

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,654	5,234	5,302	32,190	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,654	5,234	5,302	32,190	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.91%

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 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 3,060

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 12/31/15 Fiscal Year: 1/1 to 12/31/15

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

Facility Name & ID Number Stearns Nsg & Rehab Center # 0046870 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	236,451	18,753	3,319	258,523		258,523	(11,838)	246,685		1
2	Food Purchase		210,736		210,736		210,736	(1,634)	209,102		2
3	Housekeeping	140,381	35,523	357	176,261		176,261		176,261		3
4	Laundry	40,514	14,143		54,657		54,657	(369)	54,288		4
5	Heat and Other Utilities			105,298	105,298		105,298		105,298		5
6	Maintenance	58,131	47,617	49,512	155,260		155,260	(7,564)	147,696		6
7	Other (specify):* see trial balance			27,955	27,955		27,955		27,955		7
8	TOTAL General Services	475,477	326,772	186,441	988,690		988,690	(21,405)	967,285		8
	B. Health Care and Programs										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	1,912,079	137,063	82,265	2,131,407		2,131,407	(11,044)	2,120,363		10
10a	Therapy		3,310	463,527	466,837		466,837	109,555	576,392		10a
11	Activities	52,600	6,639	4,619	63,858		63,858	95	63,953		11
12	Social Services	94,663	24	2,809	97,496		97,496		97,496		12
13	CNA Training										13
14	Program Transportation			18,503	18,503		18,503	414	18,917		14
15	Other (specify):* see trial balance			37,635	37,635		37,635	(21,712)	15,923		15
16	TOTAL Health Care and Programs	2,059,342	147,036	629,758	2,836,136		2,836,136	77,308	2,913,444		16
	C. General Administration										
17	Administrative	232,223		331,272	563,495		563,495	(133,182)	430,313		17
18	Directors Fees										18
19	Professional Services			112,783	112,783		112,783	(2,318)	110,465		19
20	Dues, Fees, Subscriptions & Promotions			41,879	41,879		41,879	(24,352)	17,527		20
21	Clerical & General Office Expenses	9,209	74,073	36,532	119,814		119,814	(23,839)	95,975		21
22	Employee Benefits & Payroll Taxes			424,684	424,684		424,684	(2,600)	422,084		22
23	Inservice Training & Education										23
24	Travel and Seminar			27,570	27,570		27,570	525	28,095		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			(63,089)	(63,089)		(63,089)	(2,928)	(66,017)		26
27	Other (specify):* see trial balance			152,145	152,145		152,145	(112,497)	39,648		27
28	TOTAL General Administration	241,432	74,073	1,063,776	1,379,281		1,379,281	(301,191)	1,078,090		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,776,251	547,881	1,879,975	5,204,107		5,204,107	(245,288)	4,958,819		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			36,861	36,861		36,861	331,071	367,932		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							118,987	118,987		32
33	Real Estate Taxes			95,209	95,209		95,209		95,209		33
34	Rent-Facility & Grounds			229,693	229,693		229,693	(208,055)	21,638		34
35	Rent-Equipment & Vehicles			63,321	63,321		63,321	250	63,571		35
36	Other (specify):* Off Site Storage			2,302	2,302		2,302		2,302		36
37	TOTAL Ownership			427,386	427,386		427,386	242,253	669,639		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops		135	958	1,093		1,093		1,093		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			236,777	236,777		236,777		236,777		42
43	Other (specify):* see trial balance			229,151	229,151		229,151	(84,500)	144,651		43
44	TOTAL Special Cost Centers		135	466,886	467,021		467,021	(84,500)	382,521		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,776,251	548,016	2,774,247	6,098,514		6,098,514	(87,535)	6,010,979		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	(749)	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				10
11	Discounts, Allowances, Rebates & Refunds	(18)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(160)	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	(266)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(113,909)	27		24
25	Fund Raising, Advertising and Promotional	(18,860)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(82,214)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (216,176)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	128,641		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 128,641		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (87,535)		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

