

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 Nursing and Rehabilitation Center, LLC

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: Gary F. Eye Telephone Number: (716) 662-4955 ext 392
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 01/01/11 to 12/31/11 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) 04/30/12
(Date)

(Type or Print Name) Gary F. Eye

(Title) Senior VP of Finance of Tara Cares

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 Nursing and Rehabilitation Center, LLC

#

0046870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

4/14/12

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	122	Skilled (SNF)	109	41,111	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	122	TOTALS	109	41,111	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	20,116	4,424	8,038	32,578	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,116	4,424	8,038	32,578	14

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

79.24%

D. How many bed-hold days during this year were paid by the Department?

0

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

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

YES

NO

X

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

Date started

01/01/05

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

YES

X

Date

January 1, 2005

NO

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

YES

X

NO

If YES, enter number of beds certified

109

and days of care provided

5,538

Medicare Intermediary

Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL

X

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

1/1 to 12/31/11

Fiscal Year:

1/1 to 12/31/11

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

STATE OF ILLINOIS														
Facility Name & ID Number		Stearns Nursing and Rehabilitation Center, L				#	0046870		Report Period Beginning:		01/01/11	Ending:	Page 3	12/31/11
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	208,693	14,426	4,950	228,069		228,069	(28,974)	199,095				1	
2	Food Purchase		176,293		176,293		176,293	(547)	175,746				2	
3	Housekeeping	120,784	21,806		142,590		142,590		142,590				3	
4	Laundry	43,224	9,889	(2,495)	50,618		50,618		50,618				4	
5	Heat and Other Utilities			97,353	97,353		97,353	(180)	97,173				5	
6	Maintenance	53,353	29,798	49,367	132,518		132,518	(16,389)	116,129				6	
7	Other (specify):* see trial balance			19,387	19,387		19,387	(8)	19,379				7	
8	TOTAL General Services	426,054	252,212	168,562	846,828		846,828	(46,098)	800,730				8	
	B. Health Care and Programs													
9	Medical Director			20,400	20,400		20,400		20,400				9	
10	Nursing and Medical Records	1,727,357	153,559	110,567	1,991,483		1,991,483	(16,659)	1,974,824				10	
10a	Therapy		2,339	828,545	830,884		830,884	(121,607)	709,277				10a	
11	Activities	55,472	1,647	5,142	62,261		62,261		62,261				11	
12	Social Services	73,049	933	1,555	75,537		75,537		75,537				12	
13	CNA Training												13	
14	Program Transportation												14	
15	Other (specify):* see trial balance			22,108	22,108		22,108	(16,113)	5,995				15	
16	TOTAL Health Care and Programs	1,855,878	158,478	988,317	3,002,673		3,002,673	(154,379)	2,848,294				16	
	C. General Administration													
17	Administrative	229,235		348,108	577,343		577,343	(117,421)	459,922				17	
18	Directors Fees												18	
19	Professional Services			24,923	24,923		24,923	(6,645)	18,278				19	
20	Dues, Fees, Subscriptions & Promotions			39,261	39,261		39,261	(15,299)	23,962				20	
21	Clerical & General Office Expenses		32,279	61,261	93,540		93,540	(31,025)	62,515				21	
22	Employee Benefits & Payroll Taxes			367,144	367,144		367,144	(11,175)	355,969				22	
23	Inservice Training & Education												23	
24	Travel and Seminar			35,187	35,187		35,187	13	35,200				24	
25	Other Admin. Staff Transportation												25	
26	Insurance-Prop.Liab.Malpractice			55,600	55,600		55,600	(2,600)	53,000				26	
27	Other (specify):* see trial balance			135,017	135,017		135,017	(99,212)	35,805				27	
28	TOTAL General Administration	229,235	32,279	1,066,501	1,328,015		1,328,015	(283,364)	1,044,651				28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,511,167	442,969	2,223,380	5,177,516		5,177,516	(483,841)	4,693,675				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			71,990	71,990		71,990	150,385	222,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							95,628	95,628			32
33	Real Estate Taxes			82,321	82,321		82,321		82,321			33
34	Rent-Facility & Grounds			528,400	528,400		528,400	(270,900)	257,500			34
35	Rent-Equipment & Vehicles			37,882	37,882		37,882	243	38,125			35
36	Other (specify):* see trail balance											36
37	TOTAL Ownership			720,593	720,593		720,593	(24,644)	695,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			579	579		579		579			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,686	61,686		61,686		61,686			42
43	Other (specify):* see trail balance			266,739	266,739		266,739	(76,426)	190,313			43
44	TOTAL Special Cost Centers			329,004	329,004		329,004	(76,426)	252,578			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,511,167	442,969	3,272,977	6,227,113		6,227,113	(584,911)	5,642,202			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	(434)	2		4
5	Telephone, TV & Radio in Resident Rooms	(180)	5		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	(41)	32		10
11	Discounts, Allowances, Rebates & Refunds	(148)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(113)	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	(24,680)	21		18
19	Entertainment				19
20	Contributions	(3,170)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,077)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(108,807)	27		24
25	Fund Raising, Advertising and Promotional	(15,299)	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	(103,301)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (260,250)		\$	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)	(12,612)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (324,661)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (584,911)		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

