

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	Private Pay	4 Other		
8	SNF	20,840	5,895	5,915	32,650	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,840	5,895	5,915	32,650	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.07%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

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 109 and days of care provided 2,796

Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 1/1 to 12/31/13 Fiscal Year: 1/1 to 12/31/13
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

1/1/13

Ending:

12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	228,111	13,001	3,068	244,180		244,180	(28,298)	215,882		1
2	Food Purchase		179,470		179,470		179,470	(2,018)	177,452		2
3	Housekeeping	120,774	23,481		144,255		144,255	(138)	144,117		3
4	Laundry	43,012	8,839	619	52,470		52,470		52,470		4
5	Heat and Other Utilities			94,229	94,229		94,229		94,229		5
6	Maintenance	63,777	22,298	60,167	146,242		146,242	(34,195)	112,047		6
7	Other (specify):* see trial balance			33,805	33,805		33,805		33,805		7
8	TOTAL General Services	455,674	247,089	191,888	894,651		894,651	(64,649)	830,002		8
B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	1,933,020	118,823	53,079	2,104,922		2,104,922	(8,198)	2,096,724		10
10a	Therapy		1,820	422,613	424,433		424,433	38,156	462,589		10a
11	Activities	69,072	2,318	4,077	75,467		75,467		75,467		11
12	Social Services	55,193		1,539	56,732		56,732		56,732		12
13	CNA Training										13
14	Program Transportation			24,381	24,381		24,381	(30)	24,351		14
15	Other (specify):* see trial balance			25,403	25,403		25,403	(25,955)	(552)		15
16	TOTAL Health Care and Programs	2,057,285	122,961	551,492	2,731,738		2,731,738	3,973	2,735,711		16
C. General Administration											
17	Administrative	259,423		355,368	614,791		614,791	(152,022)	462,769		17
18	Directors Fees										18
19	Professional Services			54,458	54,458		54,458	(2,369)	52,089		19
20	Dues, Fees, Subscriptions & Promotions			43,109	43,109		43,109	(22,872)	20,237		20
21	Clerical & General Office Expenses	2,616	45,032	38,557	86,205		86,205	(171)	86,034		21
22	Employee Benefits & Payroll Taxes			561,088	561,088		561,088	(6,262)	554,826		22
23	Inservice Training & Education										23
24	Travel and Seminar			25,771	25,771		25,771	(28)	25,743		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,748	67,748		67,748	(2,600)	65,148		26
27	Other (specify):* see trial balance			258,637	258,637		258,637	(213,887)	44,750		27
28	TOTAL General Administration	262,039	45,032	1,404,736	1,711,807		1,711,807	(400,211)	1,311,596		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,774,998	415,082	2,148,116	5,338,196		5,338,196	(460,887)	4,877,309		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.

Facility Name & ID Number Stearns Nsg & Rehab Center

#0046870

Report Period Beginning:

1/1/13

Ending:

12/31/13

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	
30	D. Ownership											
	Depreciation			15,751	15,751		15,751	337,388	353,139			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,728	5,728		5,728	61,306	67,034			32
33	Real Estate Taxes			97,861	97,861		97,861		97,861			33
34	Rent-Facility & Grounds			256,073	256,073		256,073	(256,073)				34
35	Rent-Equipment & Vehicles			47,671	47,671		47,671		47,671			35
36	Other (specify):*											36
37	TOTAL Ownership			423,084	423,084		423,084	142,621	565,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportator											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		336	1,206	1,542		1,542		1,542			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			240,892	240,892		240,892		240,892			42
43	Other (specify):* <u>see trial balance</u>			195,921	195,921		195,921	(22,355)	173,566			43
44	TOTAL Special Cost Centers		336	438,019	438,355		438,355	(22,355)	416,000			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,774,998	415,418	3,009,219	6,199,635		6,199,635	(340,621)	5,859,014			45

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

VI. ADJUSTMENT DETAIL

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

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

	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	(916)	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	(62,189)	32		10
11 Discounts, Allowances, Rebates & Refunds	(165)	21		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(155)	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	(757)	27		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainer				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(218,226)	27		24
25 Fund Raising, Advertising and Promotional	(22,112)	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	(102,449)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (406,969)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

	1	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)	66,348		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 66,348		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (340,621)		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 TOTAL (C): (sum of lines 38-46)			\$		47