BHF USE ONLY							
48		49		50		51	52

Stearns Nsg & Rehab Center

ID# 0046870

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin - Prof Dues	\$ (5,770)	20	1
2	Remove Non-allowable Admissions Other Supplies	(20,057)	21	2
3	Remove Non-allowable Other Purchased Service	(3,236)	27	3
4	Remove Non-allowable Admin-Books & Periodicals	(24)	21	4
5	Remove Non-allowable Insurance Costs	(2,928)	26	5
6	Remove Non-allowable Nrs Admin Purch Svcs	(18,076)	15	6
7	Remove Non-allowable BO Tax Prep Fees	(2,432)	19	7
8	Remove Non-allowable Admin Other Supplies	(133)	21	8
9	Remove Non-allowable HR EE Background Checks	278	20	9
10	Remove Non-allowable Outpatnt Svcs- Consol bill	(106)	43	10
11	Remove Non-allowable Dietary Cleaning Supplies	(142)	1	11
12	Remove Non-allowable Dietary Other Supplies	(15)	1	12
13	Remove Non-allowable Dietary Raw Food	(725)	2	13
14	Remove Non-allowable Laundry Laundry Soap	(369)	4	14
15	Remove Non-allowable Plant Ops Other Supplies	(20)	6	15
16	Remove Non-allowable Hskp Minor Non-Med Equip	(8)	6	16
17	Remove Non-allowable Plant Ops Pest Control	(260)	6	17
18	Addtl Allow Nrs Admin Med Cabinet	7	10	18
19	Addtl Allow Nrs Admin Other Supplies	797	10	19
20	Addtl Allow Activities Other Purchase Services	95	11	20
21	Addtl Allow Nrs Admin - Lodging	414	14	21
22	Addtl Allow Admin Legal	114	19	22
23	Addtl Allow Admin Minor Non-Medical Equipment	60	21	23
24	Addtl Allow Admin Other Supplies	118	21	24
25	Addtl Allow Admin Postage	11	21	25
26	Addtl Allow Human Resources Other Supplies	63	21	26
27	Addtl Allow EE Benefit Group health Ins	44	22	27
28	Addtl Allow EE Benefit Short Term Disability	39	22	28
29	Addtl Allow EE Benefit Other Emp Benefits	312	22	29
30	Addtl Allow EE Benefit Life Insurance	82	22	30
31	Addtl Allow Travel and Lodging	525	24	31
32	Addtl Allow Admin Purchased Services	563	27	32
33	Remove Non-Allowable Prior Year Costs	(20,725)	43	33
34	Remove Non-allowable Admin Contracted Service	(873)	27	34
35	Addtl Allow Nrs Admin - Rental/Lease	250	35	35
36	Remove Non-Allowable IV Prescription Drug costs	(4)	43	36
37	Offset Misc. Rev Med Surg/Food Supp/Incontinent	(2,274)	10	37
38	Offset Misc. Rev Non-Med. Equipment	(35)	6	38
39	Offset Interco Sold Services Revenue	(1,020)	10	39
40	Offset Interco Sold Services Revenue	(1,660)	6	40
41	Offset Interco Sold Services Revenue	(11,681)	1	41
42	Offset Interco Sold Services Revenue	(2,420)	22	42
43	Capitalize Repairs & Maintenance & Equipment	(2,778)	10	43
44	Capitalize Repairs & Maintenance & Equipment	(3,931)	21	44
45	Capitalize Repairs & Maintenance & Equipment	(5,581)	6	45
46	Depreciation/Amort LHI	20,084	30	46
47	Depreciation/Amort Mme	1,937	30	47
48	Current Year Depreciation Audit Adjustments LHI	(724)	30	48
49	Total	(82,214)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stearns Nsg & Rehab Center# 0046870

