FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0046870

Facility Name: Stearns Nursing & Rehabilitation Center

Address: 3900 Stearns Avenue (Number) Granite City (City) 62040 (Zip Code)

County: Madison

Telephone Number: (618) 931-3900 **Fax #** (618) 931-0766

HFS ID Number:

Date of Initial License for Current Owners: January 1, 2005

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Gary F. Eye **Telephone Number:** (716) 662-4955 ext 392
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 4/30/11
(Type or Print Name) Gary F. Eye
(Title) Senior VP of Finance of Tara Cares

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,578	4,794	5,514	30,886	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,578	4,794	5,514	30,886	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.36%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 1/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date January 1, 2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 3,975

Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 1/1 to 12/31/10 Fiscal Year: 1/1 to 12/31/10

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,184	14,176	2,095	211,455		211,455	(20,231)	191,224			1
2	Food Purchase		160,951		160,951		160,951	(841)	160,110			2
3	Housekeeping	114,906	18,592		133,498		133,498		133,498			3
4	Laundry	47,906	16,049	192	64,147		64,147		64,147			4
5	Heat and Other Utilities			111,274	111,274		111,274		111,274			5
6	Maintenance	45,354	26,962	19,892	92,208		92,208	(4,099)	88,109			6
7	Other (specify):* see trial balance			16,500	16,500		16,500		16,500			7
8	**TOTAL General Services**	403,350	236,730	149,953	790,033		790,033	(25,171)	764,862			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	1,538,698	133,860	44,171	1,716,729		1,716,729	(11,806)	1,704,923			10
10a	Therapy		2,415	812,175	814,590		814,590	(122,989)	691,601			10a
11	Activities	50,657	2,113	5,167	57,937		57,937		57,937			11
12	Social Services	32,256	37	1,592	33,885		33,885		33,885			12
13	CNA Training											13
14	Program Transportation			206	206		206		206			14
15	Other (specify):* see trial balance			11,375	11,375		11,375	(7,115)	4,260			15
16	**TOTAL Health Care and Programs**	1,621,611	138,425	895,086	2,655,122		2,655,122	(141,910)	2,513,212			16
	C. General Administration											
17	Administrative	236,530		296,088	532,618		532,618	(74,611)	458,007			17
18	Directors Fees											18
19	Professional Services			18,017	18,017		18,017	(2,207)	15,810			19
20	Dues, Fees, Subscriptions & Promotions			26,813	26,813		26,813	(8,369)	18,444			20
21	Clerical & General Office Expenses		28,082	35,966	64,048		64,048	(2,351)	61,697			21
22	Employee Benefits & Payroll Taxes			307,004	307,004		307,004	(10,557)	296,447			22
23	Inservice Training & Education											23
24	Travel and Seminar			35,121	35,121		35,121	487	35,608			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			193,184	193,184		193,184	(2,600)	190,584			26
27	Other (specify):* see trial balance			95,859	95,859		95,859	(74,136)	21,723			27
28	**TOTAL General Administration**	236,530	28,082	1,008,052	1,272,664		1,272,664	(174,344)	1,098,320			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,261,491	403,237	2,053,091	4,717,819		4,717,819	(341,425)	4,376,394			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 Nursing & Rehabilitation Center #0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			101,434	101,434		101,434	5,402	106,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			82,170	82,170		82,170	(1,713)	80,457			33
34	Rent-Facility & Grounds			542,105	542,105		542,105		542,105			34
35	Rent-Equipment & Vehicles			33,460	33,460		33,460	300	33,760			35
36	Other (specify):*											36
37	**TOTAL Ownership**			759,169	759,169		759,169	3,989	763,158			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		14	439	453		453		453			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* **see trial balance**			201,872	201,872		201,872	(44,912)	156,960			43
44	**TOTAL Special Cost Centers**		14	269,106	269,120		269,120	(44,912)	224,208			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,261,491	403,251	3,081,366	5,746,108		5,746,108	(382,348)	5,363,760			45

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(697)	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	(176)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(886)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(164)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,873)	27		24
25	Fund Raising, Advertising and Promotional	(8,369)	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	(76,411)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (155,720)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(226,628)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (226,628)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (382,348)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Stearns Nursing & Rehabilitation Center

