

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 & Rehab Ctr

Address: 3900 Stearns Ave 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) 972-2392
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 1/1/12 to 12/31/12 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) _____ (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 & Rehab Ctr

0046870 Report Period Beginning: 1/1/12 Ending: 12/31/12

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>21,925</u>	<u>5,318</u>	<u>5,750</u>	<u>32,993</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>21,925</u>	<u>5,318</u>	<u>5,750</u>	<u>32,993</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.70%

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)

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 01/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date January 1, 2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 3,600

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 1/1 to 12/31/12 Fiscal Year: 1/1 to 12/31/12
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Stearns Nursing & Rehab Ctr # 0046870 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	227,888	13,150	3,307	244,345		244,345	(34,602)	209,743			1
2	Food Purchase		188,636		188,636		188,636	(941)	187,695			2
3	Housekeeping	141,083	26,108	832	168,023		168,023		168,023			3
4	Laundry	35,568	9,092		44,660		44,660		44,660			4
5	Heat and Other Utilities			105,309	105,309		105,309		105,309			5
6	Maintenance	49,847	26,069	45,729	121,645		121,645	(17,776)	103,869			6
7	Other (specify):*			29,031	29,031		29,031		29,031			7
8	TOTAL General Services	454,386	263,055	184,208	901,649		901,649	(53,319)	848,330			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	1,875,610	123,684	132,939	2,132,233		2,132,233	(10,227)	2,122,006			10
10a	Therapy		4,081	629,574	633,655		633,655	(10,808)	622,847			10a
11	Activities	65,513	2,807	4,836	73,156		73,156		73,156			11
12	Social Services	52,835		1,644	54,479		54,479	(145)	54,334			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			25,508	25,508		25,508	(8,335)	17,173			15
16	TOTAL Health Care and Programs	1,993,958	130,572	814,901	2,939,431		2,939,431	(29,515)	2,909,916			16
	C. General Administration											
17	Administrative	258,365		346,872	605,237		605,237	(109,809)	495,428			17
18	Directors Fees											18
19	Professional Services			49,789	49,789		49,789	(2,740)	47,049			19
20	Dues, Fees, Subscriptions & Promotions			39,823	39,823		39,823	(14,253)	25,570			20
21	Clerical & General Office Expenses	1,610	32,088	56,788	90,486		90,486	(23,285)	67,201			21
22	Employee Benefits & Payroll Taxes			384,189	384,189		384,189	(6,906)	377,283			22
23	Inservice Training & Education											23
24	Travel and Seminar			32,623	32,623		32,623	(169)	32,454			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200,149	200,149		200,149	(2,600)	197,549			26
27	Other (specify):*			81,444	81,444		81,444	(6,171)	75,273			27
28	TOTAL General Administration	259,975	32,088	1,191,677	1,483,740		1,483,740	(165,933)	1,317,807			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,708,319	425,715	2,190,786	5,324,820		5,324,820	(248,767)	5,076,053			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			7,582	7,582		7,582	335,847	343,429			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,692	4,692		4,692	147,556	152,248			32
33	Real Estate Taxes			85,317	85,317		85,317		85,317			33
34	Rent-Facility & Grounds			398,331	398,331		398,331	(445,311)	(46,980)			34
35	Rent-Equipment & Vehicles			49,689	49,689		49,689		49,689			35
36	Other (specify):*											36
37	TOTAL Ownership			545,611	545,611		545,611	38,092	583,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			564	564		564		564			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			238,276	238,276		238,276		238,276			42
43	Other (specify):*			222,190	222,190		222,190	(28,451)	193,739			43
44	TOTAL Special Cost Centers			461,030	461,030		461,030	(28,451)	432,579			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,708,319	425,715	3,197,427	6,331,461		6,331,461	(239,126)	6,092,335			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	(797)	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	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds	(96)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	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	(13,987)	21		18
19	Entertainment				19
20	Contributions	(3,023)	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	(56,361)	27		24
25	Fund Raising, Advertising and Promotional	(14,253)	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	(75,010)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (163,701)		\$	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)	(75,425)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,425)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (239,126)		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 Admiss-Other Supplies	\$ (4,686)	21	1
2	Remove non-allowable Visa Cost	(169)	24	2
3	Remove non-allowable Insurance Cost	(2,600)	26	3
4	Remove non-allowable Nrsg Admin-Purch Svcs	(6,267)	15	4
5	Remove non-allowable Admin-Excise Tax	(4,510)	21	5
6	Remove non-allowable BO-Tax Prep Fees	(2,740)	19	6
7	Remove non-allowable Admin-Other Purch Svcs	(3,297)	27	7
8	Remove non-allowable IV Prescription Drugs	(3,046)	43	8
9	Remove non-allowable Prior Year Costs	4,183	43	9
10	Offset Misc. Revenue Sch XVII line 28a	(1,083)	10	10
11	Offset Misc. Revenue Sch XVII line 28a	(47)	10	11
12	Offset Misc. Revenue Sch XVII line 28a	(52)	6	12
13	Offset Misc. Revenue Sch XVII line 28a	(687)	10	13
14	Offset Misc. Revenue Sch XVII line 28a	(30)	10	14
15	Offset Misc. Revenue Sch XVII line 28a	(6)	21	15
16	Offset Interco Sold Service Rev Sch XVII ln 28a	(2,627)	10	16
17	Offset Interco Sold Service Rev Sch XVII ln 28a	(145)	12	17
18	Offset Interco Sold Service Rev Sch XVII ln 28a	(3,193)	6	18
19	Offset Interco Sold Service Rev Sch XVII ln 28a	(432)	6	19
20	Offset Interco Sold Service Rev Sch XVII ln 28a	(33,407)	1	20
21	Offset Interco Sold Service Rev Sch XVII ln 28a	(735)	1	21
22	Offset Interco Sold Service Rev Sch XVII ln 28a	(208)	17	22
23	Offset Interco Sold Service Rev Sch XVII ln 28a	(7,170)	22	23
24	Capitalize repairs&maint for Medicaid	(4,360)	6	24
25	Capitalize repairs&maint for Medicaid	(2,628)	6	25
26	Capitalize repairs&maint for Medicaid	(4,238)	6	26
27	Capitalize repairs&maint for Medicaid	(2,873)	6	27
28	Capitalize repairs&maint for Medicaid	(460)	1	28
29	Amort/Depreciate Repair/Maint Captl. For Medicaid	12,503	30	29
30				30
31				31
32				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	(75,010)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stearns Nursing & Rehab Ctr# 0046870