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(11,838)	0	0	0	0	0	0	0	0	0	0	(11,838)	1
2	Food Purchase	(1,634)	0	0	0	0	0	0	0	0	0	0	(1,634)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(369)	0	0	0	0	0	0	0	0	0	0	(369)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,564)	0	0	0	0	0	0	0	0	0	0	(7,564)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,405)	0	0	0	0	0	0	0	0	0	0	(21,405)	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	(5,268)	(5,776)	0	0	0	0	0	0	0	0	0	(11,044)	10
10a	Therapy	0	109,555	0	0	0	0	0	0	0	0	0	109,555	10a
11	Activities	95	0	0	0	0	0	0	0	0	0	0	95	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	414	0	0	0	0	0	0	0	0	0	0	414	14
15	Other (specify):*	(18,076)	(3,636)	0	0	0	0	0	0	0	0	0	(21,712)	15
16	TOTAL Health Care and Programs	(22,835)	100,143	0	0	0	0	0	0	0	0	0	77,308	16
	C. General Administration													
17	Administrative	0	(133,182)	0	0	0	0	0	0	0	0	0	(133,182)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,318)	0	0	0	0	0	0	0	0	0	0	(2,318)	19
20	Fees, Subscriptions & Promotions	(24,352)	0	0	0	0	0	0	0	0	0	0	(24,352)	20
21	Clerical & General Office Expenses	(23,911)	72	0	0	0	0	0	0	0	0	0	(23,839)	21
22	Employee Benefits & Payroll Taxes	(1,943)	(657)	0	0	0	0	0	0	0	0	0	(2,600)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	525	0	0	0	0	0	0	0	0	0	0	525	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,928)	0	0	0	0	0	0	0	0	0	0	(2,928)	26
27	Other (specify):*	(117,721)	0	5,224	0	0	0	0	0	0	0	0	(112,497)	27
28	TOTAL General Administration	(172,648)	(133,767)	5,224	0	(301,191)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(216,888)	(33,624)	5,224	0	(245,288)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	21,297	0	309,774	0	0	0	0	0	0	0	0	331,071	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	118,987	0	0	0	0	0	0	0	0	118,987	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(208,055)	0	0	0	0	0	0	0	0	(208,055)	34
35	Rent-Equipment & Vehicles	250	0	0	0	0	0	0	0	0	0	0	250	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	21,547	0	220,706	0	242,253	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):*	(20,835)	(63,665)	0	0	0	0	0	0	0	0	0	(84,500)	43
44	TOTAL Special Cost Centers	(20,835)	(63,665)	0	0	0	0	0	0	0	0	0	(84,500)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(216,176)	(97,289)	225,930	0	(87,535)	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		Granite Nursing and Rehabilitation Center, LLC	Granite City	Tara Pharmacy SE, LI	Birmingham	Pharmacy
D & N, LLC	50%	White Hall Nursing and Rehabilitation Center, LLC	White Hall	Tara Therapy, LLC	Orchard Park	Therapy
	50%	Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Raimax Healthcare Sol	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 Grou	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	\$ 331,272	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 198,090	\$ (133,182)	1
2	V	15 Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	328	(3,272)	2
3	V	15 Wireless Access Points License Fee	550	Raimax Healthcare Solutions Group, LLC	0.00%	186	(364)	3
4	V	10 Pharmacy Consulting Services	23,544	Tara Pharmacy SE, LLC	0.00%	17,768	(5,776)	4
5	V	43 Flu Vac/Prescription Drugs-Residents	187,813	Tara Pharmacy SE, LLC	0.00%	124,148	(63,665)	5
6	V	22 Flu/TB/HepB Vaccine for Employees	1,023	Tara Pharmacy SE, LLC	0.00%	366	(657)	6
7	V	10a Physical Therapy Fees	152,782	Tara Therapy, LLC	0.00%	188,834	36,052	7
8	V	10a Occupational Therapy Fees	157,596	Tara Therapy, LLC	0.00%	170,766	13,170	8
9	V	10a Speech Therapy Fees	152,460	Tara Therapy, LLC	0.00%	212,793	60,333	9
10	V	21 Telephone cost reduction project		Raimax Healthcare Solutions Group, LLC	0.00%	72	72	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,010,640			\$ 913,351	\$ * (97,289)	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	\$ 229,693	Stearns Property Company, LLC	0.00%	\$	\$ (229,693) 15
16	V	30 Depreciation Leasehold Imp		Stearns Property Company, LLC	0.00%	170,619	170,619 16
17	V	30 Depreciation Major Moveable		Stearns Property Company, LLC	0.00%	31,977	31,977 17
18	V	30 Depreciation Bldg & Improve		Stearns Property Company, LLC	0.00%	107,178	107,178 18
19	V	27 Amort Loan Acquisition Costs		Stearns Property Company, LLC	0.00%	5,224	5,224 19
20	V	32 Interest-Capital/Long-Term Debt		Stearns Property Company, LLC	0.00%	118,987	118,987 20
21	V	34 Mortgage Insurance Premium		Stearns Property Company, LLC	0.00%	21,638	21,638 21
22	V						
23	V						
24	V	1 Dietary Services	360	Scenic Nursing and Rehabilitation Center, LLC	0.00%	360	
25	V	3 Housekeeping Services	357	Scenic Nursing and Rehabilitation Center, LLC	0.00%	357	
26	V	15 Nursing Admin Services	895	Scenic Nursing and Rehabilitation Center, LLC	0.00%	895	
27	V	27 Human Resources Services	338	Scenic Nursing and Rehabilitation Center, LLC	0.00%	338	
28	V	27 Administrative Services	696	Scenic Nursing and Rehabilitation Center, LLC	0.00%	696	
29	V	12 Social Services Services	171	White Hall Nursing and Rehabilitation Center, LLC	0.00%	171	
30	V	6 Maintenance Services	245	White Hall Nursing and Rehabilitation Center, LLC	0.00%	245	
31	V	10 LPN Services	657	Stearns Nursing and Rehabilitation Center, LLC	0.00%	657	
32	V	1 Dietary Services	165	Stearns Nursing and Rehabilitation Center, LLC	0.00%	165	
33	V	27 Human Resources Services	514	Stearns Nursing and Rehabilitation Center, LLC	0.00%	514	
34	V	27 Business Office Services	140	Stearns Nursing and Rehabilitation Center, LLC	0.00%	140	
35	V	6 Maintenance Services	1,583	Stearns Nursing and Rehabilitation Center, LLC	0.00%	1,583	
36	V	15 Nursing Admin Services	6,409	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	6,409	
37	V	11 Activities Services	151	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	151	
38	V						
39	Total		\$ 242,374			\$ 468,304	\$ * 225,930 39

