



Facility Name & ID Number Stearns Nursing & Rehabilitation Center# 0046870 Report Period Beginning: 1/1/08 Ending: 12/31/08

## 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>122</u>	Skilled (SNF)	<u>122</u>	<u>44,652</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>122</u>	TOTALS	<u>122</u>	<u>44,652</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,948</u>	<u>5,243</u>	<u>6,481</u>	<u>33,672</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>21,948</u>	<u>5,243</u>	<u>6,481</u>	<u>33,672</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.41%

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)

NoneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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 1/1/05

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 122 and days of care provided 3,741Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 1/1 to 12/31/08 Fiscal Year: 1/1 to 12/31/08

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

Facility Name & ID Number      Stearns Nursing & Rehabilitation Center      #      0046870      Report Period Beginning:      1/1/08      Ending:      12/31/08

**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	
	<b>A. General Services</b>											
1	Dietary	201,987	17,010	4,913	223,910		223,910	(35,546)	188,364			1
2	Food Purchase		164,610		164,610		164,610	(119)	164,491			2
3	Housekeeping	136,814	20,317	1,859	158,990		158,990	(47)	158,943			3
4	Laundry	31,237	12,637	130	44,004		44,004	(149)	43,855			4
5	Heat and Other Utilities			100,321	100,321		100,321		100,321			5
6	Maintenance	33,633	20,827	45,142	99,602		99,602	(4,738)	94,864			6
7	Other (specify):* see trial balance			13,381	13,381		13,381		13,381			7
8	<b>TOTAL General Services</b>	<b>403,671</b>	<b>235,401</b>	<b>165,746</b>	<b>804,818</b>		<b>804,818</b>	<b>(40,599)</b>	<b>764,219</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	1,588,641	196,683	133,416	1,918,740		1,918,740	(19,923)	1,898,817			10
10a	Therapy		983	807,096	808,079		808,079	(4,564)	803,515			10a
11	Activities	44,470	1,131	3,103	48,704		48,704		48,704			11
12	Social Services	36,968	58	2,585	39,611		39,611	(1,409)	38,202			12
13	CNA Training											13
14	Program Transportation			9	9		9		9			14
15	Other (specify):* see trial balance			16,907	16,907		16,907	(2,605)	14,302			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,670,079</b>	<b>198,855</b>	<b>983,516</b>	<b>2,852,450</b>		<b>2,852,450</b>	<b>(28,501)</b>	<b>2,823,949</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	184,057		300,456	484,513		484,513	(51,456)	433,057			17
18	Directors Fees											18
19	Professional Services			24,622	24,622		24,622	220	24,842			19
20	Dues, Fees, Subscriptions & Promotions			48,068	48,068		48,068	(6,525)	41,543			20
21	Clerical & General Office Expenses	651	38,867	126,842	166,360		166,360	(106,301)	60,059			21
22	Employee Benefits & Payroll Taxes			619,935	619,935		619,935	(15,945)	603,990			22
23	Inservice Training & Education											23
24	Travel and Seminar			63,407	63,407		63,407	(1,892)	61,515			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,826	13,826		13,826	(2,600)	11,226			26
27	Other (specify):* see trial balance			147,157	147,157		147,157	(121,300)	25,857			27
28	<b>TOTAL General Administration</b>	<b>184,708</b>	<b>38,867</b>	<b>1,344,313</b>	<b>1,567,888</b>		<b>1,567,888</b>	<b>(305,799)</b>	<b>1,262,089</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,258,458</b>	<b>473,123</b>	<b>2,493,575</b>	<b>5,225,156</b>		<b>5,225,156</b>	<b>(374,899)</b>	<b>4,850,257</b>			<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Stearns Nursing & Rehabilitation Center #0046870 Report Period Beginning: 1/1/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	<b>D. Ownership</b>										
30	Depreciation			74,435	74,435	74,435	6,993	81,428			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			139,102	139,102	139,102	(524)	138,578			32
33	Real Estate Taxes			75,530	75,530	75,530		75,530			33
34	Rent-Facility & Grounds			522,936	522,936	522,936		522,936			34
35	Rent-Equipment & Vehicles			61,899	61,899	61,899		61,899			35
36	Other (specify):* Amtz Debt Acq Costs			1,043	1,043	1,043		1,043			36
37	<b>TOTAL Ownership</b>			874,945	874,945	874,945	6,469	881,414			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			36	36	36		36			39
40	Barber and Beauty Shops			485	485	485		485			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			66,978	66,978	66,978		66,978			42
43	Other (specify):* see trial balance			141,321	141,321	141,321	(9,909)	131,412			43
44	<b>TOTAL Special Cost Centers</b>			208,820	208,820	208,820	(9,909)	198,911			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,258,458	473,123	3,577,340	6,308,921	6,308,921	(378,339)	5,930,582			45