Stearns Nsg & Rehab Center

ID# 0046870

Report Period Beginning: 1/1/13

Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove non-allowable Admiss Professional Dues	\$ (760)	20	1
2	Remove non-allowable Nrs Admin Other Direct	(3,609)	15	2
3	Remove non-allowable Visa Cost	(28)	24	3
4	Remove non-allowable Insurance Cost	(2,600)	26	4
5	Remove non-allowable Nrs Admin Purch Svcs	(10,718)	15	5
6	Remove non-allowable Admiss Other Supplies	(11,325)	15	6
7	Remove non-allowable Tax Prep Fees	(2,369)	19	7
8	Remove non-allowable Admin Other Purch Svcs	(128)	27	8
9	Remove non-allow Outpatient Svcs Consol Billing	(465)	10	9
10	Remove non-allowable IV Prescription Drug costs	(5,032)	43	10
11	Remove non-allowable Prior Year costs	(334)	43	11
12	Offset Misc. Revenue Sch. XVII line 28a	(1,137)	10	12
13	Offset Misc. Revenue Sch. XVII line 28a	(46)	10	13
14	Offset Misc. Revenue Sch. XVII line 28a	(50)	6	14
15	Offset Misc. Revenue Sch. XVII line 28a	(716)	10	15
16	Offset Misc. Revenue Sch. XVII line 28a	(21)	10	16
17	Offset Misc. Revenue Sch. XVII line 28a	(6)	21	17
18	Offset Interco Sold Service Rev Sch XVII In 28a	(288)	10	18
19	Offset Interco Sold Service Rev Sch XVII In 28a	(241)	10	19
20	Offset Interco Sold Service Rev Sch XVII In 28a	(923)	10	20
21	Offset Interco Sold Service Rev Sch XVII In 28a	(691)	10	21
22	Offset Interco Sold Service Rev Sch XVII In 28a	(138)	3	22
23	Offset Interco Sold Service Rev Sch XVII In 28a	(116)	17	23
24	Offset Interco Sold Service Rev Sch XVII In 28a	(1,748)	6	24
25	Offset Interco Sold Service Rev Sch XVII In 28a	(1,112)	6	25
26	Offset Interco Sold Service Rev Sch XVII In 28a	(21,125)	1	26
27	Offset Interco Sold Service Rev Sch XVII In 28a	(7,173)	1	27
28	Offset Interco Sold Service Rev Sch XVII In 28a	(5,094)	17	28
29	Offset Interco Sold Service Rev Sch XVII In 28a	(3,373)	17	29
30	Offset Interco Sold Service Rev Sch XVII In 28a	(6,065)	22	30
31	Capitalize repairs & maintenance for Medicaid	(3,645)	6	31
32	Capitalize repairs & maintenance for Medicaid	(23,345)	6	32
33	Capitalize repairs & maintenance for Medicaid	(4,765)	6	33
34	Amort/Depreciate Repair Maint Captl for Medicaid	17,917	30	34
35	Remove Non-Allowable Dietary Raw Food	(947)	2	35
36	Remove non-allowable IV Prescription Drug costs	470	6	36
37	Remove non-allowable Depreciation Exp on LHI	(703)	30	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(102,449)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870 Report Period Beginning:

1/1/13

Ending:

12/31/13

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)	
	A. General Services													
1	Dietary	(28,298)	0	0	0	0	0	0	0	0	0	0	(28,298)	1
2	Food Purchase	(2,018)	0	0	0	0	0	0	0	0	0	0	(2,018)	2
3	Housekeeping	(138)	0	0	0	0	0	0	0	0	0	0	(138)	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	(34,195)	0	0	0	0	0	0	0	0	0	0	(34,195)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(64,649)	0	0	0	0	0	0	0	0	0	0	(64,649)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,528)	(3,670)	0	0	0	0	0	0	0	0	0	(8,198)	10
10a	Therapy	0	38,156	0	0	0	0	0	0	0	0	0	38,156	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	(30)	0	0	0	0	0	0	0	0	0	(30)	14
15	Other (specify):*	(25,652)	(303)	0	0	0	0	0	0	0	0	0	(25,955)	15
16	TOTAL Health Care and Programs	(30,180)	34,153	0	0	0	0	0	0	0	0	0	3,973	16
	C. General Administration													
17	Administrative	(8,583)	(143,439)	0	0	0	0	0	0	0	0	0	(152,022)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,369)	0	0	0	0	0	0	0	0	0	0	(2,369)	19
20	Fees, Subscriptions & Promotions	(22,872)	0	0	0	0	0	0	0	0	0	0	(22,872)	20
21	Clerical & General Office Expenses	(171)	0	0	0	0	0	0	0	0	0	0	(171)	21
22	Employee Benefits & Payroll Taxes	(6,065)	(197)	0	0	0	0	0	0	0	0	0	(6,262)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(28)	0	0	0	0	0	0	0	0	0	0	(28)	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):*	(219,111)	0	5,224	0	0	0	0	0	0	0	0	(213,887)	27
28	TOTAL General Administration	(261,799)	(143,636)	5,224	0	(400,211)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(356,628)	(109,483)	5,224	0	(460,887)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

