Closet Doors	2005	2,400		13			2,400	59
60	Smoke Damper	2005	700		10			700	60
61									61
62	Replacement Doors	2005	1,697		13			1,697	62
63	Replacement Doors	2005	2,186		13			2,186	63
64	Compressor for Walk-in Freezer	2005	1,525		10			1,525	64
65	Air Conditioning Units (strip) (23)	2005	22,573		5			22,573	65
66	Doors	2005	3,092		13			3,092	66
67									67
68	Fire Damper	2005	1,420		13			1,420	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 476,559	\$		\$	\$ #REF!	\$ 476,559	70

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

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

1	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 Improvements Made by Healthcare REIT (covered by rent at outset		\$	\$		\$	\$	\$	37
38 of Change of Ownership):								38
39 Totals from Page 23 REIT, Carried Forward		476,559					476,559	39
40 Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617		5			11,617	40
41 Pave Walkway, Roadway, Turnaround	2005	5,150		8			5,150	41
42 Exterior Siding	2006	6,440		10			6,440	42
43								43
44 5-ton Rooftop A/C Unit	2006	7,500		12			7,500	44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
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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)		\$ 507,266	\$		\$	\$	\$ 507,266	70

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

Facility Name & ID Number **Stearns Nursing and Rehabilitation Center, LLC 0046870**

Report Period Beginning: **1/1/2020** **Ending:** **12/31/2020**

XVII. INCOME STATEMENT

Page 19 Note

Line 41 Income before Income Taxes 1,171,216 **

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.