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870

Report Period Beginning: 1/1/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(149)	4		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	(524)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,067)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	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	(61,255)	21		18
19	Entertainment				19
20	Contributions	(1,142)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	220	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(115,359)	27		24
25	Fund Raising, Advertising and Promotional	(7,775)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(133,184)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (321,354)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(56,985)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (56,985)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (378,339)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Stearns Nursing &amp; Rehabilitation Center

ID# 0046870

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Remove NonAllowable Admiss- Other Supplies	\$ (8,098)	21	1
2	Remove Employee Recognition Program	(1,229)	22	2
3	Offset Interco Sold Services Revenue	(20,064)	10	3
4	Offset Interco Sold Services Revenue	(35,546)	1	4
5	Offset Interco Sold Services Revenue	(1,376)	12	5
6	Offset Interco Sold Services Revenue	(13,728)	22	6
7	Remove Interco Purchased Services Mark-Up	(364)	27	7
8	Remove Interco Purchased Services Mark-Up	(550)	15	8
9	Remove Interco Purchased Services Mark-Up	(47)	3	9
10	Remove Interco Purchased Services Mark-Up	(33)	12	10
11	Remove Interco Purchased Services Mark-Up	(28)	6	11
12	Capitalize Repairs & maintenance for Medicaid	(4,710)	6	12
13	Amort/Depreciate of LHI Capitalized for Medicaid	6,993	30	13
14	Remove NonAllowable Visa Costs	(873)	24	14
15	Remove NonAllowable Visa Costs	(514)	22	15
16	Remove NonAllowable Insurance Costs	(2,600)	26	16
17	Remove NonAllowable Prior Year Costs	(9,483)	43	17
18	Remove NonAllowable Nrs Admin-Purch Svcs	(2,055)	15	18
19	Remove NonAllowable Admin-Franchise Tax	(34,306)	21	19
20	Remove NonAllowable Acctg-Tax Fees	(2,682)	27	20
21	Remove NonAllowable Admin-Other Pruch Svcs	(1,753)	27	21
22	Remove NonAllowable Admiss-Meals/Ent	(739)	24	22
23	Remove NonAllowable Admiss-Lodging	(280)	24	23
24	Remove NonAllowable EE background checks	1,250	20	24
25	Offset Misc. Revenue	(575)	21	25
26	Remove Med Records-Consulting/Mgmt Fees	206	10	26
27				27
28				28
29				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	<b>Total</b>	(133,184)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Stearns Nursing &amp; Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(35,546)	0	0	0	0	0	0	0	0	0	0	(35,546)	1
2	Food Purchase	(119)	0	0	0	0	0	0	0	0	0	0	(119)	2
3	Housekeeping	(47)	0	0	0	0	0	0	0	0	0	0	(47)	3
4	Laundry	(149)	0	0	0	0	0	0	0	0	0	0	(149)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,738)	0	0	0	0	0	0	0	0	0	0	(4,738)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(40,599)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,599)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(19,858)	(65)	0	0	0	0	0	0	0	0	0	(19,923)	10
10a	Therapy	0	(4,564)	0	0	0	0	0	0	0	0	0	(4,564)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(1,409)	0	0	0	0	0	0	0	0	0	0	(1,409)	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):*	(2,605)	0	0	0	0	0	0	0	0	0	0	(2,605)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(23,872)</b>	<b>(4,629)</b>	<b>0</b>	<b>(28,501)</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(51,456)	0	0	0	0	0	0	0	0	0	(51,456)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	220	0	0	0	0	0	0	0	0	0	0	220	19
20	Fees, Subscriptions & Promotions	(6,525)	0	0	0	0	0	0	0	0	0	0	(6,525)	20
21	Clerical & General Office Expenses	(106,301)	0	0	0	0	0	0	0	0	0	0	(106,301)	21
22	Employee Benefits & Payroll Taxes	(15,471)	(474)	0	0	0	0	0	0	0	0	0	(15,945)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,892)	0	0	0	0	0	0	0	0	0	0	(1,892)	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):*	(121,300)	0	0	0	0	0	0	0	0	0	0	(121,300)	27
28	<b>TOTAL General Administration</b>	<b>(253,869)</b>	<b>(51,930)</b>	<b>0</b>	<b>(305,799)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(318,340)</b>	<b>(56,559)</b>	<b>0</b>	<b>(374,899)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	6,993	0	0	0	0	0	0	0	0	0	0	6,993	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(524)	0	0	0	0	0	0	0	0	0	0	(524)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>6,469</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6,469</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(9,483)	(426)	0	0	0	0	0	0	0	0	0	(9,909)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(9,483)</b>	<b>(426)</b>	<b>0</b>	<b>(9,909)</b>	<b>44</b>								
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(321,354)</b>	<b>(56,985)</b>	<b>0</b>	<b>(378,339)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See attached schedule detailing information for Schedule VII, Section A				