1/1/13

Ending:

12/31/13

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)	
30	D. Ownership													
	Depreciation	17,214	0	320,174	0	0	0	0	0	0	0	0	337,388	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(62,189)	0	123,495	0	0	0	0	0	0	0	0	61,306	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(256,073)	0	0	0	0	0	0	0	0	(256,073)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(44,975)	0	187,596	0	142,621	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,366)	(52,635)	35,646	0	0	0	0	0	0	0	0	(22,355)	43
44	TOTAL Special Cost Centers	(5,366)	(52,635)	35,646	0	(22,355)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(406,969)	(162,118)	228,466	0	(340,621)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DTD HC, LLC	50%	Granite Nursing and Rehabilitation Center, LLC	Granite City	Tara Pharmacy SE, L	Birmingham	Pharmacy
D & N, LLC	50%	White Hall Nursing and Rehabilitation Center, LLC	White Hall	Tara Therapy, LLC	Orchard Park	Therapy
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Raimax Healthcare So	Orchard Park	Software
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Stearns Property Com	Granite City	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 Associates, LLC	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Gro	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d	Orchard Park	Support Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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 \$ 355,368	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 211,929	\$ (143,439) 1
2	V	14	Nursing Services 30	Tara Pharmacy SE, LLC	0.00%		(30) 2
3	V	10	Pharmacy Consulting Services 23,544	Tara Pharmacy SE, LLC	0.00%	20,639	(2,905) 3
4	V	10	Medication Administration Records 1,199	Tara Pharmacy SE, LLC	0.00%	434	(765) 4
5	V	43	Flu Vac/Prescription Drugs-Residents 168,125	Tara Pharmacy SE, LLC	0.00%	115,490	(52,635) 5
6	V	22	Flu/TB/HepB Vaccine for Employees 1,884	Tara Pharmacy SE, LLC	0.00%	1,687	(197) 6
7	V	10a	Physical Therapy Fees 207,192	Tara Therapy, LLC	0.00%	255,160	47,968 7
8	V	10a	Occupational Therapy Fees 146,898	Tara Therapy, LLC	0.00%	135,386	(11,512) 8
9	V	10a	Speech Therapy Fees 68,523	Tara Therapy, LLC	0.00%	70,223	1,700 9
10	V	15	Patient Care Software 3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,291	(2,309) 10
11	V	15	Wireless Access Points License Fee 229	Raimax Healthcare Solutions Group, LLC	0.00%	2,235	2,006 11
12	V						
13	V						
14	Total		\$ 976,592			\$ 814,474	\$ * (162,118) 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rent	\$ 256,073	Stearns Property Company, LLC	0.00%	\$	\$ (256,073)
16	V	30 Depreciation Leasehold Imp		Stearns Property Company, LLC	0.00%	170,949	170,949
17	V	30 Depreciation Major Moveable		Stearns Property Company, LLC	0.00%	41,554	41,554
18	V	30 Depreciation Bldg & Improve		Stearns Property Company, LLC	0.00%	107,178	107,178
19	V	27 Amort Loan Acquisition Costs		Stearns Property Company, LLC	0.00%	5,224	5,224
20	V	32 Interest-Capital/Long-Term Debt		Stearns Property Company, LLC	0.00%	123,495	123,495
21	V	43 Interest Expense - M.I.P.		Stearns Property Company, LLC	0.00%	35,646	35,646
22	V	30 Gain (Loss) on sale of Asset		Stearns Property Company, LLC	0.00%	493	493
23	V	1 Dietary Services	721	Scenic Nursing and Rehabilitation Center, LLC	0.00%	721	
24	V	27 Administrative Services	4,694	Riverside Nursing and Rehabilitation Center, LLC	0.00%	4,694	
25	V	15 Nursing Services	261	Granite Nursing and Rehabilitation Center, LLC	0.00%	261	
26	V	27 HR Services	2,513	Granite Nursing and Rehabilitation Center, LLC	0.00%	2,513	
27	V	27 Business Office Services	11,230	Granite Nursing and Rehabilitation Center, LLC	0.00%	11,230	
28	V	6 Maintenance Services	55	Granite Nursing and Rehabilitation Center, LLC	0.00%	55	
29	V	15 Nursing Services	288	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	288	
30	V	27 Administrative Services	349	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	349	
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 276,184			\$ 504,650	\$ * 228,466

