

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0046888

Facility Name: Calhoun Nursing & Rehabilitation Center

Address: 1 Myrtle Lane Hardin 62047
 Number City Zip Code

County: Calhoun

Telephone Number: (618) 576-2278 **Fax #** (618) 576-2487

HFS ID Number: 20-1752491001

Date of Initial License for Current Owners: 1/1/05

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 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) _____
	(Type or Print Name) <u>Gary F. Eye</u>	
	(Title) <u>Senior VP of Finance of Tara Cares</u>	
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 Calhoun Nursing & Rehabilitation Center

0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,792	6,842	3,971	25,605	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,792	6,842	3,971	25,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.69%

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

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

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

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

None

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

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/1/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date January 1, 2005 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 80 and days of care provided 3,581

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 1/1 to 12/31/06 Fiscal Year: 1/1 to 12/31/06

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	118,874	9,268	1,744	129,886		129,886	(810)	129,076		1
2	Food Purchase		99,893		99,893		99,893	(638)	99,255		2
3	Housekeeping	65,841	11,096		76,937		76,937		76,937		3
4	Laundry	20,465	7,394	261	28,120		28,120		28,120		4
5	Heat and Other Utilities			63,489	63,489		63,489		63,489		5
6	Maintenance	26,674	20,814	41,246	88,734		88,734	(10,772)	77,962		6
7	Other (specify):* see trial balance			3,218	3,218		3,218		3,218		7
8	TOTAL General Services	231,854	148,465	109,958	490,277		490,277	(12,220)	478,057		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	962,441	74,169	10,560	1,047,170		1,047,170	(152)	1,047,018		10
10a	Therapy		4,973	311,124	316,097		316,097	(8,375)	307,722		10a
11	Activities	24,629	1,043	2,075	27,747		27,747		27,747		11
12	Social Services	22,344	302	2,484	25,130		25,130		25,130		12
13	CNA Training			515	515		515		515		13
14	Program Transportation			750	750		750		750		14
15	Other (specify):* see trial balance			2,009	2,009		2,009		2,009		15
16	TOTAL Health Care and Programs	1,009,414	80,487	336,717	1,426,618		1,426,618	(8,527)	1,418,091		16
	C. General Administration										
17	Administrative	114,964		158,004	272,968		272,968	15,713	288,681		17
18	Directors Fees										18
19	Professional Services			14,146	14,146		14,146		14,146		19
20	Dues, Fees, Subscriptions & Promotions			15,517	15,517		15,517	(4,962)	10,555		20
21	Clerical & General Office Expenses	8,996	18,936	22,239	50,171		50,171	(7,748)	42,423		21
22	Employee Benefits & Payroll Taxes			176,744	176,744		176,744	(3,260)	173,484		22
23	Inservice Training & Education										23
24	Travel and Seminar			30,574	30,574		30,574	(389)	30,185		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			139,686	139,686		139,686	(2,600)	137,086		26
27	Other (specify):* see trial balance			29,041	29,041		29,041	(16,340)	12,701		27
28	TOTAL General Administration	123,960	18,936	585,951	728,847		728,847	(19,586)	709,261		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,365,228	247,888	1,032,626	2,645,742		2,645,742	(40,333)	2,605,409		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 Calhoun Nursing & Rehabilitation Center #0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,939	20,939		20,939	1,623	22,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,136	102,136		102,136	(5,153)	96,983			32
33	Real Estate Taxes			60,168	60,168		60,168		60,168			33
34	Rent-Facility & Grounds			382,714	382,714		382,714		382,714			34
35	Rent-Equipment & Vehicles			12,232	12,232		12,232		12,232			35
36	Other (specify):* Amtz Customer Rights			3,768	3,768		3,768		3,768			36
37	TOTAL Ownership			581,957	581,957		581,957	(3,530)	578,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,555	4,555		4,555		4,555			39
40	Barber and Beauty Shops		319		319		319		319			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* see trial balance			93,792	93,792		93,792	(11,276)	82,516			43
44	TOTAL Special Cost Centers		319	142,147	142,466		142,466	(11,276)	131,190			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,365,228	248,207	1,756,730	3,370,165		3,370,165	(55,139)	3,315,026			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 Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning: 1/1/06