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	\$ 300,456	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 249,000	\$ (51,456)	1
2	V	34	Sublease Building & Equip	522,936	Tara Midwest, LLC	0.00%	522,936		2
3	V	10	Pharmacy Consulting Services	19,032	Tara Pharmacy SE, LLC	0.00%	18,857	(175)	3
4	V	10	Medical Transcription	5,368	Tara Pharmacy SE, LLC	0.00%	5,478	110	4
5	V	43	Flu Vaccines for Residents	1,288	Tara Pharmacy SE, LLC	0.00%	862	(426)	5
6	V	22	Flu Vaccines for Employees	1,467	Tara Pharmacy SE, LLC	0.00%	993	(474)	6
7	V	10a	Physical Therapy Fees	322,071	Tara Therapy, LLC	0.00%	304,705	(17,366)	7
8	V	10a	Occupational Therapy Fees	246,979	Tara Therapy, LLC	0.00%	220,517	(26,462)	8
9	V	10a	Speech Therapy Fees	234,338	Tara Therapy, LLC	0.00%	273,602	39,264	9
10	V	32	Capital Interest Expense	139,102	Tara Midwest, LLC	0.00%	139,102		10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,793,037			\$ 1,736,052	\$ * (56,985)		14

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

Facility Name & ID Number      Stearns Nursing & Rehabilitation Center      #      0046870      Report Period Beginning:      1/1/08      Ending:      12/31/08

## 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	See Attachment	See attachment	50.00	See Attachment	See Attached	See Attached	See Attached	\$ See Attachmer	17	1
2	D & N, LLC	See Attachment	See attachment	50.00	See Attachment	See Attached	See Attached	See Attached	See Attachmer	17	2
3											3
4											4
5	Suzette Wilson	Vice President	See attachment	0.00	***			VP		17	5
6											6
7											7
8	*** Compensation paid only through Support Office and allocated share reported in column 7.										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 & Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending: 12/31/08