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

Facility Name & ID Number

Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

1/1/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Jonesboro Nursing and Rehabilitation Center, L	Jonesboro				1
2			Lake City Nursing and Rehabilitation Center, L	Lake City				2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile				3
4			Florence Nursing and Rehabilitation Center, LL	Florence				4
5			Birmingham Nrs&Rehab Center East, LLC	Birmingham				5
6			Birmingham Nursing and Rehabilitation Center,	Birmingham				6
7			Eight Mile Nursing and Rehabilitation Center, L	Eight Mile				7
8			North Hill Nursing and Rehabilitation Center, L	North Hill				8
9			Elba Nursing and Rehabilitation Center, LLC	Elba				9
10			Quince Nursing and Rehabilitation Center, LLC	Memphis				10
11			Allenbrooke Nursing and Rehabilitation Center,	Memphis				11
12			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo				12
13			Brandon Nursing and Rehabilitation Center, LL	Brandon				13
14			Lakeland Nursing and Rehabilitation Center, LI	Jackson				14
15			McComb Nursing and Rehabilitation Center, LI	McComb				15
16			Cleveland Nursing and Rehabilitation Center, L	Cleveland				16
17			Chadwick Nursing and Rehabilitation Center, L	Jackson				17
18			Manhattan Nursing and Rehabilitation Center, I	Jackson				18
19			Ruleville Nursing and Rehabilitation Center, LL	Ruleville				19
20			Farmerville Nursing and Rehabilitation Center,	Farmerville				20
21			Bernice Nursing and Rehabilitation Center, LLC	Bernice				21
22			Ruston Nursing and Rehabilitation Center, LLC	Ruston				22
23			Natchitoches Nursing and Rehabilitation Center	Natchitoches				23
24			Winnfield Nursing and Rehabilitation Center, L	Winnfield				24
25			Ringgold Nursing and Rehabilitation Center, LI	Ringgold				25
26			Arcadia Nursing and Rehabilitation Center, LL	Arcadia				26
27			Jena Nursing and Rehabilitation Center, LLC	Jena				27
28								28
29			** The above listed facilities are related by					29
30			common ownership					30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.71	1.78	Fin/ Adm. of TC	5,102	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.71	1.78	Fin/ Adm. of TC	5,102	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.71	1.78	VP of TC	4,143	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	\$ 14,347		13

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

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

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870 Report Period Beginning: 1/1/13

Ending: 12/31/13

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	Total Costs	41	\$ 346,431	\$ 263,368	5,781,636	\$ 5,672	1	
2	5	Administrative Services Costs	Days	37	41,284	0	32,629	913	2	
3	6	Administrative Services Costs	Days	37	71,472	0	32,629	1,581	3	
4	10	Administrative Services Costs	Total Costs	41	3,382,826	2,681,559	5,781,636	55,388	4	
5	17	Administrative Services Costs	Days	37	5,196,557	5,196,557	32,629	114,823	5	
6	19	Administrative Services Costs	Days	37	31,367	0	32,629	693	6	
7	20	Administrative Services Costs	Days	37	12,440	0	32,629	274	7	
8	21	Administrative Services Costs	Days	37	241,710	0	32,629	5,342	8	
9	22	Administrative Services Costs	Days	37	802,842	0	32,629	17,740	9	
10	24	Administrative Services Costs	Days	37	105,969	0	32,629	2,344	10	
11	26	Administrative Services Costs	Days	37	7,389	0	32,629	163	11	
12	27	Administrative Services Costs	Days	37	62,648	0	32,629	1,385	12	
13	30	Administrative Services Costs	Days	37	165,080	0	32,629	3,648	13	
14	31	Administrative Services Costs	Days	37	10,708	0	32,629	237	14	
15	32	Administrative Services Costs	Days	37	278	0	32,629	6	15	
16	33	Administrative Services Costs	Days	37	29,222	0	32,629	646	16	
17	34	Administrative Services Costs	Days	37	47,896	0	32,629	1,058	17	
18	35	Administrative Services Costs	Days	37	718	0	32,629	16	18	
19									19	
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42 CRF 421.404.								22
23									23	
24									24	
25	TOTALS				\$ 10,556,837	\$ 8,141,484		\$ 211,929	25	