Report Period Beginning:

1/1/12

Ending:

12/31/12

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	(34,602)	0	0	0	0	0	0	0	0	0	0	(34,602)	1
2	Food Purchase	(941)	0	0	0	0	0	0	0	0	0	0	(941)	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	(17,776)	0	0	0	0	0	0	0	0	0	0	(17,776)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(53,319)	0	0	0	0	0	0	0	0	0	0	(53,319)	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	(4,474)	(5,753)	0	0	0	0	0	0	0	0	0	(10,227)	10
10a	Therapy	0	(10,808)	0	0	0	0	0	0	0	0	0	(10,808)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(145)	0	0	0	0	0	0	0	0	0	0	(145)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(6,267)	(2,068)	0	0	0	0	0	0	0	0	0	(8,335)	15
16	TOTAL Health Care and Programs	(10,886)	(18,629)	0	0	0	0	0	0	0	0	0	(29,515)	16
	C. General Administration													
17	Administrative	(208)	(109,601)	0	0	0	0	0	0	0	0	0	(109,809)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,740)	0	0	0	0	0	0	0	0	0	0	(2,740)	19
20	Fees, Subscriptions & Promotions	(14,253)	0	0	0	0	0	0	0	0	0	0	(14,253)	20
21	Clerical & General Office Expenses	(23,285)	0	0	0	0	0	0	0	0	0	0	(23,285)	21
22	Employee Benefits & Payroll Taxes	(7,170)	264	0	0	0	0	0	0	0	0	0	(6,906)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(169)	0	0	0	0	0	0	0	0	0	0	(169)	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):*	(62,681)	0	56,510	0	0	0	0	0	0	0	0	(6,171)	27
28	TOTAL General Administration	(113,106)	(109,337)	56,510	0	0	0	0	0	0	0	0	(165,933)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(177,311)	(127,966)	56,510	0	0	0	0	0	0	0	0	(248,767)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nursing & Rehab Ctr # 0046870 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	12,503	0	323,344	0	0	0	0	0	0	0	0	335,847	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	0	147,586	0	0	0	0	0	0	0	0	147,556	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(445,311)	0	0	0	0	0	0	0	0	(445,311)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	12,473	0	25,619	0	0	0	0	0	0	0	0	38,092	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):*	1,137	(53,691)	24,103	0	0	0	0	0	0	0	0	(28,451)	43
44	TOTAL Special Cost Centers	1,137	(53,691)	24,103	0	0	0	0	0	0	0	0	(28,451)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(163,701)	(181,657)	106,232	0	0	0	0	0	0	0	0	(239,126)	45