* 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:

01/01/15

Ending:

12/31/15

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, LLC					1
2			Lake City Nursing and Rehabilitation Center, LLC					2
3			Mobile Nursing and Rehabilitation Center, LLC					3
4			Florence Nursing and Rehabilitation Center, LLC					4
5			Birmingham Nrs&Rehab Center East, LLC					5
6			Birmingham Nursing and Rehabilitation Center, LLC					6
7			Eight Mile Nursing and Rehabilitation Center, LLC					7
8			North Hill Nursing and Rehabilitation Center, LLC					8
9			Elba Nursing and Rehabilitation Center, LLC					9
10			Quince Nursing and Rehabilitation Center, LLC					10
11			Allenbrooke Nursing and Rehabilitation Center, LLC					11
12			Tupelo Nursing and Rehabilitation Center, LLC					12
13			Brandon Nursing and Rehabilitation Center, LLC					13
14			Lakeland Nursing and Rehabilitation Center, LLC					14
15			McComb Nursing and Rehabilitation Center, LLC					15
16			Cleveland Nursing and Rehabilitation Center, LLC					16
17			Chadwick Nursing and Rehabilitation Center, LLC					17
18			Manhattan Nursing and Rehabilitation Center, LLC					18
19			Ruleville Nursing and Rehabilitation Center, LLC					19
20			Farmerville Nursing and Rehabilitation Center, LLC					20
21			Bernice Nursing and Rehabilitation Center, LLC					21
22			Ruston Nursing and Rehabilitation Center, LLC					22
23			Natchitoches Nursing and Rehabilitation Center, LLC					23
24			Winnfield Nursing and Rehabilitation Center, LLC					24
25			Ringgold Nursing and Rehabilitation Center, LLC					25
26			Arcadia Nursing and Rehabilitation Center, LLC					26
27			Jena Nursing and Rehabilitation Center, LLC					27
28								28
29			** The above listed facilities are related by					29
30			common ownership					30

Facility Name & ID Number

Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	***	0.67	1.68	Fin/ Adm. of TC	5,024	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.67	1.68	Fin/ Adm. of TC	5,024	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President	Admin of	0.00	***	0.67	1.68	VP of TC	4,456	17	7
8			Tara Cares								8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										
10											10
11											11
12											12
13								TOTAL	\$ 14,504		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:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Aurora Cares, LLC d/b/a Tara Cares
 Street Address PO Box 428
 City / State / Zip Code Orchard Park, NY 14127
 Phone Number (716)662-4955
 Fax Number (716)662-2529

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Administrative Services Costs	Total Costs	40	\$ 341,807	\$ 262,439	5,766,042	\$ 5,225	1
2	5	Administrative Services Costs	Days	36	40,064	0	32,177	840	2
3	6	Administrative Services Costs	Days	36	85,860	0	32,177	1,800	3
4	10	Administrative Services Costs	Total Costs	40	2,765,952	2,197,104	5,766,042	42,276	4
5	17	Administrative Services Costs	Days	36	5,577,068	5,577,068	32,177	117,013	5
6	19	Administrative Services Costs	Days	36	10,399	0	32,177	218	6
7	20	Administrative Services Costs	Days	36	20,434	0	32,177	429	7
8	21	Administrative Services Costs	Days	36	248,288	0	32,177	5,210	8
9	22	Administrative Services Costs	Days	36	742,289	0	32,177	15,573	9
10	24	Administrative Services Costs	Days	36	139,206	0	32,177	2,921	10
11	26	Administrative Services Costs	Days	36	5,592	0	32,177	117	11
12	27	Administrative Services Costs	Days	36	104,557	0	32,177	2,194	12
13	30	Administrative Services Costs	Days	36	101,450	0	32,177	2,129	13
14	31	Administrative Services Costs	Days	36	13,775	0	32,177	289	14
15	33	Administrative Services Costs	Days	36	29,603	0	32,177	621	15
16	34	Administrative Services Costs	Days	36	57,221	0	32,177	1,201	16
17	35	Administrative Services Costs	Days	36	1,602	0	32,177	34	17
18									18
19									19
20	NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								
21	Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								
22	considered a Home Office by CMS and as defined in 42 CRF 421.404.								
23									23
24									24
25	TOTALS				\$ 10,285,167	\$ 8,036,611		\$ 198,090	25