Facility Name & ID Number Stearns Nsg & Rehab Center # 0046870 Report Period Beginning: 1/1/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lancaster Pollard Mortgage Company	X	Refinance purchase of plant	\$19,041.05	6/20/12	\$ 4,566,200	\$ 4,454,032	7/1/47	0.0275	\$ 123,495	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	M&T BANK	X	Working capital - floating balan	\$329.83	6/26/09	4,324	77,403	demand not	0.0450	3,958	6									
7											7									
8											8									
9	TOTAL Facility Related			\$19,370.88		\$ 4,570,524	\$ 4,531,435			\$ 127,453	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 4,570,524	\$ 4,531,435			\$ 127,453	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,151 Line # 34

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	86,850	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.)		\$	90,101			2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,251			3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	94,600			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$				5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$				6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		\$	97,851			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2008	76,163	8	FOR BHF USE ONLY	
		2009	78,257	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$
		2010	80,241	10	14	PLUS APPEAL COST FROM LINE 5 \$
		2011	82,717	11	15	LESS REFUND FROM LINE 6 \$
		2012	90,101	12	16	AMOUNT TO USE FOR RATE CALCULATION\$
The 2013 assessment was estimated to be a 5% increase over the 2012 assessment.						

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stearns Nsg & Rehab Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046870

CONTACT PERSON REGARDING THIS REPORT 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>22-1-20-09-07-201-013</u>	<u>3900 Stearns Avenue</u>	\$ <u>90,100.60</u>	\$ <u>90,100.60</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>90,100.60</u></u>	\$ <u><u>90,100.60</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 32,477 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: 136,427 2. Number of Years Over Which it is Being Amortized: 5 Years (60 Months)
 3. Current Period Amortization: Included in Schedule VII N ln 1-8 4. Dates Incurred: Various and on the books of related entities

