



Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	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	17,873	5,621	5,437	28,931	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,873	5,621	5,437	28,931	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.97%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

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

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

YES  NO

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 3,173

Medicare 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 12/31/09 Fiscal Year: 1/1 to 12/31/09

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

**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	179,661	12,768	4,923	197,352		197,352	(15,239)	182,113		1
2	Food Purchase		153,802		153,802		153,802	(332)	153,470		2
3	Housekeeping	104,537	18,204	820	123,561		123,561		123,561		3
4	Laundry	42,465	11,110	124	53,699		53,699		53,699		4
5	Heat and Other Utilities			86,130	86,130		86,130		86,130		5
6	Maintenance	30,161	20,178	37,380	87,719		87,719	(8)	87,711		6
7	Other (specify):* see trial balance			13,072	13,072		13,072		13,072		7
8	<b>TOTAL General Services</b>	356,824	216,062	142,449	715,335		715,335	(15,579)	699,756		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	1,421,595	102,977	81,287	1,605,859		1,605,859	(11,503)	1,594,356		10
10a	Therapy		322	815,119	815,441		815,441	(94,788)	720,653		10a
11	Activities	49,325	2,208	4,122	55,655		55,655		55,655		11
12	Social Services	32,422	341	1,707	34,470		34,470		34,470		12
13	CNA Training										13
14	Program Transportation			266	266		266		266		14
15	Other (specify):* see trial balance			10,769	10,769		10,769	(7,753)	3,016		15
16	<b>TOTAL Health Care and Programs</b>	1,503,342	105,848	933,670	2,542,860		2,542,860	(114,044)	2,428,816		16
	<b>C. General Administration</b>										
17	Administrative	203,463		299,040	502,503		502,503	(67,422)	435,081		17
18	Directors Fees										18
19	Professional Services			25,133	25,133		25,133	(5,867)	19,266		19
20	Dues, Fees, Subscriptions & Promotions			30,340	30,340		30,340	(7,087)	23,253		20
21	Clerical & General Office Expenses		33,386	74,478	107,864		107,864	(50,541)	57,323		21
22	Employee Benefits & Payroll Taxes			234,006	234,006		234,006	(13,024)	220,982		22
23	Inservice Training & Education										23
24	Travel and Seminar			30,505	30,505		30,505	(94)	30,411		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			265,673	265,673		265,673	(2,600)	263,073		26
27	Other (specify):* see trial balance			90,868	90,868		90,868	(70,510)	20,358		27
28	<b>TOTAL General Administration</b>	203,463	33,386	1,050,043	1,286,892		1,286,892	(217,145)	1,069,747		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,063,629	355,296	2,126,162	4,545,087		4,545,087	(346,768)	4,198,319		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 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			96,506	96,506		96,506	5,259	101,765			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,542	58,542		58,542	(34)	58,508			32
33	Real Estate Taxes			79,970	79,970		79,970	633	80,603			33
34	Rent-Facility & Grounds			534,118	534,118		534,118		534,118			34
35	Rent-Equipment & Vehicles			29,838	29,838		29,838		29,838			35
36	Other (specify):* <b>Amtz Debt Acq Costs</b>			1,043	1,043		1,043		1,043			36
37	<b>TOTAL Ownership</b>			800,017	800,017		800,017	5,858	805,875			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			503	503		503	(10)	493			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* <b>see trial balance</b>			138,248	138,248		138,248	(23,381)	114,867			43
44	<b>TOTAL Special Cost Centers</b>			205,546	205,546		205,546	(23,391)	182,155			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,063,629	355,296	3,131,725	5,550,650		5,550,650	(364,301)	5,186,349			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: 1/1/09

Ending: 12/31/09

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(199)	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	(34)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,599)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(133)	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				18
19	Entertainment				19
20	Contributions	(1,393)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	767	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,143)	27		24
25	Fund Raising, Advertising and Promotional	(7,087)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(120,738)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (197,559)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(166,742)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (166,742)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (364,301)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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