Facility Name & ID Number

Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

01/01/15

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12/31/15

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		7	8	9	10						
		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		Land and Building	\$16,942.00	6/20/12	\$ 4,566,200	\$ 4,288,059	7/1/47	0.0275	\$ 118,987	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$16,942.00		\$ 4,566,200	\$ 4,288,059			\$ 118,987	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,566,200	\$ 4,288,059			\$ 118,987	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,638 Line # 34

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2014 report.		\$	94,990	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.)		\$	92,799	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,191)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	97,400	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.		\$	95,209	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2010	80,241	8
	2011	82,717	9
	2012	90,101	10
	2013	90,466	11
	2014	92,799	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	\$		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.

2014 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) 622-4955, ext.392 FAX #: (716) 662-4468

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>92,798.68</u>	\$ <u>92,798.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>92,798.68</u></u>	\$ <u><u>92,798.68</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,576 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).

None

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: 92,983 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&OtherCostsIncurred2009&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	195,584		\$ 191,114	3

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$	\$ 482,301	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Alumalite Front Sign	2005		515	26	10	26		515	9
10		Sign	2005		800	40	10	40		800	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		8,693	12
13		Emergency Lights (outside)	2006		1,621	135	12	135		1,283	13
14		Painting - Back Railings	2006		3,780		5			3,780	14
15		Outside Lights	2006		1,419	118	12	118		1,123	15
16		Walkway	2006		2,100	175	12	175		1,663	16
17		Roof	2006		152,600	12,717	12	12,717		120,809	17
18		Cabinetry - Therapy Room	2006		2,433	203	12	203		1,926	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		10			10,033	21
22		Closet Doors	2007		7,675	698	11	698		5,931	22
23		Kitchen Hoods and Sprinklers	2007		11,130	1,012	11	1,012		8,601	23
24		Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, paint	2007		85,475	8,548	10	8,548		72,654	24
25		1 Resident Shower Room- tile, mirrors, drains, fixtures, shut offs	2007		50,679	4,607	11	4,607		39,161	25
26		Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling	2008		7,820	782	10	782		5,865	26
27		3 Shower Rooms - tile, drains, shut offs, paint, faucets	2008		61,673	6,167	10	6,167		46,254	27
28		Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs	2008		54,775	5,477	10	5,477		41,081	28
29		Electrical & Floor Repair capitalized for Medicaid	2008		4,710		3			4,710	29
30		A/C Unites (5)	2008		2,150		5			2,150	30
31		Fire Alarm Motherboard	2008		3,165	316	10	316		2,373	31
32		Nurses Stations (North & South)	2008		34,900	3,490	10	3,490		26,175	32
33		Kitchen Upgrade-waste/water line, metal studs, interior partition, new electrical	2008		44,605	4,460	10	4,460		33,453	33
34		Facility Sign	2008		11,365	1,137	10	1,137		8,524	34
35		Dish Machine	2008		14,180	1,418	10	1,418		10,635	35
36											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