Nature of Costs: Inc.CapitalizedPre-openingSalaries,Benefits&OtherCostsIncurred2007,2009&2010.AllocatedViaRelatedOrgCost&ReportedSchVII B
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	109	2011	1972	\$ 4,287,120	\$ 107,178	40	\$ 107,178	\$	\$ 267,945	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Alumalite Front Sign	2005		515	52	10	52		438	9
10	Sign	2005		800	80	10	80		680	10
11	Electrical and Mechanical Repairs capitalized for Medicaid	2005		11,308		3			11,308	11
12	Cabinetry Install for Therapy Room	2006		10,980	915	12	915		6,863	12
13	Emergency Lights (outside)	2006		1,621	135	12	135		1,013	13
14	Painting - Back Railings	2006		3,780		5			3,780	14
15	Outside Lights	2006		1,419	118	12	118		886	15
16	Walkway	2006		2,100	175	12	175		1,312	16
17	Roof	2006		152,600	12,717	12	12,717		95,375	17
18	Cabinetry - Therapy Room	2006		2,433	203	12	203		1,521	18
19	Plumbing and Mechanical Repairs capitalized for Medicaid	2006		3,808		3			3,808	19
20	Plumbing and Mechanical Repairs capitalized for Medicaid	2007		9,163		3			9,163	20
21	Air Conditioners (10)	2007		10,033		4			10,033	21
22	Closet Doors	2007		7,675	698	11	698		4,536	22
23	Kitchen Hoods and Sprinklers	2007		11,130	1,012	11	1,012		6,577	23
24	Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, pain	2007		85,475	8,548	10	8,548		55,559	24
25	1 Resident Shower Room- tile, mirrors, drains, fixtures, shut off:	2007		50,679	4,607	11	4,607		29,947	25
26	Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling	2008		7,820	782	10	782		4,301	26
27	3 Shower Rooms - tile, drains, shut offs, paint, faucets	2008		61,673	6,167	10	6,167		33,920	27
28	Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs	2008		54,775	5,477	10	5,477		30,126	28
29	Commercial Disposal	2008			49	10	49			29
30	Electrical & Floor Repair capitalized for Medicaid	2008		4,710		3			4,710	30
31	A/C Unites (5)	2008		2,150	215	5	215		2,150	31
32	Fire Alarm Motherboard	2008		3,165	316	10	316		1,740	32
33	Nurses Stations (North & South)	2008		34,900	3,490	10	3,490		19,195	33
34	Kitchen Upgrade-waste/water line, metal studs, interior partition, new electric	2008		44,605	4,460	10	4,460		24,532	34
35	Facility Sign	2008		11,365	1,137	10	1,137		6,251	35
36	Dish Machine	2008		14,180	1,418	10	1,418		7,799	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37	Hot Water Heater Pump	2009	\$ 527	\$ 59	9	\$ 59	\$	\$ 264	37	
38	Floor Installation	2009	40,021	4,447	9	4,447		20,011	38	
39	Office Countertops	2009	1,259	140	9	140		630	39	
40	Water Heater 100 Gallon & Pump	2009	8,225	914	9	914		4,113	40	
41	Direct TV Systems	2009	15,858	1,762	9	1,762		7,929	41	
42	Water Heater	2010	6,800	850	8	850		2,975	42	
43	Water Heater (100 gallon)	2010	8,200	1,025	8	1,025		3,588	43	
44	Phone System Upgrade (Nurse Station)	2010	1,061	133	8	133		465	44	
45	Back Door / frame replacement	2010	3,409	426	8	426		1,491	45	
46	Awning	Removed on Audit	2010		8				46	
47	Keypad (Electric - Lock)	Removed on Audit	2010		8				47	
48	Lighting & Room Signage capitalized for Medicaid		2010	13,829	2,304	3	2,304		13,829	48
49	Shed (Oxygen)	Removed on Audit	2011		7				49	
50	A/C Unit	Removed on Audit	2011		5				50	
51	TCU Wing Renovation		2011	630,780	90,111	7	90,111		225,278	51
52	Ceiling & Door Replacement		2011	80,229	11,461	7	11,461		28,653	52
53	Locks (6 coded/keved)		2011	3,352	335	10	335		768	53
54	Electrical (Dining/NRS)		2011	4,466	298	15	298		683	54
55	A/C Unit		2011	1,104	221	5	221		506	55
56	Utility Room Renovation Drywall/plumbing/electric/cabinets		2011	16,150	1,077	15	1,077		2,468	56
57	Landscaping		2011	7,890	526	15	526		1,205	57
58	Water Softener		2011	2,074	207	10	207		475	58
59	Installation of 61 overbed lights-Capitalized for Medicaid		2011	12,272	2,454	5	2,454		6,135	59
60	Addtl TCU Wing Renovation - generator/flooring		2011	23,658	3,380	7	3,380		8,450	60
61	Ceiling, Smoke Door & Door Replacement		2011	19,522	2,789	7	2,789		6,972	61
62	Replace 41 Windows - Capitalized for Medicaid		2011	6,070	1,214	5	1,214		3,035	62
63	Dining Room Wall Repair - Capitalized for Medicaid		2011	3,220	645	5	645		1,611	63
64	Laundry Room Ceiling/Lighting/Drywall/Painting-Cap for MCD		2011	5,769	1,154	5	1,154		2,885	64
65	Apoxy Coating Front Porch Floor		2011	5,005	1,001	5	1,001		2,294	65
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 5,812,732	\$ 288,882		\$ 288,882	\$	\$ 992,181	70	