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	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>\$ 331,400</u>	<u>\$ 330,524</u>	<u>33,672</u>	<u>\$ 7,784</u>	1
2	5	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>54,676</u>	<u>0</u>	<u>33,672</u>	<u>1,284</u>	2
3	6	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>62,381</u>	<u>1,810</u>	<u>33,672</u>	<u>1,464</u>	3
4	17	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>7,614,392</u>	<u>7,614,392</u>	<u>33,672</u>	<u>178,852</u>	4
5	19	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>6,890</u>	<u>0</u>	<u>33,672</u>	<u>162</u>	5
6	20	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>24,654</u>	<u>0</u>	<u>33,672</u>	<u>579</u>	6
7	21	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>322,147</u>	<u>0</u>	<u>33,672</u>	<u>7,565</u>	7
8	22	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>1,019,506</u>	<u>0</u>	<u>33,672</u>	<u>23,947</u>	8
9	24	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>289,109</u>	<u>0</u>	<u>33,672</u>	<u>6,789</u>	9
10	25	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>347,091</u>	<u>0</u>	<u>33,672</u>	<u>8,152</u>	10
11	26	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>5,811</u>	<u>0</u>	<u>33,672</u>	<u>137</u>	11
12	27	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>77,338</u>	<u>0</u>	<u>33,672</u>	<u>1,815</u>	12
13	30	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>281,539</u>	<u>0</u>	<u>33,672</u>	<u>6,612</u>	13
14	31	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>35,842</u>	<u>0</u>	<u>33,672</u>	<u>842</u>	14
15	33	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>26,254</u>	<u>0</u>	<u>33,672</u>	<u>617</u>	15
16	34	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>93,028</u>	<u>0</u>	<u>33,672</u>	<u>2,185</u>	16
17	35	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,433,603</u>	<u>35</u>	<u>9,111</u>	<u>0</u>	<u>33,672</u>	<u>214</u>	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					<u>\$ 10,601,169</u>	<u>\$ 7,946,726</u>		<u>\$ 249,000</u>	25

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/08 Ending: 12/31/08

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Health Care REIT, Inc.		X	Acquisition of Operating Rights	Interest Only	12/31/04	\$ 2,156,000	\$ 2,156,000	6/30/2018	5.7500	\$ 124,008	1
2					until Maturity							2
3	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	1/23/06	348,950	115,551	1/23/2010	9.6300	15,094	3
4					with add'l 25 basis points each year							4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 2,504,950	\$ 2,271,551			\$ 139,102	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 2,504,950	\$ 2,271,551			\$ 139,102	15

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

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

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

**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 2007 report.		\$	<b>72,975</b>	<b>1</b>
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.)		\$	<b>71,933</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,042)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>76,572</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>75,530</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<b>59,259</b>	<b>8</b>	
	2004	<b>63,462</b>	<b>9</b>	
	2005	<b>66,201</b>	<b>10</b>	
	2006	<b>69,504</b>	<b>11</b>	
	2007	<b>71,933</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Stearns Nursing & Rehabilitation Center 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>22-1-20-09-07-201-013</u>	<u>3900 Stearns Avenue</u>	<u>\$ 71,932.68</u>	<u>\$ 71,932.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ 71,932.68</b>	<b>\$ 71,932.68</b>

**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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,542 B. General Construction Type: Exterior Masonry Frame Steel Reinforcement Number of Stories one