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		\$ 381	37
38	Floor Installation	2009	40,021	4,447	9	4,447		28,904	38
39	Office Countertops	2009	1,259	140	9	140		909	39
40	Water Heater 100 Gallon & Pump	2009	8,225	914	9	914		5,940	40
41	Direct TV Systems	2009	15,858	1,762	9	1,762		11,453	41
42	Water Heater	2010	6,800	850	8	850		4,675	42
43	Water Heater (100 gallon)	2010	8,200	1,025	8	1,025		5,638	43
44	Phone System Upgrade (Nurse Station)	2010	1,061	133	8	133		730	44
45	Back Door / frame replacement	2010	3,409	426	8	426		2,344	45
46	Lighting & Room Signage capitalized for Medicaid	2010	13,829		3			13,829	46
47	TCU Wing Renovation	2011	630,780	90,111	7	90,111		405,501	47
48	Ceiling & Door Replacement	2011	80,229	11,461	7	11,461		51,576	48
49	Locks (6 coded/keyed)	2011	3,352	335	10	335		1,438	49
50	Electrical (Dining/NRS)	2011	4,466	298	15	298		1,278	50
51	A/C Unit	2011	1,104	221	5	221		948	51
52	Utility Room Renovation Drywall/plumbing/electric/cabinets	2011	16,150	1,077	15	1,077		4,621	52
53	Landscaping	2011	7,890	526	15	526		2,257	53
54	Water Softener	2011	2,074	207	10	207		890	54
55	Installation of 61 overbed lights-Capitalized for Medicaid	2011	12,272	2,454	5	2,454		11,043	55
56	Addtl TCU Wing Renovation - generator/flooring	2011	23,658	3,380	7	3,380		15,209	56
57	Ceiling, Smoke Door & Door Replacement	2011	19,522	2,789	7	2,789		12,550	57
58	Replace 41 Windows - Capitalized for Medicaid	2011	6,070	1,214	5	1,214		5,463	58
59	Dining Room Wall Repair - Capitalized for Medicaid	2011	3,220	644	5	644		2,899	59
60	Laundry Room Ceiling/Lighting/Drywall/Painting-Cap for MCD	2011	5,769	1,154	5	1,154		5,193	60
61	Apoxy Coating Front Porch Floor	2011	5,005	1,001	5	1,001		4,296	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,812,732	\$ 286,247		\$ 286,247		\$ 1,564,737	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	\$ 286,247		\$ 286,247	\$	\$ 1,564,737	1
2	Kitchen Sewer Line	2012	28,671	1,433	20	1,433		5,017	2
3	Additional new drains for sinks	2012	725	36	20	36		127	3
4	MagLock System Courtyard Gate	2012	4,800	480	10	480		1,527	4
5	Dietary Mixer Repair Capitalized for Medicaid	2012	2,873	481	3	481		2,873	5
6	Lobby/Lounge Door Hardware Capitalized for Medicaid	2012	4,360	725	3	725		4,360	6
7	Burnisher Repair Capitalized for Medicaid	2012	2,628	438	3	438		2,628	7
8	Sewer&DrainCleaning/Cableing,WaterLines-Cap for Medicaid	2012	4,698	783	3	783		4,698	8
9	RAC PTAC Unit	2013	672	134	5	134		335	9
10	81 gal Water Heater	2013	6,577	658	10	658		1,644	10
11	Cabling Installation for Wireless Access Point	2013	2,589	129	20	129		323	11
12	Asphalt parking lot	2013	49,183	6,148	8	6,148		15,370	12
13	Plumbing,Sprinkler,Wall&Burnisher Repairs - Cap for MCD	2013	31,755	10,585	3	10,585		26,462	13
14	Remove/Replace sidewalks to tie to existing 2 exit doors	2014	7,500	500	15	500		750	14
15	Seal Parking Lot	2014	2,900	1,450	2	1,450		2,175	15
16	Pave Walkway	2015	2,500	156	8	156		156	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Note: See additional building improvements made by former property owner Healthcare REIT, Inc. on supplemental schedule included as page 24 of the cost report.		533,613	30,549		30,549		446,436	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,498,776	\$ 340,932		\$ 340,932	\$	\$ 2,079,618	34

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

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 331,570	\$ 41,550	\$ 41,550	\$	various	\$ 222,200	71
72	Current Year Purchases	17,715	1,761	1,761		various	1,761	72
73	Fully Depreciated Assets	137,257	586	586		various	137,140	73
74								74
75	TOTALS	\$ 486,542	\$ 43,897	\$ 43,897	\$		\$ 361,101	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	Residents to/from Doctors	2013 Champion Bus	2014	\$ 54,596	\$ 13,649	\$ 13,649	\$	4	\$ 20,473	76
77										77
78										78
79										79
80	TOTALS			\$ 54,596	\$ 13,649	\$ 13,649	\$		\$ 20,473	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)	\$ 7,231,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 398,478	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 398,478	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)	\$ 2,461,192	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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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: 01/01/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2016	\$ _____
13.	_____ /2017	\$ _____
14.	_____ /2018	\$ _____