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 Co	Granite City	Property Company
D & N, LLC	50%	White Hall Nursing and Rehabilitation Center, LLC	White Hall	Stearns Property Company	Granite City	Property Company
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Hardin Property Company	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Herculaneum Property Company	Herculaneum	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Jefferson City Property Company	Jefferson City	Property Company
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Riverside Property Company	Kansas City	Property Company
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Terrace Square (Douglasville)	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 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	\$ 346,872	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 237,271	\$ (109,601)	1
2	V								2
3	V	10	Pharmacy Consulting Services	23,544	Tara Pharmacy SE, LLC	0.00%	20,597	(2,947)	3
4	V	10	Medication Administration Records	7,194	Tara Pharmacy SE, LLC	0.00%	4,388	(2,806)	4
5	V	43	Flu Vac/Prescription Drugs-Residents	200,050	Tara Pharmacy SE, LLC	0.00%	146,359	(53,691)	5
6	V	22	Flu/TB/HepB Vaccine for Employees	2,199	Tara Pharmacy SE, LLC	0.00%	2,463	264	6
7	V	10a	Physical Therapy Fees	313,665	Tara Therapy, LLC	0.00%	334,807	21,142	7
8	V	10a	Occupational Therapy Fees	190,392	Tara Therapy, LLC	0.00%	153,798	(36,594)	8
9	V	10a	Speech Therapy Fees	125,360	Tara Therapy, LLC	0.00%	130,004	4,644	9
10	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,532	(2,068)	10
11	V	10	LPN Service	2,594	Granite Nursing and Rehabilitation Center, LLC	0.00%	2,594		11
12	V	15	Nursing Service	299	Granite Nursing and Rehabilitation Center, LLC	0.00%	299		12
13	V	27	HR Service	126	Granite Nursing and Rehabilitation Center, LLC	0.00%	126		13
14	Total			\$ 1,215,895			\$ 1,034,238	\$ * (181,657)	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	\$ 445,311	Stearns Property Company, LLC	0.00%	\$	(445,311)	15
16	V	30	Depreciation Leasehold Imp		Stearns Property Company, LLC	0.00%	171,213	171,213	16
17	V	30	Depreciation Major Moveable		Stearns Property Company, LLC	0.00%	44,953	44,953	17
18	V	30	Depreciation Bldg & Improve		Stearns Property Company, LLC	0.00%	107,178	107,178	18
19	V	27	Amort Loan Acquisition Costs		Stearns Property Company, LLC	0.00%	56,510	56,510	19
20	V	32	Interest-Capital/Long-Term Debt		Stearns Property Company, LLC	0.00%	147,586	147,586	20
21	V	43	Interest Expense - M.I.P.		Stearns Property Company, LLC	0.00%	24,103	24,103	21
22	V	27	Business Office Service	1,856	Granite Nursing and Rehabilitation Center, LLC	0.00%	1,856		22
23	V	27	HR Service	60	Scenic Nursing and Rehabilitation Center, LLC	0.00%	60		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			\$ 447,227			\$ 553,459	\$ * 106,232	39