<b>BHF USE ONLY</b>						
48		49		50		51
						52

## Stearns Nursing &amp; Rehabilitation Center

ID# 0046870

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admiss-Other Supplies	\$ (6,062)	21	1
2	Remove Non-allowable EE Recognition Program	(1,197)	22	2
3	Offset Interco Sold Services Revenue	(13,831)	10	3
4	Offset Interco Sold Services Revenue	(15,239)	1	4
5	Offset Interco Sold Services Revenue	(1,858)	17	5
6	Offset Interco Sold Services Revenue	(7,450)	22	6
7	Remove Interco Purchased Services Mark-up	(95)	27	7
8	Remove Interco Purchased Services Mark-up	(8)	6	8
9	Amort/Depreciate Repair/Maint Captl. For Medicaid	5,259	30	9
10	Remove Non-allowable Employee Benefits	(3,892)	22	10
11	Remove Non-allowable Visa Costs	(94)	24	11
12	Remove Non-allowable Visa Costs	(22)	22	12
13	Remove Non-allowable Insurance Costs	(2,600)	26	13
14	Remove Non-allowable Nrs Admin-Purch Svcs	(7,753)	15	14
15	Remove Non-allowable Admin. - Other Fees	(54)	27	15
16	Remove Non-allowable Admin Franchise Tax	(42,365)	21	16
17	Remove Non-allowable- Acctg - Tax Fees	(6,634)	19	17
18	Remove Non-allowable Admin Other Purchased Svcs	(1,825)	27	18
19	Remove Non-allowable Admin- Other Direct	(36)	21	19
20	Remove Non-allowable Barber and Beauty	(10)	40	20
21	Remove Non-allowable Prior Year costs	(14,862)	43	21
22	Remove Non-allowable IV Prescription Drug Costs	(264)	43	22
23	Offset Misc. Revenue	(479)	21	23
24	Remove Real Estate Tax Under/(Over) Accrual	633	33	24
25				25
26				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>		(120,738)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stearns Nursing & Rehabilitation Center# 0046870

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	(15,239)	0	0	0	0	0	0	0	0	0	0	(15,239)	1
2	Food Purchase	(332)	0	0	0	0	0	0	0	0	0	0	(332)	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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(15,579)</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>(15,579)</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	(13,831)	2,328	0	0	0	0	0	0	0	0	0	(11,503)	10
10a	Therapy	0	(94,788)	0	0	0	0	0	0	0	0	0	(94,788)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(7,753)	0	0	0	0	0	0	0	0	0	0	(7,753)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(21,584)</b>	<b>(92,460)</b>	<b>0</b>	<b>(114,044)</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	(1,858)	(65,564)	0	0	0	0	0	0	0	0	0	(67,422)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,867)	0	0	0	0	0	0	0	0	0	0	(5,867)	19
20	Fees, Subscriptions & Promotions	(7,087)	0	0	0	0	0	0	0	0	0	0	(7,087)	20
21	Clerical & General Office Expenses	(50,541)	0	0	0	0	0	0	0	0	0	0	(50,541)	21
22	Employee Benefits & Payroll Taxes	(12,561)	(463)	0	0	0	0	0	0	0	0	0	(13,024)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(94)	0	0	0	0	0	0	0	0	0	0	(94)	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):*	(70,510)	0	0	0	0	0	0	0	0	0	0	(70,510)	27
28	<b>TOTAL General Administration</b>	<b>(151,118)</b>	<b>(66,027)</b>	<b>0</b>	<b>(217,145)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(188,281)</b>	<b>(158,487)</b>	<b>0</b>	<b>(346,768)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nursing & Rehabilitation Center

# 0046870

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	5,259	0	0	0	0	0	0	0	0	0	0	5,259	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34)	0	0	0	0	0	0	0	0	0	0	(34)	32
33	Real Estate Taxes	633	0	0	0	0	0	0	0	0	0	0	633	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>5,858</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>5,858</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	(10)	0	0	0	0	0	0	0	0	0	0	(10)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,126)	(8,255)	0	0	0	0	0	0	0	0	0	(23,381)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(15,136)</b>	<b>(8,255)</b>	<b>0</b>	<b>(23,391)</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(197,559)</b>	<b>(166,742)</b>	<b>0</b>	<b>(364,301)</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	\$ 299,040	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 233,476	\$ (65,564)	1
2	V	34	Sublease Building & Equip	534,118	Tara Midwest, LLC	0.00%	534,118		2
3	V	10	Pharmacy Consulting Services	19,032	Tara Pharmacy SE, LLC	0.00%	20,557	1,525	3
4	V	10	Medication Administration Records	8,052	Tara Pharmacy SE, LLC	0.00%	8,855	803	4
5	V	43	Flu Vac/Prescription Drugs-Residents	36,816	Tara Pharmacy SE, LLC	0.00%	28,561	(8,255)	5
6	V	22	Flu/TB/HepB Vaccine for Employees	1,567	Tara Pharmacy SE, LLC	0.00%	1,104	(463)	6
7	V	10a	Physical Therapy Fees	320,934	Tara Therapy, LLC	0.00%	290,486	(30,448)	7
8	V	10a	Occupational Therapy Fees	290,740	Tara Therapy, LLC	0.00%	218,650	(72,090)	8
9	V	10a	Speech Therapy Fees	203,350	Tara Therapy, LLC	0.00%	211,100	7,750	9
10	V	32	Capital Interest Expense	55,430	Tara Midwest, LLC	0.00%	55,430		10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,769,079			\$ 1,602,337	\$ *	(166,742)	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: 1/1/09 Ending: 12/31/09