ID#

0046870

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Remove Non-allowable Admiss-Other Supplies	\$ (6,194)	21	1
2	Remove Non-allowable EE Recognition Program	(1,045)	22	2
3	Remove Non-allowable Visa Costs	(85)	24	3
4	Remove Non-allowable Visa Costs	(250)	22	4
5	Remove Non-allowable Insurance Costs	(2,600)	26	5
6	Remove Non-allowable Nrs Admin-Purch Svcs	(15,316)	15	6
7	Remove Non-allowable Physicians-Purch Svcs	(113)	43	7
8	Accrue NRS Admin-Rental/Lease Moveable Equip	243	35	8
9	Remove Non-allowable Tax Prep Fees	(2,568)	19	9
10	Remove Non-allowable Admin-Other Purch Svcs	(5,167)	27	10
11	Accrue Dietary-Lodging	98	24	11
12	Remove Non-allowable Prior Year Costs	(5,567)	43	12
13	Remove Non-allowable IV Prescription Drug Cost	(5,071)	43	13
14	Offset Misc. Revenue Sch XVII line 28a	(614)	10	14
15	Offset Misc. Revenue Sch XVII line 28a	(16)	10	15
16	Offset Misc. Revenue Sch XVII line 28a	(197)	6	16
17	Offset Misc. Revenue Sch XVII line 28a	(365)	10	17
18	Offset Misc. Revenue Sch XVII line 28a	(38)	10	18
19	Offset Misc. Revenue Sch XVII line 28a	(3)	21	19
20	Offset Misc. Revenue Sch XVII line 28a	(8)	7	20
21	Offset Interco Sold Service Rev Sch XVII ln 28a	(118)	10	21
22	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,133)	6	22
23	Offset Interco Sold Service Rev Sch XVII ln 28a	(27,086)	1	23
24	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,863)	1	24
25	Offset Interco Sold Service Rev Sch XVII ln 28a	(25)	1	25
26	Offset Interco Sold Service Rev Sch XVII ln 28a	(8,997)	22	26
27	Capitalize Repairs&Maint for Medicaid	(3,220)	6	27
28	Capitalize Repairs&Maint for Medicaid	(3,870)	6	28
29	Capitalize Repairs&Maint for Medicaid	(5,769)	6	29
30	Capitalize Repairs&Maint for Medicaid	(2,200)	6	30
31	Capitalize Repairs&Maint for Medicaid	-12272	10	31
32	Amort/Depre on LHI capitalized for Medicaid	8128	30	32
33				33
34				34
35				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	(103,301)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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	Colonnades Property C	Granite City	Property Company
D & N, LLC	50%	White Hall Nursing and Rehabilitation Center, LLC	White Hall	Stearns Property Com	Granite City	Property Company
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Hardin Property Com	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Herculaneum Property	Herculaneum	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Jefferson City Propert	Jefferson City	Property Company
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Riverside Property Co	Kansas City	Property Company
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Terrace Square (Doug	Douglasville	Property Company