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

Facility Name & ID Number

Stearns Nursing & Rehab Ctr

0046870

Report Period Beginning:

1/1/12

Ending:

12/31/12

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, I	Eight Mile	Eight Mile Property C	Eight Mile	Property Company	8
9			Quince Nursing and Rehabilitation Center, LLC	Memphis	Quince Property Com	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 Com	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 Co	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	Clearing Account fo	29
30					Tara Healthcare, LLC	Orchard Park	Clearing Account fo	30

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					Tara Pharmacy SE, L	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					3690 N. H. Associates,	Orchard Park	Clearing Account fo	5
6					3690 Associates, LLC	Orchard Park	Clearing Account fo	6
7					Health Care Risk Gro	Orchard Park	Insurance	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

Facility Name & ID Number Stearns Nursing & Rehab Ctr # 0046870 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.71	1.78	Fin/ Adm. TC	4,959	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.71	1.78	Fin/ Adm. TC	4,959	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.71	1.78	VP	4,115	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	\$ 14,033		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 & Rehab Ctr# 0046870

Report Period Beginning:

1/1/12Ending: 12/31/12

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	1,473,669	35	\$ 257,223	\$ 220,671	32,976	\$ 5,756	1
2	5	Administrative Services Costs	Days	1,473,669	35	36,825	0	32,976	825	2
3	6	Administrative Services Costs	Days	1,473,669	35	55,513	0	32,976	1,243	3
4	10	Administrative Services Costs	Days	1,473,669	35	2,440,929	2,173,122	32,976	54,621	4
5	17	Administrative Services Costs	Days	1,473,669	35	5,663,604	5,663,604	32,976	126,731	5
6	19	Administrative Services Costs	Days	1,473,669	35	9,265	0	32,976	207	6
7	20	Administrative Services Costs	Days	1,473,669	35	14,781	0	32,976	331	7
8	21	Administrative Services Costs	Days	1,473,669	35	305,257	0	32,976	6,832	8
9	22	Administrative Services Costs	Days	1,473,669	35	1,272,672	0	32,976	28,479	9
10	24	Administrative Services Costs	Days	1,473,669	35	113,930	0	32,976	2,550	10
11	26	Administrative Services Costs	Days	1,473,669	35	5,104	0	32,976	114	11
12	27	Administrative Services Costs	Days	1,473,669	35	133,549	0	32,976	2,989	12
13	30	Administrative Services Costs	Days	1,473,669	35	154,779	0	32,976	3,463	13
14	31	Administrative Services Costs	Days	1,473,669	35	4,919	0	32,976	110	14
15	32	Administrative Services Costs	Days	1,473,669	35	91	0	32,976	2	15
16	33	Administrative Services Costs	Days	1,473,669	35	28,086	0	32,976	628	16
17	34	Administrative Services Costs	Days	1,473,669	35	106,649	0	32,976	2,386	17
18	35	Administrative Services Costs	Days	1,473,669	35	173	0	32,976	4	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					\$ 10,603,349	\$ 8,057,397		\$ 237,271	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	\$14,824.72	6/22/11	\$ 4,786,812	\$	6/20/12	libor+3.5%	\$ 81,536	1	
2	Lancaster Pollard Mortgage Company	X		Refinance Purchase of Plant	\$16,942.18	6/20/12	4,566,200	4,533,661	7/1/47	0.0275	66,050	2	
3												3	
4												4	
5												5	
	Working Capital												
6	M&T BANK		X	Working Capital-Floating Balance	\$317.00	6/26/09	4,324	100,403	demand note	0.0450	3,807	6	
7												7	
8												8	
9	TOTAL Facility Related				\$32,083.90		\$ 9,357,336	\$ 4,634,064			\$ 151,393	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 9,357,336	\$ 4,634,064			\$ 151,393	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,772 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 2011 report.			\$	84,250	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.)			\$	82,717	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,533)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	86,850	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.			\$	85,317	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	71,933	8	
		2008	76,163	9	
		2009	78,257	10	
		2010	80,241	11	
		2011	82,717	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2011 \$		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.