ID# 0046870

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admiss-Other Supplies	$ (2,172)	21	1
2	Remove Non-allowable EE Recognition Program	(571)	22	2
3	Remove Non-allowable Employee Benefits	(440)	22	3
4	Remove Non-allowable Visa Costs	(88)	24	4
5	Remove Non-allowable Visa Costs	(855)	22	5
6	Remove Non-allowable Insurance Cost	(2,600)	26	6
7	Remove Non-allowable Nrs Admin- Purch Svcs	(6,920)	15	7
8	Remove Non-allowable Acctg- Tax Fees	(2,043)	19	8
9	Remove Non-allowable Admin- Other Purch Svcs	(4,362)	27	9
10	Remove Non-allowable Prior Year Costs	(5,687)	43	10
11	Remove Non-allowable IV Prescription Drug Costs	(527)	43	11
12	Remove Real Estate Tax Under/(Over) Accrual	(1,713)	33	12
13	Offset Interco Sold Services Revenue	(1,035)	10	13
14	Offset Interco Sold Services Revenue	(420)	10	14
15	Offset Interco Sold Services Revenue	(976)	10	15
16	Offset Interco Sold Services Revenue	(9,457)	10	16
17	Offset Interco Sold Services Revenue	(19,460)	1	17
18	Offset Interco Sold Services Revenue	(676)	1	18
19	Offset Interco Sold Services Revenue	(95)	1	19
20	Offset Interco Sold Services Revenue	(7,737)	22	20
21	Remove Interco Purchased Services Mark-up	(15)	27	21
22	Remove Capitalized Repairs & Maintenance	(4,099)	6	22
23	Remove Capitalized Repairs & Maintenance	(9,730)	10	23
24	Amort/Depreciate Repair/Maint Captl. For Medicaid	5,402	30	24
25	Offset Misc. Revenue	(653)	10	25
26	Offset Misc. Revenue	(34)	10	26
27	Offset Misc. Revenue	(363)	10	27
28	Offset Misc. Revenue	(23)	10	28
29	Offset Misc. Revenue	(3)	21	29
30	Accrue Nrs Admin Rental/Lease	300	35	30
31	Accrue Nrs Admin - Meals&Entertainment	333	24	31
32	Accrue Nrs Admin - Lodging	242	24	32
33	Accrue Nrs Admin - Other Supplies	66	10	33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(76,411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(20,231)	0	0	0	0	0	0	0	0	0	0	(20,231)	1
2	Food Purchase	(841)	0	0	0	0	0	0	0	0	0	0	(841)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,099)	0	0	0	0	0	0	0	0	0	0	(4,099)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,171)	0	0	0	0	0	0	0	0	0	0	(25,171)	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	(22,625)	10,819	0	0	0	0	0	0	0	0	0	(11,806)	10
10a	Therapy	0	(122,989)	0	0	0	0	0	0	0	0	0	(122,989)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(6,920)	(195)	0	0	0	0	0	0	0	0	0	(7,115)	15
16	**TOTAL Health Care and Programs**	(29,545)	(112,365)	0	0	0	0	0	0	0	0	0	(141,910)	16
	C. General Administration													
17	Administrative	0	(74,611)	0	0	0	0	0	0	0	0	0	(74,611)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,207)	0	0	0	0	0	0	0	0	0	0	(2,207)	19
20	Fees, Subscriptions & Promotions	(8,369)	0	0	0	0	0	0	0	0	0	0	(8,369)	20
21	Clerical & General Office Expenses	(2,351)	0	0	0	0	0	0	0	0	0	0	(2,351)	21
22	Employee Benefits & Payroll Taxes	(9,603)	(954)	0	0	0	0	0	0	0	0	0	(10,557)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	487	0	0	0	0	0	0	0	0	0	0	487	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):*	(74,136)	0	0	0	0	0	0	0	0	0	0	(74,136)	27
28	**TOTAL General Administration**	(98,779)	(75,565)	0	0	0	0	0	0	0	0	0	(174,344)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,495)	(187,930)	0	0	0	0	0	0	0	0	0	(341,425)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stearns Nursing & Rehabilitation Center **#** 0046870 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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	Depreciation	5,402	0	0	0	0	0	0	0	0	0	0	5,402	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(1,713)	0	0	0	0	0	0	0	0	0	0	(1,713)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	300	0	0	0	0	0	0	0	0	0	0	300	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,989	0	0	0	0	0	0	0	0	0	0	3,989	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):*	(6,214)	(38,698)	0	0	0	0	0	0	0	0	0	(44,912)	43
44	**TOTAL Special Cost Centers**	(6,214)	(38,698)	0	0	0	0	0	0	0	0	0	(44,912)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(155,720)	(226,628)	0	0	0	0	0	0	0	0	0	(382,348)	45