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	\$ 348,108	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 230,687	\$ (117,421)	1
2	V	34	Sublease Building & Equip	257,500	Tara Midwest, LLC	0.00%	257,500		2
3	V	10	Pharmacy Consulting Services	26,352	Tara Pharmacy SE, LLC	0.00%	23,516	(2,836)	3
4	V	10	Medication Administration Records	8,052	Tara Pharmacy SE, LLC	0.00%	7,652	(400)	4
5	V	43	Flu Vac/Prescription Drugs-Residents	235,270	Tara Pharmacy SE, LLC	0.00%	167,118	(68,152)	5
6	V	22	Flu/TB/HepB Vaccine for Employees	2,394	Tara Pharmacy SE, LLC	0.00%	1,511	(883)	6
7	V	10a	Physical Therapy Fees	363,884	Tara Therapy, LLC	0.00%	328,447	(35,437)	7
8	V	10a	Occupational Therapy Fees	250,191	Tara Therapy, LLC	0.00%	180,849	(69,342)	8
9	V	10a	Speech Therapy Fees	214,357	Tara Therapy, LLC	0.00%	197,529	(16,828)	9
10	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	2,850	(750)	10
11	V	15	Nursing Service	1,221	Granite Nursing and Rehabilitation Center, LLC	0.00%	1,174	(47)	11
12	V	27	Business Office Service	490	Granite Nursing and Rehabilitation Center, LLC	0.00%	468	(22)	12
13	V	27	HR Service	172	Granite Nursing and Rehabilitation Center, LLC	0.00%	164	(8)	13
14	Total			\$ 1,711,591			\$ 1,399,465	\$ * (312,126)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34	Rent	\$ 270,900	Stearns Property Company, LLC	0.00%	\$	\$ (270,900)	15
16	V	30	Depreciation Leasehold Imp		Stearns Property Company, LLC	0.00%	61,082	61,082	16
17	V	30	Depreciation Major Moveable		Stearns Property Company, LLC	0.00%	27,586	27,586	17
18	V	30	Depreciation Bldg & Improve		Stearns Property Company, LLC	0.00%	53,589	53,589	18
19	V	27	Amort Loan Acquisition Costs		Stearns Property Company, LLC	0.00%	17,962	17,962	19
20	V	32	Interest-Capital/Long-Term Debt		Stearns Property Company, LLC	0.00%	95,669	95,669	20
21	V	43	(Gain)/Loss-Sale of Property		Stearns Property Company, LLC	0.00%	2,477	2,477	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			\$ 270,900			\$ 258,365	\$ * (12,535)	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL 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	Jonesboro Property Co	Jonesboro	Property Company	1
2			Lake City Nursing and Rehabilitation Center, L	Lake City	Rex Road Property Co	Lake City	Property Company	2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile	Mobile Property Comp	Mobile	Property Company	3
4			Fairfield Nursing and Rehabilitation Center, LL	Fairfield	Fairfield Property Cor	Fairfield	Property Company	4
5			Florence Nursing and Rehabilitation Center, LL	Florence	Florence Property Cor	Florence	Property Company	5
6			Birmingham Nrs&Rehab Center East, LLC	Birmingham	Birmingham East Prop	Birmingham	Property Company	6
7			Birmingham Nursing and Rehabilitation Center,	Birmingham	Birmingham Property	Birmingham	Property Company	7
8			Eight Mile Nursing and Rehabilitation Center, L	Eight Mile	Eight Mile Property C	Eight Mile	Property Company	8
9			Quince Nursing and Rehabilitation Center, LLC	Memphis	Quince Property Comp	Memphis	Property Company	9
10			Allenbrooke Nursing and Rehabilitation Center,	Memphis	Allenbrooke Property	Memphis	Property Company	10
11			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo	Tupelo Property Comp	Tupelo	Property Company	11
12			Brandon Nursing and Rehabilitation Center, LL	Brandon	Brandon Property Cor	Brandon	Property Company	12
13			Lakeland Nursing and Rehabilitation Center, LI	Jackson	Lakeland Property Co	Jackson	Property Company	13
14			McComb Nursing and Rehabilitation Center, LI	McComb	McComb Property Co	McComb	Property Company	14
15			Cleveland Nursing and Rehabilitation Center, L	Cleveland	Cleveland Property Co	Cleveland	Property Company	15
16			Chadwick Nursing and Rehabilitation Center, L	Jackson	Chadwick (Jackson) P	Jackson	Property Company	16
17			Manhattan Nursing and Rehabilitation Center, I	Jackson	Manhattan Property C	Jackson	Property Company	17
18			Ruleville Nursing and Rehabilitation Center, LL	Ruleville	Ruleville Property Cor	Ruleville	Property Company	18
19			Farmerville Nursing and Rehabilitation Center,	Farmerville	Farmerville Property C	Farmerville	Property Company	19
20			Bernice Nursing and Rehabilitation Center, LLC	Bernice	Bernice Property Com	Bernice	Property Company	20
21			Ruston Nursing and Rehabilitation Center, LLC	Ruston	Longleaf (Ruston) Pro	Ruston	Property Company	21
22			Natchitoches Nursing and Rehabilitation Center,	Natchitoches	Natchitoches Property	Natchitoches	Property Company	22
23			Winnfield Nursing and Rehabilitation Center, L	Winnfield	Winnfield Property Co	Winnfield	Property Company	23
24			Ringgold Nursing and Rehabilitation Center, LI	Ringgold	Ringgold Property Cor	Ringgold	Property Company	24
25			Arcadia Nursing and Rehabilitation Center, LL	Arcadia	Willow Ridge (Arcadia	Arcadia	Property Company	25
26			Jena Nursing and Rehabilitation Center, LLC	Jena	Aimwell (Jena) Proper	Jena	Property Company	26
27					Aurora Cares Property	Orchard Park	Property Company	27
28			** The above listed facilites are related by		Aurora Cares, LLC d/	Orchard Park	Support Office	28
29			common ownership		Tara Midwest, LLC	Orchard Park	Subleases Bldg&Eq	29
30					Tara Healthcare, LLC	Orchard Park	Subleases Bldg&Eq	30