FACILITY NAME	Stearns Nursing & Rehab Ctr	COUNTY	Madison
---------------	-----------------------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

Page 10A

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.CapitalizedPre-openingSalaries,Benefits&OtherCostsIncurred2007,2009&2010.AllocatedViaRelatedOrgCost&ReportedSchVII B

(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	\$ 107,178	40	\$ 107,178		\$ 160,767
5										
6										
7										
8										
	Improvement Type**									
9	Alumalite Front Sign			2005	515	52	10	52		387
10	Sign			2005	800	80	10	80		600
11	Electrical and Mechanical Repairs capitalized for Medicaid			2005	11,308		3			11,308
12	Cabinetry Install for Therapy Room			2006	10,980	915	12	915		5,948
13	Emergency Lights (outside)			2006	1,621	135	12	135		878
14	Painting - Back Railings			2006	3,780		5			3,780
15	Outside Lights			2006	1,419	118	12	118		768
16	Walkway			2006	2,100	175	12	175		1,138
17	Roof			2006	152,600	12,717	12	12,717		82,659
18	Cabinetry - Therapy Room			2006	2,433	203	12	203		1,318
19	Plumbing and Mechanical Repairs capitalized for Medicaid			2006	3,808		3			3,808
20	Plumbing and Mechanical Repairs capitalized for Medicaid			2007	9,163		3			9,163
21	Air Conditioners (10)			2007	10,033		4			10,033
22	Closet Doors			2007	7,675	698	11	698		3,838
23	Kitchen Hoods and Sprinklers			2007	11,130	1,012	11	1,012		5,566
24	Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, paint			2007	85,475	8,548	10	8,548		47,012
25	1 Resident Shower Room- tile, mirrors, drains, fixtures, shut offs			2007	50,679	4,607	11	4,607		25,339
26	Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling			2008	7,820	782	10	782		3,519
27	3 Shower Rooms - tile, drains, shut offs, paint, faucets			2008	61,673	6,167	10	6,167		27,752
28	Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs			2008	54,775	5,477	10	5,477		24,649
29	Commercaill Disposal			2008	987	99	10	99		445
30	Electrical & Floor Repair capitalized for Medicaid			2008	4,710		3			4,710
31	A/C Unites (5)			2008	2,150	430	5	430		1,935
32	Fire Alarm Motherboard			2008	3,165	316	10	316		1,424
33	Nurses Stations (North & South)			2008	34,900	3,490	10	3,490		15,705
34	Kitchen Upgrade-waste/water line, metal studs, interior partition, new electrical			2008	44,605	4,460	10	4,460		20,072
35	Facility Sign			2008	11,365	1,136	10	1,136		5,113
36	Dish Machine			2008	14,180	1,418	10	1,418		6,381

*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 & Rehab Ctr

0046870

Report Period Beginning:

1/1/12

Ending:

12/31/12

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		\$ 206	37
38	Floor Installation	2009	40,021	4,447	9	4,447		15,564	38
39	Office Countertops	2009	1,259	140	9	140		490	39
40	Water Heater 100 Gallon & Pump	2009	8,225	914	9	914		3,199	40
41	Direct TV Systems	2009	15,858	1,762	9	1,762		6,167	41
42	Water Heater	2010	6,800	850	8	850		2,125	42
43	Water Heater (100 gallon)	2010	8,200	1,025	8	1,025		2,563	43
44	Phone System Upgrade (Nurse Station)	2010	1,061	133	8	133		332	44
45	Back Door / frame replacement	2010	3,409	426	8	426		1,065	45
46	Awning	2010	1,239	155	8	155		387	46
47	Keypad (Electric - Lock)	2010	721	90	8	90		225	47
48	Lighting & Room Signage capitalized for Medicaid	2010	13,829	4,610	3	4,610		11,525	48
49	Shed (Oxygen)	2011	2,139	305	7	305		458	49
50	A/C Unit	2011	656	131	5	131		197	50
51	TCU Wing Renovation	2011	630,780	90,111	7	90,111		135,167	51
52	Ceiling & Door Replacement	2011	80,229	11,461	7	11,461		17,192	52
53	Locks (6 coded/keyed)	2011	3,352	335	10	335		433	53
54	Electrical (Dining/NRS)	2011	4,466	298	15	298		385	54
55	A/C Unit	2011	1,104	221	5	221		285	55
56	Utility Room Renovation Drywall/plumbing/electric/cabinets	2011	16,150	1,077	15	1,077		1,391	56
57	Landscaping	2011	7,890	526	15	526		679	57
58	Water Softener	2011	2,074	208	10	208		268	58
59	Installation of 61 overbed lights-Capitalized for Medicaid	2011	12,272	2,454	5	2,454		3,681	59
60	Addtl TCU Wing Renovation - generator/flooring	2011	23,658	3,380	7	3,380		5,070	60
61	Ceiling, Smoke Door & Door Replacement	2011	19,522	2,789	7	2,789		4,183	61
62	Replace 41 Windows - Capitalized for Medicaid	2011	6,070	1,214	5	1,214		1,821	62
63	Dining Room Wall Repair - Capitalized for Medicaid	2011	3,220	644	5	644		966	63
64	Laundry Room Ceiling/Lighting/Drywall/Painting-Cap for MCD	2011	5,769	1,154	5	1,154		1,731	64
65	Apoxoy Coating Front Porch Floor	2011	5,005	1,001	5	1,001		1,293	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,818,474	\$ 292,133		\$ 292,133		\$ 705,063	70

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

Facility Name & ID Number Stearns Nursing & Rehab Ctr

0046870

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,818,474	\$ 292,133		\$ 292,133	\$	\$ 705,063	1
2	Kitchen Sewer Line	2012	28,671	717	20	717		717	2
3	Additional new drains for sinks	2012	725	18	20	18		18	3
4	MagLock System Courtyard Gate	2012	4,800	87	10	87		87	4
5	Dietary Mixer Repair Capitalized for Medicaid	2012	2,873	478	3	478		478	5
6	Lobby/Lounge Door Hardware Capitalized for Medicaid	2012	4,360	727	3	727		727	6
7	Burnisher Repair Capitalized for Medicaid	2012	2,628	438	3	438		438	7
8	Sewer&DrainCleaning/Cableing,WaterLines-Cap for Medicaid	2012	4,698	783	3	783		783	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	Note: See additional building improvements made by former								24
25	property owner Healthcare REIT, Inc. on supplemental								25
26	schedule included as page 24 of the cost report.								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,867,229	\$ 295,381		\$ 295,381	\$	\$ 708,311	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	\$ 342,930	\$ 46,856	\$ 46,856	\$	various	\$ 155,326	71
72	Current Year Purchases	18,778	1,192	1,192		various	1,192	72
73	Fully Depreciated Assets	66,495				various	66,496	73
74								74
75	TOTALS	\$ 428,203	\$ 48,048	\$ 48,048	\$		\$ 223,014	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			\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	6,486,546
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	343,429
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	343,429
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)			\$	931,325

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

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A	N/A	N/A	\$ N/A	N/A	N/A	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: N/A
- *