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	$ 296,088	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 221,477	$ (74,611)	1
2	V	34	Sublease Building & Equip	542,105	Tara Midwest, LLC	0.00%	542,105		2
3	V	10	Pharmacy Consulting Services	26,352	Tara Pharmacy SE, LLC	0.00%	36,374	10,022	3
4	V	10	Medication Administration Records	8,052	Tara Pharmacy SE, LLC	0.00%	8,849	797	4
5	V	43	Flu Vac/Prescription Drugs-Residents	176,312	Tara Pharmacy SE, LLC	0.00%	137,614	(38,698)	5
6	V	22	Flu/TB/HepB Vaccine for Employees	3,217	Tara Pharmacy SE, LLC	0.00%	2,263	(954)	6
7	V	10a	Physical Therapy Fees	292,719	Tara Therapy, LLC	0.00%	256,766	(35,953)	7
8	V	10a	Occupational Therapy Fees	287,301	Tara Therapy, LLC	0.00%	206,608	(80,693)	8
9	V	10a	Speech Therapy Fees	231,048	Tara Therapy, LLC	0.00%	224,705	(6,343)	9
10	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	3,405	(195)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,866,794			$ 1,640,166	$ * (226,628)	14

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	DTD HC, LLC	Owner		50.00	0	0	0	0	$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/Admin	0.00	***	0.73	0.02	Fin/Adm. TC	4,920	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/Admin	0.00	***	0.73	0.02	Fin/Adm. TC	4,920	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.73	0.02	VP	4,015	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	$ 13,855		13

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

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Administrative Services Costs	Days	1,418,531	36	$ 253,727	$ 241,032	30,872	$ 5,522	1
2	5	Administrative Services Costs	Days	1,418,531	36	36,729	0	30,872	799	2
3	6	Administrative Services Costs	Days	1,418,531	36	57,523	1,453	30,872	1,252	3
4	10	Administrative Services Costs	Days	1,418,531	36	879,684	771,995	30,872	19,145	4
5	17	Administrative Services Costs	Days	1,418,531	36	6,601,121	6,601,121	30,872	143,657	5
6	19	Administrative Services Costs	Days	1,418,531	36	106,999	0	30,872	2,329	6
7	20	Administrative Services Costs	Days	1,418,531	36	10,087	0	30,872	220	7
8	21	Administrative Services Costs	Days	1,418,531	36	287,981	0	30,872	6,267	8
9	22	Administrative Services Costs	Days	1,418,531	36	1,344,595	0	30,872	29,263	9
10	24	Administrative Services Costs	Days	1,418,531	36	100,686	0	30,872	2,191	10
11	26	Administrative Services Costs	Days	1,418,531	36	6,260	0	30,872	136	11
12	27	Administrative Services Costs	Days	1,418,531	36	134,804	0	30,872	2,934	12
13	30	Administrative Services Costs	Days	1,418,531	36	213,053	0	30,872	4,637	13
14	31	Administrative Services Costs	Days	1,418,531	36	10,497	0	30,872	228	14
15	33	Administrative Services Costs	Days	1,418,531	36	27,056	0	30,872	589	15
16	34	Administrative Services Costs	Days	1,418,531	36	105,664	0	30,872	2,300	16
17	35	Administrative Services Costs	Days	1,418,531	36	351	0	30,872	8	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,176,817	$ 7,615,601		$ 221,477	25

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center **#** 0046870 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 2009 report.	$	79,970	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.)	$	78,257	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,713)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	82,170	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.	$	80,457	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	66,201	8
2006	69,504	9
2007	71,933	10
2008	76,163	11
2009	78,257	12

The 2010 assessment was estimated to be a 5% increase over the 2009 assessment.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stearns Nursing & Rehabilitation Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046870

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

TELEPHONE (716) 662-4955, ext 392 FAX #: (716) 662-4468

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-1-20-09-07-201-013	3900 Stearns Avenue	$ 78,256.84	$ 78,256.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 78,256.84	$ 78,256.84