This page may also be used to list the Board of Directors for non-profit facilities. In the "Ownership %", enter "BOD".
IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

VII. RELATED PARTIES

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

	1		2		3			
	OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Tara Pharmacy SE, LI	Birmingham	Pharmacy	1
2					Tara Therapy, LLC	Orchard Park	Therapy	2
3					Raimax Healthcare So	Orchard Park	Software	3
4					White Hall Property C	White Hall	Property Company	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

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	0.00	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Stearns Nursing and Rehabilitation Center, LLC # 0046870 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Days	1,438,901	36	\$ 238,080	\$ 220,332	32,554	\$ 5,386	1
2	5	Administrative Services Costs	Days	1,438,901	36	32,904	0	32,554	744	2
3	6	Administrative Services Costs	Days	1,438,901	36	59,825	1,412	32,554	1,353	3
4	10	Administrative Services Costs	Days	1,438,901	36	2,062,719	1,958,819	32,554	46,667	4
5	17	Administrative Services Costs	Days	1,438,901	36	5,701,164	5,701,164	32,554	128,985	5
6	19	Administrative Services Costs	Days	1,438,901	36	15,009	0	32,554	340	6
7	20	Administrative Services Costs	Days	1,438,901	36	14,140	0	32,554	320	7
8	21	Administrative Services Costs	Days	1,438,901	36	282,582	0	32,554	6,393	8
9	22	Administrative Services Costs	Days	1,438,901	36	1,301,441	0	32,554	29,444	9
10	24	Administrative Services Costs	Days	1,438,901	36	120,117	0	32,554	2,718	10
11	26	Administrative Services Costs	Days	1,438,901	36	6,145	0	32,554	139	11
12	27	Administrative Services Costs	Days	1,438,901	36	70,082	0	32,554	1,586	12
13	30	Administrative Services Costs	Days	1,438,901	36	159,143	0	32,554	3,600	13
14	31	Administrative Services Costs	Days	1,438,901	36	5,670	0	32,554	128	14
15	33	Administrative Services Costs	Days	1,438,901	36	27,413	0	32,554	620	15
16	34	Administrative Services Costs	Days	1,438,901	36	99,870	0	32,554	2,259	16
17	35	Administrative Services Costs	Days	1,438,901	36	236	0	32,554	5	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 42 CRF 421.404.								22
23										23
24										24
25	TOTALS					\$ 10,196,540	\$ 7,881,727		\$ 230,687	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	M&T Bank		X	Purchase of Physical Plant	\$15,209.00	6/22/11	\$ 4,785,728	\$ 4,785,728	7/22/13	0.0380	\$ 95,669	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$15,209.00		\$ 4,785,728	\$ 4,785,728			\$ 95,669	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,785,728	\$ 4,785,728			\$ 95,669	15