## 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	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/Admin	0.00	***	0.69	2.03	Fin/Adm TC	4,567	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/Admin	0.00	***	0.69	2.03	Fin/Adm TC	4,567	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.69	2.03	VP	3,712	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										
10											10
11											11
12											12
13								TOTAL	\$ 12,846		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:

1/1/09

Ending: 12/31/09

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

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

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

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	1,423,603	35	\$ 416,436	\$ 379,293	28,926	\$ 8,462	1
2	5	Administrative Services Costs	Days	1,423,603	35	37,610	0	28,926	764	2
3	6	Administrative Services Costs	Days	1,423,603	35	73,626	1,472	28,926	1,497	3
4	10	Administrative Services Costs	Days	1,423,603	35	2,221,486	2,101,998	28,926	45,138	4
5	17	Administrative Services Costs	Days	1,423,603	35	5,838,208	5,838,208	28,926	118,626	5
6	19	Administrative Services Costs	Days	1,423,603	35	24,843	0	28,926	505	6
7	20	Administrative Services Costs	Days	1,423,603	35	12,912	0	28,926	262	7
8	21	Administrative Services Costs	Days	1,423,603	35	300,184	0	28,926	6,099	8
9	22	Administrative Services Costs	Days	1,423,603	35	1,889,823	0	28,926	38,399	9
10	24	Administrative Services Costs	Days	1,423,603	35	149,650	0	28,926	3,041	10
11	26	Administrative Services Costs	Days	1,423,603	35	5,945	0	28,926	121	11
12	27	Administrative Services Costs	Days	1,423,603	35	111,064	0	28,926	2,257	12
13	30	Administrative Services Costs	Days	1,423,603	35	261,348	0	28,926	5,310	13
14	31	Administrative Services Costs	Days	1,423,603	35	15,588	0	28,926	317	14
15	33	Administrative Services Costs	Days	1,423,603	35	26,615	0	28,926	541	15
16	34	Administrative Services Costs	Days	1,423,603	35	103,418	0	28,926	2,101	16
17	35	Administrative Services Costs	Days	1,423,603	35	1,782	0	28,926	36	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 11,490,538	\$ 8,320,971		\$ 233,476	25

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/09 Ending: 12/31/09

**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		3	4	5	6		8	9	10	11						
		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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Health Care REIT, Inc.		X	Acquisition of Operating	Interst only	12/31/04	\$ 2,156,000	\$	6/1/2009	0.0575	\$ 51,670	1						
2				Rights	until Maturity							2						
3	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	1/23/06	348,950		6/1/2009	0.0989	3,760	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	\$			\$ 55,430	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	\$			\$ 55,430	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.	\$	<b>75,530</b>	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.)	\$	<b>76,163</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>633</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>79,970</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>80,603</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>63,462</b>	8
	2005	<b>66,201</b>	9
	2006	<b>69,504</b>	10
	2007	<b>71,933</b>	11
	2008	<b>76,163</b>	12

**2009 Real Estate Tax accrual was calculated by taking the 2008 Real Estate Tax bills divided by the 2008 assessment, the result was then multiplied by the estimated 2009 assessment. The 2009 assessment was estimated to be a 5% increase over the 2008 assessment.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>76,162.76</u>	\$ <u>76,162.76</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,542 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).