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

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

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

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

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

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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: 849,335 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 1/1/05. Costs allocated via related org cost & reported on Sch V.  
(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				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number Stearns Nursing &amp; Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Alumalite Front Sign		2005	515	52	10	52		180	9
10		Sign		2005	800	80	10	80		280	10
11		Electrical and Mechanical Repairs capitalized for Medicaid		2005	11,308	1,885	3	1,885		11,308	11
12		Cabinetry Install for Therapy Room		2006	10,980	915	12	915		2,288	12
13		Emergency Lights (outside)		2006	1,621	135	12	135		338	13
14		Painting - Back Railings		2006	3,780	756	5	756		1,890	14
15		Outside Lights		2006	1,419	118	12	118		296	15
16		Walkway		2006	2,100	175	12	175		438	16
17		Roof		2006	152,600	12,717	12	12,717		31,792	17
18		Cabinetry - Therapy Room		2006	2,433	203	12	203		507	18
19		Plumbing and Mechanical Repairs capitalized for Medicaid		2006	3,808	1,269	3	1,269		3,173	19
20		Plumbing and Mechanical Repairs capitalized for Medicaid		2007	9,163	3,054	3	3,054		4,581	20
21		Air Conditioners (10)		2007	10,033	2,508	4	2,508		3,762	21
22		Closet Doors		2007	7,675	698	11	698		1,047	22
23		Kitchen Hoods and Sprinklers		2007	11,130	1,012	11	1,012		1,518	23
24		Renovation of Resident Restrooms		2007	85,475	8,548	10	8,548		12,821	24
25		1 Resident Shower Room		2007	50,679	4,607	11	4,607		6,911	25
26		Guest Bathroom Renovation		2008	7,820	391	10	391		391	26
27		3 Shower Rooms		2008	61,673	3,084	10	3,084		3,084	27
28		Res bathrooms		2008	54,775	2,739	10	2,739		2,739	28
29		Comm Disposal		2008	987	49	10	49		49	29
30		Electrical & Floor Repair capitalized for Medicaid		2008	4,710	785	3	785		785	30
31		A/C Unites (5)		2008	2,150	215	5	215		215	31
32		Fire Alarm Motherboard		2008	3,165	158	10	158		158	32
33		Nurses Stations (North & South)		2008	34,900	1,744	10	1,744		1,744	33
34		Kitchen Upgrade		2008	44,605	2,230	10	2,230		2,230	34
35		Facility Sign		2008	11,365	568	10	568		568	35
36		Dish Machine		2008	14,180	709	10	709		709	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 & Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 605,850	\$ 51,404		\$ 51,404	\$	\$ 95,801	70

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 150,185	\$ 24,969	\$ 24,969	\$		\$ 71,200	71
72	Current Year Purchases	75,960	5,055	5,055			5,055	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 226,145	\$ 30,024	\$ 30,024	\$		\$ 76,255	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 831,995	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,428	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,428	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)	\$ 172,056	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CDW Direct- Kiosks License	\$ 209	92
93			93
94			94
95		\$ 209	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.

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:	<u>1972</u>	<u>122</u>	<u>1/1/05</u>	\$ <u>522,936</u>	<u>13.5 yrs</u>	<u>1-15yrs</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>122</b>		\$ <b>522,936</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 06/30/2018

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>12/31/2009</u>	\$	<u>522,936</u>
13.	<u>12/31/2010</u>	\$	<u>522,936</u>
14.	<u>12/31/2011</u>	\$	<u>522,936</u>

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: 60 days notice \*

**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: \$ 78,422 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	<u>See separate schedule</u>		\$ _____	\$ <u>400</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <b>400</b>	<b>21</b>

\* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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.)**

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	<b>TOTAL</b>			\$		\$	\$		\$	14

**NOTE:** This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Stearns Nursing & Rehabilitation Center# 0046870Report Period Beginning: 1/1/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (1,125,634)	\$	1
2	Cash-Patient Deposits	19,431		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,040,912		3
4	Supply Inventory (priced at <u>cost</u> )	7,675		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,197		6
7	Other Prepaid Expenses	24,673		7
8	Accounts Receivable (owners or related parties)	(2,086,837)		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	486		9
	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ (2,118,097)	\$	10
	<b>B. Long-Term Assets</b>			
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	576,861		15
16	Equipment, at Historical Cost	226,145		16
17	Accumulated Depreciation (book methods)	(152,210)		17
18	Deferred Charges	1,043		18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(1,313)		21
22	Other Long-Term Assets (spe <u>Long Term Deposits</u> )	600		22
23	Other(specify): <u>Construction in progress</u>	209		23
	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 651,335	\$	24
	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ (1,466,762)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 122,493	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,511		28
29	Short-Term Notes Payable	98,223		29
30	Accrued Salaries Payable	210,820		30
	Accrued Taxes Payable (excluding real estate taxes)	33,984		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,530		32
33	Accrued Interest Payable	927		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Employee Benefits Payable</u>	(6,146)		36
37	<u>Accrued Expenses</u>	546,354		37
	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,121,696	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,173,328		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Restricted Funds</u>			43
44				44
	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,173,328	\$	45
	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,295,024	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (4,761,786)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ (1,466,762)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,058,752)	1
2	Restatements (describe):		2
3	Prior Period Adjustment Operating Rights Impairment	(1,644,078)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,702,830)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,058,956)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,058,956)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (4,761,786)	24 *