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

* 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 2010 report.			\$	82,170	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.)			\$	80,241	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,929)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	84,250	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.			\$	82,321	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	69,504	8	
		2007	71,933	9	
		2008	76,163	10	
		2009	78,257	11	
		2010	80,241	12	
The 2011 assessment was estimated to be a 5% increase over the 2010 assessment.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$		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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stearns Nursing and Rehabilitation Center, LLC COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046870

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

TELEPHONE (716) 662-4955, ext. 392 FAX #: (716) 662-4468

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>22-1-20-09-07-201-013</u>	<u>3900 Stearns Avenue</u>	\$ <u>80,241.00</u>	\$ <u>80,241.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>80,241.00</u>	\$ <u>80,241.00</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 a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

A. Square Feet: 32,477

B. General Construction Type: ExteriorMasonryFrameSteel Reinforcement

Number of Storiesone

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).

N/A

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: 131,730

2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)

3. Current Period Amortization: Included in Schedule VII B Ln 1-8

4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc.capitalized pre-opening salaries, fringe benefits&other costs incurred prior 1/1/06.Costs allocated via related org cost&reported on Sch VII

(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

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	109		2011	1972	\$ 4,287,120	\$ 53,589	40	\$ 53,589	\$	53,589	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Front Sign			2005	515	52	10	52		335	9
10	Sign			2005	800	80	10	80		520	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	915	12	915		5,033	12
13	Emergency Lights (outside)			2006	1,621	135	12	135		743	13
14	Painting - Back Railings			2006	3,780	378	5	378		3,780	14
15	Outside Lights			2006	1,419	118	12	118		650	15
16	Walkway			2006	2,100	175	12	175		963	16
17	Roof			2006	152,600	12,717	12	12,717		69,942	17
18	Cabinetry - Therapy Room			2006	2,433	203	12	203		1,115	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)			2007	10,033	1,254	4	1,254		10,033	21
22	Closet Doors			2007	7,675	698	11	698		3,140	22
23	Kitchen Hoods and Sprinklers			2007	11,130	1,012	11	1,012		4,554	23
24	Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, paint			2007	85,475	8,548	10	8,548		38,464	24
25	1 Resident Shower Room- tile, mirrors, drains, fixtures, shut offs			2007	50,679	4,607	11	4,607		20,732	25
26	Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling			2008	7,820	782	10	782		2,737	26
27	3 Shower Rooms - tile, drains, shut offs, paint, faucets			2008	61,673	6,167	10	6,167		21,585	27
28	Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs			2008	54,775	5,478	10	5,478		19,172	28
29	Commercaill Disposal			2008	987	99	10	99		346	29
30	Electrical & Floor Repair capitalized for Medicaid			2008	4,710	785	3	785		4,710	30
31	A/C Unites (5)			2008	2,150	430	5	430		1,505	31
32	Fire Alarm Motherboard			2008	3,165	317	10	317		1,108	32
33	Nurses Stations (North & South)			2008	34,900	3,490	10	3,490		12,215	33
34	Kitchen Upgrade-waste/water line, metal studs, interior partition, new electrical			2008	44,605	4,461	10	4,461		15,612	34
35	Facility Sign			2008	11,365	1,136	10	1,136		3,977	35
36	Dish Machine			2008	14,180	1,418	10	1,418		4,963	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 Nursing and Rehabilitation Center, LLC