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: 659,477 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 1  
 (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:

1/1/09

Ending:

12/31/09

**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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		232	9
10		Sign	2005		800	80	10	80		360	10
11		<b>Electrical and Mechanical Repairs capitalized for Medicaid</b>	2005		11,308		3			11,308	11
12		Cabinetry Install for Therapy Room	2006		10,980	915	12	915		3,203	12
13		Emergency Lights (outside)	2006		1,621	135	12	135		473	13
14		Painting - Back Railings	2006		3,780	756	5	756		2,646	14
15		Outside Lights	2006		1,419	118	12	118		414	15
16		Walkway	2006		2,100	175	12	175		613	16
17		Roof	2006		152,600	12,717	12	12,717		44,508	17
18		Cabinetry - Therapy Room	2006		2,433	203	12	203		710	18
19		<b>Plumbing and Mechanical Repairs capitalized for Medicaid</b>	2006		3,808	635	3	635		3,808	19
20		<b>Plumbing and Mechanical Repairs capitalized for Medicaid</b>	2007		9,163	3,054	3	3,054		7,635	20
21		Air Conditioners (10)	2007		10,033	2,508	4	2,508		6,271	21
22		Closet Doors	2007		7,675	698	11	698		1,744	22
23		Kitchen Hoods and Sprinklers	2007		11,130	1,012	11	1,012		2,530	23
24		Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, paint	2007		85,475	8,548	10	8,548		21,369	24
25		1 Resident Shower Room- tile, mirrors, drains, fixtures, shut offs	2007		50,679	4,607	11	4,607		11,518	25
26		Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling	2008		7,820	782	10	782		1,173	26
27		3 Shower Rooms - tile, drains, shut offs, paint, faucets	2008		61,673	6,167	10	6,167		9,251	27
28		Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs	2008		54,775	5,478	10	5,478		8,216	28
29		Commercaill Disposal	2008		987	99	10	99		148	29
30		<b>Electrical &amp; Floor Repair capitalized for Medicaid</b>	2008		4,710	1,570	3	1,570		2,355	30
31		A/C Unites (5)	2008		2,150	430	5	430		645	31
32		Fire Alarm Motherboard	2008		3,165	317	10	317		475	32
33		Nurses Stations (North & South)	2008		34,900	3,490	10	3,490		5,235	33
34		Kitchen Upgrade-waste/water line, metal studs, interior partition, new electrical	2008		44,605	4,461	10	4,461		6,691	34
35		Facility Sign	2008		11,365	1,136	10	1,136		1,705	35
36		<b>Dish Machine</b>	2008		14,180	1,418	10	1,418		2,127	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:

1/1/09

Ending:

12/31/09

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	
37	Hot Water Heater Pump	2009	\$ 527	\$ 29	9	\$ 29	\$	\$ 29	37
38	Floor Installation	2009	40,021	2,223	9	2,223		2,223	38
39	Office Countertops	2009	1,259	70	9	70		70	39
40	100 Gallon Water Heater	2009	8,225	457	9	457		457	40
41	Direct TV Systems	2009	15,858	881	9	881		881	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	Note: See additional building improvements made by property								
64	owner Healthcare REIT, Inc. on supplemental schedule								
65	included as Page 24 of the cost report.								
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 671,739	\$ 65,219		\$ 65,219	\$	\$ 161,021	70

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

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	\$ 208,318	\$ 32,403	\$ 32,403	\$		\$ 94,396	71
72	Current Year Purchases	50,777	4,143	4,143			4,143	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 259,095	\$ 36,546	\$ 36,546	\$		\$ 98,539	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)	\$ 930,834	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,765	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,765	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)	\$ 259,560	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	Architect Fees	\$ 15,810	92
93	Application Fees to State	2,760	93
94			94
95		\$ 18,570	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>534,118</u>	<u>13.5</u>	<u>1-15 yr.</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		122		\$ <u>534,118</u>			7

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. 12/31/2010 \$ 540,995

13. 12/31/2011 \$ 540,995

14. 12/31/2012 \$ 540,995

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 day 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: \$ 31,876 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>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/09 Ending: 12/31/09  
**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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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**

# **0046870**

Report Period Beginning: **1/1/09**

Ending:

**12/31/09**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/09** (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	\$ 49,709	\$	1
2	Cash-Patient Deposits	45,235		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	638,592		3
4	Supply Inventory (priced at <u>cost</u> )	7,354		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,143		6
7	Other Prepaid Expenses	23,857		7
8	Accounts Receivable (owners or related parties)	(2,856,259)		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	10,937		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (2,079,432)	\$	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	642,750		15
16	Equipment, at Historical Cost	259,095		16
17	Accumulated Depreciation (book methods)	(234,454)		17
18	Deferred Charges	2,898		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(490)		21
22	Other Long-Term Assets (spec <u>Deposits long term</u> )	1,600		22
23	Other(specify): <u>Construction in progress</u>	18,570		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 689,969	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (1,389,463)	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 100,887	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,235		28
29	Short-Term Notes Payable	4,324		29
30	Accrued Salaries Payable	148,306		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,395		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,970		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Employee Benefits Payable</u>	1,244		36
37	<u>Accrued Expenses</u>	429,481		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 833,842	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Due To/From HC REIT</u>	193,154		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 193,154	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,026,996	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,416,459)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (1,389,463)	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,761,786)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,761,786)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(482,065)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	2,827,392	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)	\$ 2,345,327	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)	\$ (2,416,459)	24 *

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

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

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

		1		
Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 3,365,318	1	
2	Discounts and Allowances for all Levels	1,022,605	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,387,923	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	646,707	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 646,707	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	10	13	
14	Non-Patient Meals	199	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	3,905	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray	103	20	
21	Other Medical Services	128	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,345	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	4,870	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,870	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>Prior Year Net Revenue</b>	24,740	28	
28a	<b>Prch Disc / Vending Commissions / Sold Srvc Rev</b>		28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 24,740	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,068,585	30	

		2		
Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	715,335	31	
32	Health Care	2,542,860	32	
33	General Administration	1,286,892	33	
<b>B. Capital Expense</b>				
34	Ownership	800,017	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	138,751	35	
36	Provider Participation Fee	66,795	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,550,650	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(482,065)	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (482,065)	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:

1/1/09

Ending:

12/31/09

**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	1,776	2,000	\$ 71,714	\$ 35.86	1
2	Assistant Director of Nursing	1,888	2,080	52,998	25.48	2
3	Registered Nurses	1,756	1,924	51,608	26.82	3
4	Licensed Practical Nurses	25,037	26,734	566,667	21.20	4
5	CNAs & Orderlies	52,792	56,607	543,655	9.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,831	1,955	34,575	17.69	9
10	Activity Assistants	1,607	1,848	14,750	7.98	10
11	Social Service Workers	2,116	2,148	32,422	15.09	11
12	Dietician					12
13	Food Service Supervisor	3,256	3,680	62,750	17.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,791	6,291	53,773	8.55	15
16	Dishwashers	7,270	7,698	63,138	8.20	16
17	Maintenance Workers	1,820	2,057	30,161	14.66	17
18	Housekeepers	11,076	12,000	104,537	8.71	18
19	Laundry	4,745	4,942	42,465	8.59	19
20	Administrator	3,039	3,191	105,018	32.91	20
21	Assistant Administrator					21
22	Other Administrative	1,740	1,957	32,854	16.79	22
23	Office Manager	1,623	1,842	37,979	20.62	23
24	Clerical	2,011	2,166	27,612	12.75	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 C: MDS Coordinator	4,920	5,428	103,987	19.16	32
33	Other(specify) <u>Nrsg Admin Cleric</u>	2,353	2,538	30,966	12.20	33
34	TOTAL (lines 1 - 33)	138,447	149,086	\$ 2,063,629 *	\$ 13.84	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	33	\$ 1,605	1-3	35
36	Medical Director	120	20,400	9-3	36
37	Medical Records Consultant	44	2,670	10-3	37
38	Nurse Consultant			0	38
39	Pharmacist Consultant	\$13/bed	19,032	10-3	39
40	Physical Therapy Consultant			0	40
41	Occupational Therapy Consultant			0	41
42	Respiratory Therapy Consultant			0	42
43	Speech Therapy Consultant			0	43
44	Activity Consultant	27	1,707	11-3	44
45	Social Service Consultant	27	1,707	12-3	45
46	Other(specify)			0	46
47	<u>Medical Records Preparation</u>	\$5.50/bed	8,052	10-3	47
48					48
49	TOTAL (lines 35 - 48)	251	\$ 55,173		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	546	\$ 51,389	10-3	50
51	Licensed Practical Nurses			0	51
52	Certified Nurse Assistants/Aides	8	144	10-3	52
53	TOTAL (lines 50 - 52)	554	\$ 51,533		53