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: _____*

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: \$ 63,321 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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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	\$ 64,711	\$	1
2	Cash-Patient Deposits	14,335		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,238,010		3
4	Supply Inventory (priced at <u>cost</u>)	9,158		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,885		6
7	Other Prepaid Expenses	11,792		7
8	Accounts Receivable (owners or related parties)	68,117		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	179,989		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,589,997	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	141,599		15
16	Equipment, at Historical Cost	130,823		16
17	Accumulated Depreciation (book methods)	(90,896)		17
18	Deferred Charges			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 (spe <u>Deposits-Long Term</u>)	2,200		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 183,072	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,773,069	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 146,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,335		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,125		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,425		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(11,702)		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>	16,231		36
37	<u>Accrued Expenses</u>	153,509		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 603,689	\$	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)	\$ 603,689	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,169,380	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,773,069	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 515,533	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 515,533	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(421,900)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,100,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(24,253)	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)	\$ 653,847	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,169,380	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	\$ 4,889,835	1
2	Discounts and Allowances for all Levels	477,815	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,367,650	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	284,021	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 284,021	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	749	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,423	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	124	19
20	Radiology and X-Ray	74	20
21	Other Medical Services	542	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,912	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,196	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,196	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	(273)	28
28a	Purchase Discounts & Misc Revenue	19,108	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,835	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,676,614	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	988,690	31
32	Health Care	2,836,136	32
33	General Administration	1,379,281	33
B. Capital Expense			
34	Ownership	427,386	34
C. Ancillary Expense			
35	Special Cost Centers	230,244	35
36	Provider Participation Fee	236,777	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,098,514	40
41	Income before Income Taxes (line 30 minus line 40)**	(421,900)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (421,900)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,807,170	44
45	Private Pay - Net Inpatient Revenue	819,474	45
46	Medicare - Net Inpatient Revenue	1,640,370	46
47	Other-(specify) <u>Hospice</u>	100,636	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,367,650	49

* 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 Nsg & Rehab Center**

0046870

Report Period Beginning:

01/01/15

Ending:

12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,024	2,080	\$ 87,294	\$ 41.97	1
2	Assistant Director of Nursing	1,706	1,738	48,445	27.87	2
3	Registered Nurses	5,038	5,412	151,840	28.06	3
4	Licensed Practical Nurses	30,217	32,738	704,104	21.51	4
5	CNAs & Orderlies	68,923	74,264	771,753	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,742	2,009	24,313	12.10	9
10	Activity Assistants	2,733	2,967	28,287	9.53	10
11	Social Service Workers	4,103	4,703	94,663	20.13	11
12	Dietician	1,475	1,592	51,333	32.24	12
13	Food Service Supervisor	2,128	2,375	46,208	19.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,649	5,212	42,015	8.06	15
16	Dishwashers	10,181	10,803	96,895	8.97	16
17	Maintenance Workers	4,600	4,828	58,131	12.04	17
18	Housekeepers	13,251	14,391	140,381	9.75	18
19	Laundry	3,701	4,008	40,514	10.11	19
20	Administrator	1,912	2,452	95,152	38.81	20
21	Assistant Administrator					21
22	Other Administrative	3,585	3,935	88,244	22.43	22
23	Office Manager	1,869	2,080	36,356	17.48	23
24	Clerical	1,376	1,489	21,680	14.56	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	1,962	2,097	30,957	14.76	31
32	Other Health C: MDS Coordinator	3,126	3,224	91,661	28.43	32
33	Other(specify) <u>Central Supply</u>	2,182	2,334	26,025	11.15	33
34	TOTAL (lines 1 - 33)	172,483	186,731	\$ 2,776,251 *	\$ 14.87	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	264	20,400	9-3	36
37	Medical Records Consultant	48	3,300	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18/bed/month	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	40	2,638	11-3	44
45	Social Service Consultant	40	2,638	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	393	\$ 52,520		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	476	\$ 33,419	10-3	50
51	Licensed Practical Nurses	334	11,748	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	811	\$ 45,167		53