0046870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	Hot Water Heater Pump	2009	\$ 527	\$ 59	9	\$ 59	\$	\$ 147	37
38	Floor Installation	2009	40,021	4,447	9	4,447		11,117	38
39	Office Countertops	2009	1,259	140	9	140		350	39
40	100 Gallon Water Heater	2009	8,225	914	9	914		2,285	40
41	Direct TV Systems	2009	15,858	1,762	9	1,762		4,405	41
42	Water Heater	2010	6,800	850	8	850		1,275	42
43	Water Heater (100 gallon)	2010	8,200	1,025	8	1,025		1,538	43
44	Phone System (Nurse Station)	2010	1,061	133	8	133		199	44
45	Door (Service Entry)	2010	3,409	426	8	426		639	45
46	Awnings	2010	1,239	155	8	155		232	46
47	Keypads (Electric - Lock)	2010	721	90	8	90		135	47
48	Lighting & Room Signage capitalized for Medicaid	2010	13,829	4,610	3	4,610		6,915	48
49	Shed (Oxygen)	2011	2,139	153	7	153		153	49
50	A/C Unit	2011	656	66	5	66		66	50
51	Memories/TCU Wing Renovation	2011	654,438	46,746	7	46,746		46,746	51
52	Ceiling & Door Replacement	2011	99,751	7,125	7	7,125		7,125	52
53	Locks (6 coded/keyed)	2011	3,352	98	10	98		98	53
54	Electrical (Dining/NRS)	2011	4,466	87	15	87		87	54
55	A/C Unit	2011	1,104	64	5	64		64	55
56	Utility Room Renovation (North Wing)	2011	16,150	314	15	314		314	56
57	Landscaping	2011	7,890	153	15	153		153	57
58	Water Softener	2011	2,074	60	10	60		60	58
59	Lighting/Windows/Laundry&DiningRoom rpr cap for Medicaid	2011	27,331	2,733	5	2,733		2,733	59
60									60
61									61
62									62
63									63
64	Note: See additional building improvements made by former								64
65	property owner Healthcare REIT, Inc. on supplemental								65
66	schedule included as page 24 of the cost report.								66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,813,469	\$ 181,254		\$ 181,254	\$	\$ 412,638	70

**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	\$ 238,244	\$ 32,594	\$ 32,594	\$	various	\$ 111,302	71
72	Current Year Purchases	120,762	8,527	8,527		various	8,527	72
73	Fully Depreciated Assets	55,424					55,424	73
74								74
75	TOTALS	\$ 414,430	\$ 41,121	\$ 41,121	\$		\$ 175,253	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,419,013	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,375	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,375	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)	\$ 587,891	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc. for the period 1/1/11 thru 6/22/11
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:	1972	109	01/01/05	\$ 257,500	6.5 years	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		109		\$ 257,500			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: exercised June 22, 2011
- *

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: \$ 36,669
- 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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 01/01/05

Ending 06/22/11

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$ N/A
13.	/2013	\$ N/A
14.	/2014	\$ N/A

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 18,533	\$	1
2	Cash-Patient Deposits	34,885		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,406,348		3
4	Supply Inventory (priced at cost)	7,457		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,206		6
7	Other Prepaid Expenses	4,495		7
8	Accounts Receivable (owners or related parties)	(2,854,180)		8
9	Other(specify): Non resident A/R (see TB)	2,875		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,377,381)	\$	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	35,036		15
16	Equipment, at Historical Cost	16,815		16
17	Accumulated Depreciation (book methods)	(1,624)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(529)		21
22	Other Long-Term Assets (specify) Deposits long term	2,100		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 51,798	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,325,583)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,610	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,885		28
29	Short-Term Notes Payable	4,324		29
30	Accrued Salaries Payable	217,280		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,470		31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,250		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	2,031		36
37	Accrued Expenses	232,502		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 684,352	\$	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)	\$ 684,352	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,009,935)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,325,583)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,643,035)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,643,035)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	341,192	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	708,392	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,416,484)	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)	\$ (366,900)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,009,935)	24 *

* This must agree with page 17, line 47.