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 5,812,732	\$ 288,882		\$ 288,882	\$	\$ 992,181		1
2	Kitchen Sewer Line	2012 28,671	1,433	20	1,433		2,150		2
3	Additional new drains for sinks	2012 725	36	20	36		54		3
4	MagLock System Courtyard Gate	2012 4,800	480	10	480		567		4
5	Dietary Mixer Repair Capitalized for Medicaid	2012 2,873	956	3	956		1,434		5
6	Lobby/Lounge Door Hardware Capitalized for Medicaid	2012 4,360	1,455	3	1,455		2,182		6
7	Burnisher Repair Capitalized for Medicaid	2012 2,628	876	3	876		1,314		7
8	Sewer&DrainCleaning/Cableing,WaterLines-Cap for Medicaid	2012 4,698	1,566	3	1,566		2,349		8
9	RAC PTAC Unit	2013 672	67	5	67		67		9
10	81 gal Water Heater	2013 6,577	329	10	329		329		10
11	Cabling Installation for Wireless Access Point	2013 2,589	65	20	65		65		11
12	Asphalt parking lot	2013 49,183	3,074	8	3,074		3,074		12
13	Plumbing,Sprinkler,Wall&Burnisher Repairs - Cap for MCD	2013 31,755	5,292	3	5,292		5,292		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Note: See additional building improvements made by former								24
25	property owner Healthcare REIT, Inc. on supplemental								25
26	schedule included as page 24 of the cost report.								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,952,263	\$ 304,511		\$ 304,511	\$	\$ 1,011,058		34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 328,217	\$ 43,778	\$ 43,778	\$	various	\$ 168,864	71
72	Current Year Purchases	25,871	2,294	2,294		various	2,294	72
73	Fully Depreciated Assets	99,991	2,063	2,063		various	99,991	73
74								74
75	TOTALS	\$ 454,079	\$ 48,135	\$ 48,135	\$		\$ 271,149	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 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)	\$ 6,597,456	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 352,646	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 352,646	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)	\$ 1,282,207	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning: 1/1/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	\$ <u>N/A</u>	<u>N/A</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 47,427 Description: see separate schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2014 \$ N/A

13. /2015 \$ N/A

14. /2016 \$ N/A

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

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

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?</p> <p style="text-align: right;"> <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><i>*Response to No: Facility required employees to be certified prior to employment.</i></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			
	1 Drop-outs	2 Completed	3 Contract	4 Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies				
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 CNA Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

1	Service	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				
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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ (3,200)	\$ 1
2	Cash-Patient Deposits	26,037	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,283,553	3
4	Supply Inventory (priced at <u>cost</u>)	9,373	4
5	Short-Term Investments		5
6	Prepaid Insurance	413	6
7	Other Prepaid Expenses	4,886	7
8	Accounts Receivable (owners or related parties)	(1,620,478)	8
9	Other(specify): <u>Non resident A/R (see TB)</u>	3,280	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (296,136)	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cos	134,099	15
16	Equipment, at Historical Cost	56,459	16
17	Accumulated Depreciation (book methods)	(24,958)	17
18	Deferred Charges	885	18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds	(654)	21
22	Other Long-Term Assets (spec <u>Deposits-Long Term</u>)	2,200	22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 168,031	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (128,105)	\$ 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 176,408	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	26,517	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	251,063	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,679	31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,251	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	<u>Employee Benefits Payable</u>	6,329	36
37	<u>Accrued Expenses</u>	326,911	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 807,158	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 807,158	\$ 46
47	TOTAL EQUITY (page 18, line 24)	\$ (935,263)	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (128,105)	\$ 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,861,852)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,861,852)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(354,638)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,291,227	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(10,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 926,589	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (935,263)	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,600,234	1
2	Discounts and Allowances for all Levels	823,118	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,423,352	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	286,174	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 286,174	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	916	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,074	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	69	20
21	Other Medical Services	4,542	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,601	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	62,189	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,189	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	14,453	28
28a	Purchase Discounts & Misc Revenue	50,228	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 64,681	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,844,997	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	894,651	31
32	Health Care	2,731,738	32
33	General Administration	1,711,807	33
B. Capital Expense			
34	Ownership	423,084	34
C. Ancillary Expense			
35	Special Cost Centers	197,463	35
36	Provider Participation Fee	240,892	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,199,635	40
41	Income before Income Taxes (line 30 minus line 40)**	(354,638)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (354,638)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,776,142	44
45	Private Pay - Net Inpatient Revenue	836,999	45
46	Medicare - Net Inpatient Revenue	1,425,277	46
47	Other-(specify) Hospice Contract	384,934	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,423,352	49