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 639,907
2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8
4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc.capitalized pre-opening salaries, fringe benefits & other costs incurred prior 1/1/06.Costs allocated via related org cost & reported on Sch V
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Front Sign			2005	515	51	10	51		283	9
10	Sign			2005	800	80	10	80		440	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		4,118	12
13	Emergency Lights (outside)			2006	1,621	135	12	135		608	13
14	Painting - Back Railings			2006	3,780	756	5	756		3,402	14
15	Outside Lights			2006	1,419	118	12	118		532	15
16	Walkway			2006	2,100	175	12	175		788	16
17	Roof			2006	152,600	12,717	12	12,717		57,225	17
18	Cabinetry - Therapy Room			2006	2,433	203	12	203		912	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	1,527	3	1,527		9,163	20
21	Air Conditioners (10)			2007	10,033	2,508	4	2,508		8,779	21
22	Closet Doors			2007	7,675	698	11	698		2,442	22
23	Kitchen Hoods and Sprinklers			2007	11,130	1,012	11	1,012		3,542	23
24	Resident Restrooms- tile, mirrors, drains, fixtures, shut offs, handrails, paint			2007	85,475	8,548	10	8,548		29,916	24
25	1 Resident Shower Room- tile, mirrors, drains, fixtures, shut offs			2007	50,679	4,607	11	4,607		16,125	25
26	Guest Bathroom - tile, sinks, faucets, toilet, drains, shut offs, paint, ceiling			2008	7,820	782	10	782		1,955	26
27	3 Shower Rooms - tile, drains, shut offs, paint, faucets			2008	61,673	6,167	10	6,167		15,418	27
28	Res bathrooms- tile, lighting, mirrors, hand rails, toilets, faucets, shut offs			2008	54,775	5,477	10	5,477		13,694	28
29	Commercail Disposal			2008	987	99	10	99		247	29
30	Electrical & Floor Repair capitalized for Medicaid			2008	4,710	1,570	3	1,570		2,355	30
31	A/C Unites (5)			2008	2,150	430	5	430		1,075	31
32	Fire Alarm Motherboard			2008	3,165	316	10	316		791	32
33	Nurses Stations (North & South)			2008	34,900	3,490	10	3,490		8,725	33
34	Kitchen Upgrade-waste/water line, metal studs, interior partition, new electrical			2008	44,605	4,461	10	4,461		11,151	34
35	Facility Sign			2008	11,365	1,136	10	1,136		2,841	35
36	**Dish Machine**			2008	14,180	1,418	10	1,418		3,545	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Hot Water Heater Pump	2009	$ 527	$ 59	9	$ 59	$	$ 88	37
38	Floor Installation	2009	40,021	4,447	9	4,447		6,671	38
39	Office Countertops	2009	1,259	140	9	140		210	39
40	100 Gallon Water Heater	2009	8,225	914	9	914		1,371	40
41	Direct TV Systems	2009	15,858	1,762	9	1,762		2,643	41
42	Water Heater	2010	6,800	425	8	425		425	42
43	Water Heater (100 gallon)	2010	8,200	513	8	513		512	43
44	Phone System (Nurse Station)	2010	1,061	66	8	66		66	44
45	Door (Service Entry)	2010	3,409	213	8	213		213	45
46	Awnings	2010	1,239	77	8	77		77	46
47	Keypads (Electric - Lock)	2010	721	45	8	45		45	47
48	Lighting & Room Signage capitalized for Medicaid	2010	13,829	2,305	3	2,305		2,305	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Note: See additional building improvements made by property								63
64	owner Healthcare REIT, Inc. on supplemental schedule								64
65	included as Page 24 of the cost report.								65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 706,998	$ 70,362		$ 70,362	$	$ 229,814	70

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 259,095	$ 33,410	$ 33,410	$	various	$ 131,949	71
72	Current Year Purchases	38,532	3,064	3,064		various	3,064	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 297,627	$ 36,474	$ 36,474	$		$ 135,013	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,004,625	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,836	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,836	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)	$ 364,827	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Memories/TCU Unit	$ 508,685	92
93	Generator Switch	24,105	93
94			94
95		$ 532,790	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 Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] 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:	1972	122	1/1/05	$ 542,105	13.5	1-15yr.	3
4	Additions							4
5								5
6								6
7	TOTAL		122		$ 542,105 **			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: [X] YES [ ] NO Terms: 60 day notice - see attached *