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,153,551	1
2	Discounts and Allowances for all Levels	1,844,220	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,997,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,216	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 490,216	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	434	14
15	Telephone, Television and Radio	180	15
16	Rental of Facility Space		16
17	Sale of Drugs	4,992	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,527	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,133	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	59	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	22,271	28
28a	Purchase Discounts/Sold Services Rev/Rebates	42,855	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 65,126	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,568,305	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	846,828	31
32	Health Care	3,002,673	32
33	General Administration	1,328,015	33
	B. Capital Expense		
34	Ownership	720,593	34
	C. Ancillary Expense		
35	Special Cost Centers	267,318	35
36	Provider Participation Fee	61,686	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,227,113	40
41	Income before Income Taxes (line 30 minus line 40)**	341,192	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 341,192	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? [see attached](#) 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	1,896	1,920	\$ 68,703	\$ 35.78	1
2	Assistant Director of Nursing	1,928	2,080	62,100	29.86	2
3	Registered Nurses	4,308	4,517	126,391	27.98	3
4	Licensed Practical Nurses	27,673	29,465	627,608	21.30	4
5	CNAs & Orderlies	64,718	68,899	701,028	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,927	2,031	36,183	17.82	9
10	Activity Assistants	1,995	2,202	19,289	8.76	10
11	Social Service Workers	3,822	4,056	73,049	18.01	11
12	Dietician					12
13	Food Service Supervisor	3,833	4,160	78,054	18.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,400	5,895	54,057	9.17	15
16	Dishwashers	8,232	9,035	76,582	8.48	16
17	Maintenance Workers	2,989	3,128	53,353	17.06	17
18	Housekeepers	12,108	13,047	120,784	9.26	18
19	Laundry	4,355	4,693	43,224	9.21	19
20	Administrator	3,818	4,070	130,342	32.03	20
21	Assistant Administrator					21
22	Other Administrative	1,952	2,080	35,462	17.05	22
23	Office Manager	1,774	1,844	32,578	17.67	23
24	Clerical	1,902	2,107	30,853	14.64	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					31
32	Other Health Care MDS	4,922	5,677	126,888	22.35	32
33	Other(specify) <u>NRS Adm Clerical</u>	1,061	1,153	14,639	12.70	33
34	TOTAL (lines 1 - 33)	160,613	172,059	\$ 2,511,167 *	\$ 14.59	34

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		\$		35
36	Medical Director	624	20,400	9-3	36
37	Medical Records Consultant	48	2,934	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18/bed	26,352	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	28	1,751	11-3	44
45	Social Service Consultant	24	1,555	12-3	45
46	Other(specify)				46
47	<u>Medical Adm Record Preparation</u>	\$5.50/bed	8,052	10-3	47
48					48
49	TOTAL (lines 35 - 48)	724	\$ 61,044		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	377	\$ 29,730	10-3	50
51	Licensed Practical Nurses	51	1,808	10-3	51
52	Certified Nurse Assistants/Aides	1,513	31,748	10-3	52
53	TOTAL (lines 50 - 52)	1,941	\$ 63,286		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberStearns Nursing and Rehabilitation Center, LLC# 0046870Report Period Beginning: 01/01/11Ending: 12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brett Hoffman	Administrator	0	\$ 102,461
Janice Bush	Bus. Office Mgr	0	16,561
Kimberly Holmes	Bus. Office Mgr	0	16,434
Eric Olsson	Payroll/AP	0	30,909
Clealone Douglas	HR	0	1,667
Lisa Dokes	HR	0	25,104
Miranda Scoggins	Admis Coordinator	0	36,099
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 229,235