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: \$ 53,421
- 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.	/2013	\$ N/A
13.	/2014	\$ N/A
14.	/2015	\$ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (114,828)	\$	1
2	Cash-Patient Deposits	20,703		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,172,738		3
4	Supply Inventory (priced at cost)	8,138		4
5	Short-Term Investments			5
6	Prepaid Insurance	449		6
7	Other Prepaid Expenses	7,810		7
8	Accounts Receivable (owners or related parties)	(3,016,938)		8
9	Other(specify): Non resident A/R (see TB)	4,330		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (917,598)	\$	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	74,237		15
16	Equipment, at Historical Cost	30,588		16
17	Accumulated Depreciation (book methods)	(9,206)		17
18	Deferred Charges	2,655		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	2,200		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 99,945	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (817,653)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 154,386	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,703		28
29	Short-Term Notes Payable	100,403		29
30	Accrued Salaries Payable	250,379		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,229		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,815		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	6,221		36
37	Accrued Expenses	448,063		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,044,199	\$	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)	\$ 1,044,199	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,861,852)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (817,653)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,009,935)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,009,935)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	234,083	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	44,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(130,000)	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)	\$ 148,083	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)	\$ (1,861,852)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Stearns Nursing & Rehab Ctr

0046870

Report Period Beginning: 1/1/12

Ending: 12/31/12

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	\$ 4,400,090	1
2	Discounts and Allowances for all Levels	1,304,224	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,704,314	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	510,416	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 510,416	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	797	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,027	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,171	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,995	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	291,747	28
28a	Purchase Discounts & Misc Revenue	52,042	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 343,789	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,565,544	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	901,649	31
32	Health Care	2,939,431	32
33	General Administration	1,483,740	33
	B. Capital Expense		
34	Ownership	545,611	34
	C. Ancillary Expense		
35	Special Cost Centers	222,754	35
36	Provider Participation Fee	238,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,331,461	40
41	Income before Income Taxes (line 30 minus line 40)**	234,083	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 234,083	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,975,469	44
45	Private Pay - Net Inpatient Revenue	729,669	45
46	Medicare - Net Inpatient Revenue	1,762,892	46
47	Other-(specify) <u>Hospice</u>	236,284	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,704,314	49

* 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	1,248	1,395	\$ 45,466	\$ 32.59	1
2	Assistant Director of Nursing	1,752	2,080	61,576	29.60	2
3	Registered Nurses	5,912	6,244	167,171	26.77	3
4	Licensed Practical Nurses	26,982	29,394	635,340	21.61	4
5	CNAs & Orderlies	70,424	75,642	796,969	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,769	1,966	35,331	17.97	9
10	Activity Assistants	3,041	3,290	30,182	9.17	10
11	Social Service Workers	3,273	3,655	52,835	14.46	11
12	Dietician					12
13	Food Service Supervisor	3,672	4,160	86,734	20.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,293	5,720	54,430	9.52	15
16	Dishwashers	9,136	9,825	86,724	8.83	16
17	Maintenance Workers	2,737	3,005	49,847	16.59	17
18	Housekeepers	13,662	14,536	141,083	9.71	18
19	Laundry	3,430	3,627	35,568	9.81	19
20	Administrator	1,960	2,080	105,089	50.52	20
21	Assistant Administrator	1,296	1,368	40,748	29.79	21
22	Other Administrative	3,531	3,964	59,875	15.10	22
23	Office Manager	1,186	1,383	22,985	16.62	23
24	Clerical	1,897	2,099	31,278	14.90	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(specify)	5,228	6,041	135,060	22.36	32
33	Other(specify)	2,494	2,787	34,028	12.21	33
34	TOTAL (lines 1 - 33)	169,923	184,261	\$ 2,708,319 *	\$ 14.70	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		\$		35
36	Medical Director	636	20,400	9-3	36
37	Medical Records Consultant	44	2,690	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18 per bed/mo	23,544	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	1,644	11-3	44
45	Social Service Consultant	28	1,644	12-3	45
46	Other(specify)				46
47	Medical Adm Record Preparation	\$5.50 per bed/mo	7,194	10-3	47
48					48
49	TOTAL (lines 35 - 48)	736	\$ 57,116		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	952	\$ 96,917	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	952	\$ 96,917		53