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

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

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

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

Facility Name & ID Number Stearns Nsg & Rehab Center

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	1,664	1,784	\$ 75,522	\$ 42.33	1
2	Assistant Director of Nursing	1,896	2,080	63,314	30.44	2
3	Registered Nurses	7,833	8,105	222,221	27.42	3
4	Licensed Practical Nurses	26,158	28,017	613,376	21.89	4
5	CNAs & Orderlies	72,900	77,465	806,412	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,908	2,038	38,500	18.89	9
10	Activity Assistants	3,051	3,325	30,572	9.19	10
11	Social Service Workers	2,939	3,307	55,193	16.69	11
12	Dietician					12
13	Food Service Supervisor	3,359	3,824	81,237	21.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,498	5,021	52,469	10.45	15
16	Dishwashers	10,052	10,731	94,405	8.80	16
17	Maintenance Workers	3,493	3,962	63,777	16.10	17
18	Housekeepers	11,820	12,908	120,774	9.36	18
19	Laundry	4,379	4,593	43,012	9.36	19
20	Administrator	1,712	2,080	100,766	48.45	20
21	Assistant Administrator	888	936	21,381	22.84	21
22	Other Administrative	3,512	3,721	76,149	20.46	22
23	Office Manager	1,933	2,012	32,228	16.02	23
24	Clerical	2,143	2,352	31,515	13.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,972	2,163	28,060	12.97	31
32	Other Health Care(specify)	4,796	5,490	122,915	22.39	32
33	Other(specify) Central Supply	28	39	1,200	30.77	33
34	TOTAL (lines 1 - 33)	172,934	185,953	\$ 2,774,998 *	\$ 14.92	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	648	20,400	9-3	36
37	Medical Records Consultant	45	2,745	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18 per bed/mo	23,544	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,539	11-3	44
45	Social Service Consultant	26	1,539	12-3	45
46	Other(specify)				46
47	Medical Adm Record Preparation	\$5.50 per bed/mo	1,199	10-3	47
48					48
49	TOTAL (lines 35 - 48)	745	\$ 50,966		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	338	\$ 25,591	10-3	50
51	Licensed Practical Nurses	N/A	0		51
52	Certified Nurse Assistants/Aides	N/A	0		52
53	TOTAL (lines 50 - 52)	338	\$ 25,591		53

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

1/1/13

Ending:

12/31/13

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$1,695 net of non-allowable
- (3) Did the nursing home make political contributions or payments to a political 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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,354 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 240,892
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 benefit on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 916
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of service 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:

1/1/2013

Ending: 12/31/2013

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
2	Improvements Made by Healthcare REIT (covered by rent at outset								
3	of Change of Ownership):								
4	Cove Base	2006	16,775	1,398	12	1,398		10,484	4
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450		78,375	5
6	Sprinkler System Addl Cost Post 6/30/06	2006	4,750						6
7	Painting of Facility Cost @ 6/30/06	2006	117,665		5			118,415	7
8	Painting of Facility Addl Cost Post 6/30/06	2006	750						8
9	Exterior Siding Cost @ 6/30/06	2006	54,360	3,993	12	3,993		29,950	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		7,941	11
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	145	10	145		1,084	12
13	A/C Units (10)	2006	9,284		5			9,284	13
14	Carpeting	2006	3,894		5			3,894	14
15	Grease Trap	2005	8,421	648	13	648		5,506	15
16	Air Conditioning Units (6)	2005	3,818		5			3,818	16
17	Air Conditioning Units (5)	2005	2,600	200	13	200		1,700	17
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157		1,336	18
19	Doors (2)	2005	3,997	307	13	307		2,613	19
20	Replacement Windows	2005	6,555	655	10	655		5,571	20
21	Sprinkler System	2005	56,150	4,319	13	4,319		36,713	21
22	Fire Alarm System	2005	22,294	2,229	10	2,229		18,950	22
23	Closet Doors	2005	2,400	185	13	185		1,570	23
24	Smoke Damper	2005	700	70	10	70		595	24
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350		11,475	25
26	Replacement Doors	2005	1,697	131	13	131		1,110	26
27	Replacement Doors	2005	2,186	168	13	168		1,429	27
28	Compressor for Walk-in Freezer	2005	1,525	152	10	152		1,297	28
29	Air Conditioning Units (strip) (23)	2005	22,573		5			22,573	29
30	Doors	2005	3,092	238	13	238		2,022	30
31	Aspire Telephone System	2005	10,992	1,099	10	1,099		9,343	31
32	Fire Damper	2005	1,420	109	13	109		928	32
33	Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617		5			11,617	33
34	Pave Walkway, Roadway, Turnaround	2005	5,150	322	8	322		5,150	34
35	Exterior Siding	2006	6,440	644	10	644		4,830	35
36	Double Bowl Sinks (2)	2006	1,104	92	12	92		690	36
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750		5,625	37
38	TOTAL (lines 1 thru 37)		\$ 533,613	\$ 30,870		\$ 30,870	\$ 0	\$ 415,888	38

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