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	\$ 348,108
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 348,108

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	\$ 2,318
Freed, Maxick & Battaglia	Tax Fees	2,568
Various Legal Fees - See Attached detailed listing		20,037
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 24,923

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 21,827
Unemployment Compensation Insurance	78,214
FICA Taxes	187,658
Employee Health Insurance	52,436
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Benefits - WC safety rec. prog	1,500
Employee Benefits - other	13,252
Employee Benefits - Short Term Disability	644
Employee Benefits - Hepatitis B Vaccination	438
TOTAL (agree to Schedule V, line 22, col.8)	\$ 355,969

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	\$ 1,242
Advertising: Employee Recruitment	12,072
Health Care Worker Background Check (Indicate # of checks performed 449)	7,731
Facility Advertising	9,911
Licenses/SamsClub/Society for HR Mgrs	625
Chamber of Commerce	1,065
Non Allow Chamber of Commerce	(1,065)
IL. Health Care Association	6,615
Non Allowable IL Health Care Assn	(4,323)
Less: Public Relations Expense	()
Non-allowable advertising	(9,911)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,962

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	28,401
Seminar Expense	6,799
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 35,200

* 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 \$2,291.00 net of non-allowable
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,155 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,686
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. \$ 434
- (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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees



XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-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			\$	\$		\$	\$	\$	1
2	Improvements Made by Healthcare REIT (covered by rent at outset								2
3	of Change of Ownership):								3
4	Cove Base	2006	16,775	1,398	12	1,398		7,689	4
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450		57,475	5
6	Sprinkler System Addl Cost Post 6/30/06	2006	4,750						6
7	Painting of Facility Cost @ 6/30/06	2006	117,665	11,842	5	11,842		118,415	7
8	Painting of Facility Addl Cost Post 6/30/06	2006	750						8
9	Exterior Siding Cost @ 6/30/06	2006	54,360	3,993	12	3,993		21,963	9
10	Exterior Siding Addl Cost Post 6/30/06	2006	(6,440)						10
11	Handrails and Chairrails	2006	12,705	1,059	12	1,059		5,823	11
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	145	10	145		795	12
13	A/C Units (10)	2006	9,284	928	5	928		9,284	13
14	Carpeting	2006	3,894	389	5	389		3,894	14
15	Grease Trap	2005	8,421	648	13	648		4,211	15
16	Air Conditioning Units (6)	2005	3,818		5			3,818	16
17	Air Conditioning Units (5)	2005	2,600	200	13	200		1,300	17
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157		1,022	18
19	Doors (2)	2005	3,997	307	13	307		1,998	19
20	Replacement Windows	2005	6,555	655	10	655		4,260	20
21	Sprinkler System	2005	56,150	4,319	13	4,319		28,075	21
22	Fire Alarm System	2005	22,294	2,229	10	2,229		14,491	22
23	Closet Doors	2005	2,400	185	13	185		1,200	23
24	Smoke Damper	2005	700	70	10	70		455	24
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350		8,775	25
26	Replacement Doors	2005	1,697	131	13	131		849	26
27	Replacement Doors	2005	2,186	168	13	168		1,093	27
28	Compressor for Walk-in Freezer	2005	1,525	153	10	153		991	28
29	Air Conditioning Units (strip) (23)	2005	22,573		5			22,573	29
30	Doors	2005	3,092	238	13	238		1,546	30
31	Aspire Telephone System	2005	10,992	1,099	10	1,099		7,145	31
32	Fire Damper	2005	1,420	109	13	109		710	32
33	Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617		5			11,617	33
34	Pave Walkway, Roadway, Turnaround	2005	5,150	644	8	644		4,184	34
35	Exterior Siding	2006	6,440	644	10	644		3,542	35
36	Double Bowl Sinks (2)	2006	1,104	92	12	92		506	36
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750		4,125	37
38	TOTAL (lines 1 thru 37)		\$ 533,613	\$ 44,352		\$ 44,352	\$ 0	\$ 353,824	38

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