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center# 0046870Report Period Beginning: 1/1/08Ending: 12/31/08**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,743,130	1
2	Discounts and Allowances for all Levels	832,600	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,575,730	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	619,859	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 619,859	8
<b>C. Other Operating Revenue</b>			
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	149	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,642	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4	20
21	Other Medical Services	2,003	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 5,798	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	636	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 636	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Prior Year Net Revenue</b>	(34,975)	28
28a	<b>Prch Disc / Vending Comm / Rebates / Sold Srvcs Rev</b>	82,917	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 47,942	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,249,965	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	804,818	31
32	Health Care	2,852,450	32
33	General Administration	1,567,888	33
<b>B. Capital Expense</b>			
34	Ownership	874,945	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	141,842	35
36	Provider Participation Fee	66,978	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,308,921	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,058,956)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,058,956)	43

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

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

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

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870

Report Period Beginning: 1/1/08

Ending:

12/31/08

**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	2,080	2,166	\$ 79,605	\$ 36.75	1
2	Assistant Director of Nursing	1,505	1,598	44,387	27.78	2
3	Registered Nurses	729	862	19,221	22.30	3
4	Licensed Practical Nurses	30,330	32,073	664,027	20.70	4
5	CNAs & Orderlies	63,723	67,106	642,324	9.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,637	1,825	26,784	14.68	9
10	Activity Assistants	1,930	2,079	17,686	8.51	10
11	Social Service Workers	2,253	2,366	36,968	15.62	11
12	Dietician					12
13	Food Service Supervisor	3,648	4,160	79,364	19.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,681	6,586	54,082	8.21	15
16	Dishwashers	8,237	8,778	68,541	7.81	16
17	Maintenance Workers	1,928	2,080	33,633	16.17	17
18	Housekeepers	15,603	16,336	136,814	8.38	18
19	Laundry	3,530	3,837	31,237	8.14	19
20	Administrator	3,221	3,398	107,354	31.59	20
21	Assistant Administrator					21
22	Other Administrative	1,360	1,592	27,120	17.04	22
23	Office Manager	2,002	2,090	31,633	15.14	23
24	Clerical	1,849	2,047	18,602	9.09	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 Coordinator	5,513	5,979	114,136	19.09	32
33	Other(specify) Nrsng Admin Cleric	2,186	2,321	24,940	10.75	33
34	TOTAL (lines 1 - 33)	158,945	169,279	\$ 2,258,458 *	\$ 13.34	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	0	\$ 0	1-3	35
36	Medical Director	120	20,400	9-3	36
37	Medical Records Consultant	54	3,182	10-3	37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	\$13 / bed	19,032	10-3	39
40	Physical Therapy Consultant	0	0		40
41	Occupational Therapy Consultant	0	0		41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	0		43
44	Activity Consultant	31	1,909	11-3	44
45	Social Service Consultant	32	1,945	12-3	45
46	Other(specify)	0	0		46
47	Medical Records Preparation	\$5.50/bed	5,368	10-3	47
48					48
49	TOTAL (lines 35 - 48)	237	\$ 51,836		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,314	\$ 86,726	10-3	50
51	Licensed Practical Nurses	243	6,179	10-3	51
52	Certified Nurse Assistants/Aides	99	1,773	10-3	52
53	TOTAL (lines 50 - 52)	1,656	\$ 94,678		53

Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870

Report Period Beginning: 1/1/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Earl Van Dusen	Administrator	0	\$ 3,583	Workers' Compensation Insurance	\$ 322,813	IDPH License Fee	\$ 995	
Brent Hoffman	Administrator	0	90,177	Unemployment Compensation Insurance	76,971	Advertising: Employee Recruitment	31,656	
				FICA Taxes	170,937	Health Care Worker Background Check	6,078	
				Employee Health Insurance	22,335	(Indicate # of checks performed <u>536</u> )		
Other Administrative Salaries		0	90,297	Employee Meals		Facility Advertising	1,409	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses/SamsClub/COCMAmembership	671	
				Employee Benefits - WC safety rec. prog	2,750	Chamber of Commerce	1,775	
				Employee Benefits - other	7,775	Non Allow Chamber of Commerce	(1,775)	
				Employee Benefits - Short Term Disability	409	IL Health Care Association	6,734	
						Non Allowable IL Health Care Assn	(4,591)	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 184,057</b>			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	(1,409)	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 41,543</b>	
Description			Amount					
Tara Cares Administrative Services Fee			\$ 300,456					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 300,456</b>					
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount	Description	Line #	Amount		
Ernst & Young	Accounting Fees		\$ 2,287					
Ernst & Young	Tax Fees		2,682					
Various - See Attached detailed listing	Legal Fees		19,653					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 24,622</b>	<b>TOTAL</b>		<b>\$</b>		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Stearns Nursing &amp; Rehabilitation Center

**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 \$2,143 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. \$ 31,526 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? x YES        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. \$ 66,978  
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. \$ 149
- (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: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. 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 &amp; ID Number Stearns Nursing &amp; Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/08

Ending:

12/31/08

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1			\$	\$		\$	\$	\$	1
2	Improvements Made by Landlord (covered by rent at outset of Change of Ownership):								2
3									3
4	Cove Base	2006	16,775	1,398	12	1,398		3,495	4
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450		26,125	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	23,683	5	23,683		59,208	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		9,983	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		2,647	11
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	145	10	145		361	12
13	A/C Units (10)	2006	9,284	1,857	5	1,857		4,642	13
14	Carpeting	2006	3,894	779	5	779		1,947	14
15	Grease Trap	2005	8,421	648	13	648		2,267	15
16	Air Conditioning Units (6)	2005	3,818	764	5	764		2,673	16
17	Air Conditioning Units (5)	2005	2,600	200	13	200		700	17
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157		550	18
19	Doors (2)	2005	3,997	307	13	307		1,076	19
20	Replacement Windows	2005	6,555	655	10	655		2,294	20
21	Sprinkler System	2005	56,150	4,319	13	4,319		15,117	21
22	Fire Alarm System	2005	22,294	2,229	10	2,229		7,803	22
23	Closet Doors	2005	2,400	185	13	185		646	23
24	Smoke Damper	2005	700	70	10	70		245	24
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350		4,725	25
26	Replacement Doors	2005	1,697	131	13	131		457	26
27	Replacement Doors	2005	2,185	168	13	168		588	27
28	Compressor for Walk-in Freezer	2005	1,525	153	10	153		534	28
29	Air Conditioning Units (strip) (23)	2005	22,573	4,515	5	4,515		15,801	29
30	Doors	2005	3,092	238	13	238		832	30
31	Aspire Telephone System	2005	10,992	1,099	10	1,099		3,847	31
32	Fire Damper	2005	1,420	109	13	109		382	32
33	Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617	2,323	5	2,323		8,132	33
34	Pave Walkway, Roadway, Turnaround	2005	5,150	644	8	644		2,253	34
35	Exterior Siding	2006	6,440	644	10	644		1,610	35
36	Double Bowl Sinks (2)	2006	1,104	92	12	92		230	36
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750		1,875	37
38	<b>TOTAL (lines 1 thru 37)</b>		\$ 533,612	\$ 65,113		\$ 65,113	\$ 0	\$ 183,047	38

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