**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	
Brent Hoffman	Administrator	0	\$ 89,696	Workers' Compensation Insurance	\$ (27,181)	IDPH License Fee	\$ 995	
Barbara Maurer	Bus. Office Mgr	0	23,245	Unemployment Compensation Insurance	42,432	Advertising: Employee Recruitment	13,067	
Lisa Cuppy	Bus. Office Mgr	0	10,728	FICA Taxes	156,667	Health Care Worker Background Check	6,086	
Sondra Grindstaff	Bus. Office Mgr	0	3,708	Employee Health Insurance	31,751	(Indicate # of checks performed <u>398</u> )		
Eric Olsson	Payroll/AP	0	26,799	Employee Meals		Facility Advertising	2,597	
Tammy Hardesty	Admiss Coordinator	0	34,789	Illinois Municipal Retirement Fund (IMRF)*		Licenses/SamsClubMembership/Notary	329	
Tammy Harris	Human Resources	0	14,498	Employee Benefits - WC safety rec. prog	4,750	Chamber of Commerce	532	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Benefits - other	10,262	Non Allow Chamber of Commerce	(532)	
(List each licensed administrator separately.)			\$ 203,463	Employee Benefits - Short Term Disability	713	IL Health Care Association	6,734	
B. Administrative - Other				Employee Benefits - Hepatitis B Vaccination	1,588	Non Allowable IL Health Care Assn	(3,958)	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 220,982	
Tara Cares Administrative Services Fee			\$ 299,040	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 23,253	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 299,040	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description			Amount	
C. Professional Services				Line #				
Vendor/Payee	Type	Amount	Description			Amount		
Freed, Maxick & Battaglia	Accounting Fees	\$ 2,291	None in allowable cost					
Freed, Maxick & Battaglia	Tax Fees	6,634	(Column 8) of Schedule V					
Various Legal Fees - See Attached detailed listing		16,208						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,133					
				G. Schedule of Travel and Seminar**				
				Description			Amount	
				Out-of-State Travel			\$	
							25,580	
				In-State Travel				
				Seminar Expense			4,831	
				Entertainment Expense			( )	
				TOTAL (agree to Sch. V, line 24, col. 8)			\$ 30,411	

\* Attach copy of IMRF notifications

\*\*See instructions.

**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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Stearns Nursing & Rehabilitation Center# 0046870

Report Period Beginning:

1/1/09

Ending:

12/31/09**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 \$2,776 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. \$ 28,589 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. \$ 66,795  
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. \$ 199
- (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
- (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:

1/1/2009

Ending:

12/31/2009**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	<b>Improvements Made by Landlord (covered by rent at outset</b>								
3	<b>of Change of Ownership):</b>								
4	Cove Base	2006	16,775	1,398	12	1,398		4,893	4
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450		36,575	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		82,891	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		13,977	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		3,706	11
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	145	10	145		506	12
13	A/C Units (10)	2006	9,284	1,857	5	1,857		6,499	13
14	Carpeting	2006	3,894	779	5	779		2,726	14
15	Grease Trap	2005	8,421	648	13	648		2,915	15
16	Air Conditioning Units (6)	2005	3,818	764	5	764		3,436	16
17	Air Conditioning Units (5)	2005	2,600	200	13	200		900	17
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157		707	18
19	Doors (2)	2005	3,997	307	13	307		1,384	19
20	Replacement Windows	2005	6,555	655	10	655		2,949	20
21	Sprinkler System	2005	56,150	4,319	13	4,319		19,437	21
22	Fire Alarm System	2005	22,294	2,229	10	2,229		10,032	22
23	Closet Doors	2005	2,400	185	13	185		831	23
24	Smoke Damper	2005	700	70	10	70		315	24
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350		6,075	25
26	Replacement Doors	2005	1,697	131	13	131		587	26
27	Replacement Doors	2005	2,185	168	13	168		756	27
28	Compressor for Walk-in Freezer	2005	1,525	153	10	153		686	28
29	Air Conditioning Units (strip) (23)	2005	22,573	4,515	5	4,515		20,316	29
30	Doors	2005	3,092	238	13	238		1,070	30
31	Aspire Telephone System	2005	10,992	1,099	10	1,099		4,946	31
32	Fire Damper	2005	1,420	109	13	109		492	32
33	Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617	2,323	5	2,323		10,455	33
34	Pave Walkway, Roadway, Turnaround	2005	5,150	644	8	644		2,897	34
35	Exterior Siding	2006	6,440	644	10	644		2,254	35
36	Double Bowl Sinks (2)	2006	1,104	92	12	92		322	36
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750		2,625	37
38	<b>TOTAL (lines 1 thru 37)</b>		\$ 533,612	\$ 65,113		\$ 65,113	\$ 0	\$ 248,160	38

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