STATE OF ILLINOIS

Facility Name & ID Number

Stearns Nursing & Rehab Ctr

0046870

Report Period Beginning: 1/1/12

Page 21

Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Brett Hoffman

Administrator

0

\$ 105,089

Eileen Storz

Asst. Admin

0

40,748

Janice Bush

Bus. Office Mgr

0

12,884

A. Sims & A. Smith

Bus. Office Mgr

0

10,101

Angela Archer & Eric Olsson

Payroll

0

29,668

Lisa Dokes & Eric Olsson

HR

0

27,179

Miranda Scoggins

Admis Coordinator

0

32,696

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 258,365

B. Administrative - Other

Description

Amount

Tara Cares Administrative Services Fee

\$ 346,872

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 346,872

C. Professional Services

Vendor/Payee

Type

Amount

Freed, Maxick & Battaglia

Accounting Fees

\$ 2,437

Freed, Maxick & Battaglia

Tax Fees

2,740

Various Legal Fees - See attached listings

44,612

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 49,789

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ (10,109)

Unemployment Compensation Insurance

115,616

FICA Taxes

203,756

Employee Health Insurance

57,204

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Worker Compensation Safety Rec. Program

901

Employee Benefits - Other

8,375

Emploee Benefit - Short Term Disability

685

Employee Benefit- Hepatitis B Vaccination

Employee Benefit-Tuition Reimbursement

855

TOTAL (agree to Schedule V, line 22, col.8)

\$ 377,283

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

\$ 1,991

Advertising: Employee Recruitment

16,165

Health Care Worker Background Check

5,027

(Indicate # of checks performed 243)

Patient Background Checks

107

Facility Advertising

9,143

IL Health Care Assn/Chamber of Comm

7,082

Non-Allowable IHCA/Chamber of Comm

(5,110)

City Business License/Sams Club

205

Society for HR Mgr/MCAASSD Dues

210

Less: Public Relations Expense

()

Non-allowable advertising

(9,143)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 25,570

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

27,825

Seminar Expense

4,629

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 32,454

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number <u>Stearns Nursing & Rehab Ctr</u>	STATE OF ILLINOIS # <u>0046870</u>	Report Period Beginning: <u>1/1/12</u>	Page 23 Ending: <u>12/31/12</u>
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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 \$1,972 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. \$ 30,441 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. \$ 238,276
 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. \$ 797

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation. N/A
 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: 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) 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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center, LLC

0046870

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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 of Change of Ownership):								2
3									3
4	Cove Base	2006	16,775	1,398	12	1,398		9,086	4
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450		67,925	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		5			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		25,957	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		6,882	11
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	145	10	145		939	12
13	A/C Units (10)	2006	9,284		5			9,284	13
14	Carpeting	2006	3,894		5			3,894	14
15	Grease Trap	2005	8,421	648	13	648		4,858	15
16	Air Conditioning Units (6)	2005	3,818		5			3,818	16
17	Air Conditioning Units (5)	2005	2,600	200	13	200		1,500	17
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157		1,179	18
19	Doors (2)	2005	3,997	307	13	307		2,306	19
20	Replacement Windows	2005	6,555	655	10	655		4,916	20
21	Sprinkler System	2005	56,150	4,319	13	4,319		32,394	21
22	Fire Alarm System	2005	22,294	2,229	10	2,229		16,721	22
23	Closet Doors	2005	2,400	185	13	185		1,385	23
24	Smoke Damper	2005	700	70	10	70		525	24
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350		10,125	25
26	Replacement Doors	2005	1,697	131	13	131		979	26
27	Replacement Doors	2005	2,186	168	13	168		1,261	27
28	Compressor for Walk-in Freezer	2005	1,525	153	10	153		1,144	28
29	Air Conditioning Units (strip) (23)	2005	22,573		5			22,573	29
30	Doors	2005	3,092	238	13	238		1,784	30
31	Aspire Telephone System	2005	10,992	1,099	10	1,099		8,244	31
32	Fire Damper	2005	1,420	109	13	109		819	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		4,828	34
35	Exterior Siding	2006	6,440	644	10	644		4,186	35
36	Double Bowl Sinks (2)	2006	1,104	92	12	92		598	36
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750		4,875	37
38	TOTAL (lines 1 thru 37)		\$ 533,613	\$ 31,193		\$ 31,193	\$ 0	\$ 385,017	38

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