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning: 01/01/15

Ending: 12/31/15

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		
Brett Hoffman	Administrator	0	\$ 8,202	Workers' Compensation Insurance	\$ 104,275	IDPH License Fee	\$ 2,985		
Jerry Nelson	Administrator	0	71,515	Unemployment Compensation Insurance	88,791	Advertising: Employee Recruitment	9,082		
Christine Warcup	Administrator	0	15,436	FICA Taxes	212,122	Health Care Worker Background Check	141		
Areal Mitchell, L. Carlisle	HR	0	32,186	Employee Health Insurance	2,668	(Indicate # of checks performed 23)			
C.Krump,R.Wright,M.Scoggins,W. Blanquart	Admissions Director	0	46,849	Employee Meals		Patient Background Checks	119 1,190		
B.Smith,K. Baalman,N.Miner	Bus Office Manager	0	36,356	Illinois Municipal Retirement Fund (IMRF)*		Facility Advertising	18,860		
Nicole Miner	Bus Office Asst	0	21,679	Worker Compensation Safety Rec. Program	1,438	IL Health Care Assn/Chamber of Comm	7,548		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Benefits - Other	11,170	Non-AllowAcad.ofNutrition/IHCA/ChambCo	(5,770)		
(List each licensed administrator separately.)			\$ 232,223	Employee Benefits - Short Term Disability	374	City Business License/Citrix/Admin License	991		
B. Administrative - Other				Employee Benefits - Hepatitis B Vaccination		Fingerprinting/Walmart Club/Acad of Nutriti	1,360		
Description			Amount	Employee Benefits - Exchange/Dental	418	Less: Public Relations Expense	()		
Tara Cares Administrative Services Fee			\$ 331,272	H.S.A. ER Contibution		Non-allowable advertising	(18,860)		
				Employee Benefit Life Insurance (ER)	828	Yellow page advertising	()		
				TOTAL (agree to Sch. V, line 20, col. 8)			\$ 17,527		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 331,272	TOTAL (agree to Schedule V, line 22, col.8)			\$ 422,084		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Amount		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Freed, Maxick & Battaglia	Accounting Fees		\$ 2,462	None in allowable cost		\$	Out-of-State Travel	\$	
Freed, Maxick & Battaglia	Tax Fees		2,432	(Column 8) of Schedule V					
Various Legal Fees - See attached listings			107,889				In-State Travel	27,891	
							Seminar Expense	204	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				TOTAL	\$ 28,095
(For legal fee disclosure, see page 39 of instructions)			\$ 112,783						

* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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:

01/01/15

Ending:

12/31/15

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 \$1,778 net of non-allowables
- (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. \$ 26,194 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 236,777
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. \$ 749
- (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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No Personal Use
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number Stearns Nsg & Rehab Center

0046870

Report Period Beginning:

01/01/15 Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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	11,882	
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450	88,825	
6	Sprinkler System Addl Cost Post 6/30/06	2006	4,750					
7	Painting of Facility Cost @ 6/30/06	2006	117,665		5		117,665	
8	Painting of Facility Addl Cost Post 6/30/06	2006	750				750	
9	Exterior Siding Cost @ 6/30/06	2006	54,360	3,993	12	3,993	33,943	
10	Exterior Siding Addl Cost Post 6/30/06	2006	(6,440)					
11	Handrails and Chairrails	2006	12,705	1,059	12	1,059	8,999	
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	145	10	145	1,228	
13	A/C Units (10)	2006	9,284		5		9,284	
14	Carpeting	2006	3,894		5		3,894	
15	Grease Trap	2005	8,421	648	13	648	6,154	
16	Air Conditioning Units (6)	2005	3,818		5		3,818	
17	Air Conditioning Units (5)	2005	2,600	200	13	200	1,900	
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157	1,493	
19	Doors (2)	2005	3,997	307	13	307	2,921	
20	Replacement Windows	2005	6,555	655	10	655	6,227	
21	Sprinkler System	2005	56,150	4,319	13	4,319	41,033	
22	Fire Alarm System	2005	22,294	2,229	10	2,229	21,179	
23	Closet Doors	2005	2,400	185	13	185	1,754	
24	Smoke Damper	2005	700	70	10	70	665	
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350	12,825	
26	Replacement Doors	2005	1,697	131	13	131	1,240	
27	Replacement Doors	2005	2,186	168	13	168	1,597	
28	Compressor for Walk-in Freezer	2005	1,525	153	10	153	1,449	
29	Air Conditioning Units (strip) (23)	2005	22,573		5		22,573	
30	Doors	2005	3,092	238	13	238	2,260	
31	Aspire Telephone System	2005	10,992	1,099	10	1,099	10,442	
32	Fire Damper	2005	1,420	109	13	109	1,038	
33	Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617		5		11,617	
34	Pave Walkway, Roadway, Turnaround	2005	5,150		8		5,150	
35	Exterior Siding	2006	6,440	644	10	644	5,474	
36	Double Bowl Sinks (2)	2006	1,104	92	12	92	782	
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750	6,375	
38								
39	TOTAL (lines 1 thru 38)		\$ 533,613	\$ 30,549		\$ 30,549	\$ 0	\$ 446,436

See page 12B Line 24

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