10. Effective dates of current rental agreement:
Beginning 01/01/2005
Ending 06/30/2018

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2011	$ 542,105
13.	12/31/2012	$ 542,105
14.	12/31/2013	$ 542,105

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 34,070 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	See separate schedule		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,480	$	1
2	Cash-Patient Deposits	28,845		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	357,660		3
4	Supply Inventory (priced at cost)	6,846		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,344		6
7	Other Prepaid Expenses	24,124		7
8	Accounts Receivable (owners or related parties)	(1,811,894)		8
9	Other(specify): Non resident A/R (see TB)	12,707		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,366,888)	$	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	664,180		15
16	Equipment, at Historical Cost	297,627		16
17	Accumulated Depreciation (book methods)	(335,888)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(490)		21
22	Other Long-Term Assets (spe Deposits long term	2,100		22
23	Other(specify): Construction in progress	532,790		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,160,319	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (206,569)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 422,193	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,111		28
29	Short-Term Notes Payable	4,324		29
30	Accrued Salaries Payable	170,561		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,114		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,170		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	4,287		36
37	Accrued Expenses	516,552		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,243,312	$	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	Due To/From HC REIT	193,154		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 193,154	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,436,466	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,643,035)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (206,569)	$	48

*(See instructions.)

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,416,459)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,416,459)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(181,799)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	955,223	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 773,424	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)**	$ (1,643,035)	24 *

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,782,742	1
2	Discounts and Allowances for all Levels	1,156,304	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,939,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	564,580	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 564,580	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	697	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,805	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,135	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,135	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	(3,022)	28
28a	Prch Disc / Vending Commissions / Sold Srvcs Rev	46,765	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,743	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,564,309	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	790,033	31
32	Health Care	2,655,122	32
33	General Administration	1,272,664	33
	B. Capital Expense		
34	Ownership	759,169	34
	C. Ancillary Expense		
35	Special Cost Centers	202,325	35
36	Provider Participation Fee	66,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,746,108	40
41	**Income before Income Taxes (line 30 minus line 40)****	(181,799)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (181,799)	43

* **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 Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,064	$ 73,949	$ 35.83	1
2	Assistant Director of Nursing	1,872	2,080	53,701	25.82	2
3	Registered Nurses	816	958	23,142	24.16	3
4	Licensed Practical Nurses	26,536	28,373	591,660	20.85	4
5	CNAs & Orderlies	59,397	63,510	625,129	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,781	1,994	33,259	16.68	9
10	Activity Assistants	1,833	2,096	17,398	8.30	10
11	Social Service Workers	1,932	2,080	32,256	15.51	11
12	Dietician					12
13	Food Service Supervisor	3,872	4,156	69,014	16.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,180	5,769	51,174	8.87	15
16	Dishwashers	8,422	9,140	74,996	8.21	16
17	Maintenance Workers	2,555	2,619	45,354	17.32	17
18	Housekeepers	11,816	12,674	114,906	9.07	18
19	Laundry	5,187	5,576	47,906	8.59	19
20	Administrator	3,757	3,991	126,696	31.75	20
21	Assistant Administrator					21
22	Other Administrative	1,915	1,995	36,530	18.31	22
23	Office Manager	1,947	2,144	46,969	21.91	23
24	Clerical	1,878	2,099	26,335	12.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca MDS Coordinator	5,937	6,488	146,894	22.64	32
33	Other(specify) Nrsg Admin Cleric	1,850	1,993	24,223	12.15	33
34	TOTAL (lines 1 - 33)	150,491	161,799	$ 2,261,491 *	$ 13.98	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	196	20,400	9-3	36
37	Medical Records Consultant	48	2,948	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18/bed	26,352	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	25	1,552	11-3	44
45	Social Service Consultant	25	1,552	12-3	45
46	Other(specify)				46
47	Medical Records Preparation	$5.50/bed	8,052	10-3	47
48					48
49	TOTAL (lines 35 - 48)	294	$ 60,856		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	102	$ 6,233	10-3	50
51	Licensed Practical Nurses	17	586	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	119	$ 6,819		53

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brent Hoffman	Administrator	0	$ 97,653
Barbara Maurer	Bus. Office Mgr	0	47,787
Kimberly Holmes	Bus. Office Mgr	0	2,000
Eric Olsson	Payroll/AP	0	27,467
Clealone Douglas	Human Resources	0	25,881
Miranda Scoggins	Admiss Coordinator	0	35,742
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 236,530

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 296,088
TOTAL (agree to Schedule V, line 17, col. 3)	$ 296,088
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,379
Freed, Maxick & Battaglia	Tax Fees	2,043
Various Legal Fees - See Attached detailed listing		13,595
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 18,017

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 3,350
Unemployment Compensation Insurance	56,017
FICA Taxes	151,160
Employee Health Insurance	59,389
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Benefits - WC safety rec. prog	550
Employee Benefits - other	24,573
Employee Benefits - Short Term Disability	715
Employee Benefits - Hepatitis B Vaccination	693
TOTAL (agree to Schedule V, line 22, col.8)	$ 296,447

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None in allowable cost		$
(Column 8) of Schedule V		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	8,302
Health Care Worker Background Check	6,328
(Indicate # of checks performed 441)	
Facility Advertising	3,804
Licenses/SamsClubMembership	295
Chamber of Commerce	355
Non Allow Chamber of Commerce	(355)
IL. Health Care Association	6,734
Non Allowable IL Health Care Assn	(4,210)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,804)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,444

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	24,719
Seminar Expense	10,889
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,608

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

Facility Name & ID Number Stearns Nursing & Rehabilitation Center # 0046870 Report Period Beginning: 1/1/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $2,524 net of non-allowable**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **28,540** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **66,795**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **696**

(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 fo
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 othe
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 ou
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:** 1/1/2010 **Ending:** 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1			$	$		$	$	$	1
2	Improvements Made by Landlord (covered by rent at outset								2
3	of Change of Ownership):								3
4	Cove Base	2006	16,775	1,398	12	1,398		6,291	4
5	Sprinkler System Cost @ 6/30/06	2006	120,650	10,450	12	10,450		47,025	5
6	Sprinkler System Addl Cost Post 6/30/06	2006	4,750						6
7	Painting of Facility Cost @ 6/30/06	2006	117,665	23,683	5	23,683		106,574	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		17,970	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		4,764	11
12	Ducts & Fire Dampers for Fire Alarm System	2006	1,445	144	10	144		650	12
13	A/C Units (10)	2006	9,284	1,857	5	1,857		8,355	13
14	Carpeting	2006	3,894	779	5	779		3,505	14
15	Grease Trap	2005	8,421	648	13	648		3,563	15
16	Air Conditioning Units (6)	2005	3,818	382	5	382		3,818	16
17	Air Conditioning Units (5)	2005	2,600	200	13	200		1,100	17
18	Doors (2) Beauty Shop, Office	2005	2,044	157	13	157		865	18
19	Doors (2)	2005	3,997	307	13	307		1,691	19
20	Replacement Windows	2005	6,555	655	10	655		3,605	20
21	Sprinkler System	2005	56,150	4,319	13	4,319		23,756	21
22	Fire Alarm System	2005	22,294	2,229	10	2,229		12,262	22
23	Closet Doors	2005	2,400	185	13	185		1,015	23
24	Smoke Damper	2005	700	70	10	70		385	24
25	Roof Repairs - Replace Shingles, Patch, Seal	2005	13,500	1,350	10	1,350		7,425	25
26	Replacement Doors	2005	1,697	131	13	131		718	26
27	Replacement Doors	2005	2,186	168	13	168		925	27
28	Compressor for Walk-in Freezer	2005	1,525	153	10	153		839	28
29	Air Conditioning Units (strip) (23)	2005	22,573	2,257	5	2,257		22,573	29
30	Doors	2005	3,092	238	13	238		1,308	30
31	Aspire Telephone System	2005	10,992	1,099	10	1,099		6,045	31
32	Fire Damper	2005	1,420	109	13	109		601	32
33	Air Conditioning Units (2) - 4 ton & 5 ton	2005	11,617	1,162	5	1,162		11,617	33
34	Pave Walkway, Roadway, Turnaround	2005	5,150	644	8	644		3,540	34
35	Exterior Siding	2006	6,440	644	10	644		2,898	35
36	Double Bowl Sinks (2)	2006	1,104	92	12	92		414	36
37	5-ton Rooftop A/C Unit	2006	7,500	750	12	750		3,375	37
38	**TOTAL (lines 1 thru 37)**		**$ 533,613**	**$ 61,312**		**$ 61,312**	**$ 0**	**$ 309,472**	38

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