Ending: 12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(510)	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	(5,153)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,041)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(128)	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	(42)	21		18
19	Entertainment	(14)	21		19
20	Contributions	(200)	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	(16,140)	27		24
25	Fund Raising, Advertising and Promotional	(4,962)	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	(33,893)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,083)		\$	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)	6,944	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,944		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (55,139)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					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

Calhoun Nursing & Rehabilitation Center

ID# 0046888

Report Period Beginning: 1/1/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Remove Non Allowable Prior Year Costs	\$ (10,823)	43 1
2	Remove Employee Recognition Program >\$25/EE	(1,005)	22 2
3	Offset Interco Sold Services Revenue	(736)	6 3
4	Offset Interco Sold Services Revenue	(81)	22 4
5	Remove Interco Purchased Services Mark Up	(810)	1 5
6	Remove Interco Purchased Services Mark Up	(298)	6 6
7	Capitalize Repairs & Maintenance for Medicaid	(9,738)	6 7
8	Amortization of LHI Capitalized for Medicaid	1,623	30 8
9	Remove Restricted Work.Comp. Interest Income	(2,030)	22 9
10	Remove Non Allowable Visa Costs	(389)	24 10
11	Offset Misc Income-Medical Records	(20)	21 11
12	Remove Non Allowable Admiss-Other Supplies	(163)	21 12
13	Remove Non Allowable IV Prescription Drug Costs	(6,468)	21 13
14	Remove Non Allowable Insurance Costs	(2,600)	26 14
15	Remove RX-MD non formulary costs	(355)	43 15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(33,893)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(810)	0	0	0	0	0	0	0	0	0	0	(810)	1
2	Food Purchase	(638)	0	0	0	0	0	0	0	0	0	0	(638)	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	(10,772)	0	0	0	0	0	0	0	0	0	0	(10,772)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,220)	0	0	0	0	0	0	0	0	0	0	(12,220)	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	0	(152)	0	0	0	0	0	0	0	0	0	(152)	10
10a	Therapy	0	(8,375)	0	0	0	0	0	0	0	0	0	(8,375)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(8,527)	0	(8,527)	16								
	C. General Administration													
17	Administrative	0	15,713	0	0	0	0	0	0	0	0	0	15,713	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,962)	0	0	0	0	0	0	0	0	0	0	(4,962)	20
21	Clerical & General Office Expenses	(7,748)	0	0	0	0	0	0	0	0	0	0	(7,748)	21
22	Employee Benefits & Payroll Taxes	(3,116)	(144)	0	0	0	0	0	0	0	0	0	(3,260)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(389)	0	0	0	0	0	0	0	0	0	0	(389)	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):*	(16,340)	0	0	0	0	0	0	0	0	0	0	(16,340)	27
28	TOTAL General Administration	(35,155)	15,569	0	(19,586)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(47,375)	7,042	0	(40,333)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,623	0	0	0	0	0	0	0	0	0	0	1,623	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,153)	0	0	0	0	0	0	0	0	0	0	(5,153)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,530)	0	0	0	0	0	0	0	0	0	0	(3,530)	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):*	(11,178)	(98)	0	0	0	0	0	0	0	0	0	(11,276)	43
44	TOTAL Special Cost Centers	(11,178)	(98)	0	(11,276)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(62,083)	6,944	0	(55,139)	45								

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/06

Ending:

12/31/06

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Administrative Services Costs	\$ 158,004	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 173,717	\$ 15,713	1
2	V	34 Sublease Building & Equip	382,714	Tara Midwest, LLC	0.00%	382,714		2
3	V	10 Consulting Pharmacy Services	9,600	Tara Pharmacy SE, LLC	0.00%	9,448	(152)	3
4	V	43 Flu Vaccines for Residents	744	Tara Pharmacy SE, LLC	0.00%	646	(98)	4
5	V	22 Flu Vaccines for Employees	1,080	Tara Pharmacy SE, LLC	0.00%	936	(144)	5
6	V	10a Physical Therapy Fees	132,456	Tara Therapy, LLC	0.00%	170,615	38,159	6
7	V	10a Occupational Therapy Fees	129,384	Tara Therapy, LLC	0.00%	108,412	(20,972)	7
8	V	10a Speech Therapy Fees	49,284	Tara Therapy, LLC	0.00%	23,722	(25,562)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 863,266			\$ 870,210	\$ * 6,944	14

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	Donald T. Denz	Co-CEO and CFO	See attachment	45.00	***	0.7	1.75	Finance	\$ 3,881	17	1
2	Norbert A. Bennett	Co-CEO	See attachment	45.00	***	0.7	1.75	Operations	3,881	17	2
3	Gail M. Polanski	SVP Quality	See attachment	10.00	***	0.7	1.75	Quality Assuranc	5,136	17	3
4		Assurance									4
5	Suzette Wilson	Vice President	See attachment	0.00	***	0.7	1.75	Admissions	3,243	17	5
6											6
7											7
8	*** Compensation paid only through Support Office and allocated share reported in column 7.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,141		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 Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/06

Ending: 12/31/06

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	<u>17</u>	<u>Administrative Services Costs</u>	<u>Days</u>		\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Health Care REIT, Inc.		X	Acquisition of Operating		12/31/04	\$ 1,191,300	\$ 1,191,300	6/30/2018	5.7500	\$ 68,472	1								
2												2								
3	Health Care REIT, Inc.		X	Capital Improvements		1/23/06	233,951	191,970	1/23/2010	9.1300	19,069	3								
4												4								
5												5								
Working Capital																				
6	Health Care REIT, Inc.		X	Working Capital		12/31/2004	131,763	131,793	12/31/2007		14,595	6								
7										11.4100		7								
8												8								
9	TOTAL Facility Related						\$ 1,557,014	\$ 1,515,063			\$ 102,136	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,557,014	\$ 1,515,063			\$ 102,136	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	53,110	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.)		\$	55,258	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,148	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	58,020	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.		\$	60,168	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	_____	12	
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calhoun Nursing & Rehabilitation Center COUNTY Calhoun

FACILITY IDPH LICENSE NUMBER 0046888

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-08-27-200-001-F</u>	<u>PT NE 1/4 S27 T10S R2W</u>	\$ <u>55,258.10</u>	\$ <u>55,258.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>55,258.10</u>	\$ <u>55,258.10</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Calhoun Nursing & Rehabilitation Center

0046888 Report Period Beginning:

1/1/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,591 B. General Construction Type: Exterior Brick Frame Wood 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).

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: 269,573 2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: 53,914 4. Dates Incurred: Prior to January 1, 2005

Nature of Costs: Includes capitalized pre-opening salaries, fringe benefits and other costs incurred prior to 1/01/05 and allocated via related organization.
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/06

Ending:

12/31/06

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 Sign			2005	696	104	10	104		104	9
10	Blinds			2006	10,270	1,027	5	1,027		1,027	10
11	Plumbing and Mechanical repairs capitalized for Medicaid			2006	9738	1623	3	1623		1623	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 20,704	\$ 2,754		\$ 2,754	\$	\$ 2,754	70

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	\$ 58,324	\$ 17,287	\$ 17,287	\$ (0)		\$ 17,287	71
72	Current Year Purchases	36,917	2,521	2,521			2,521	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 95,241	\$ 19,808	\$ 19,808	\$ (0)		\$ 19,808	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)	\$ 115,945	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,562	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,562	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 22,562	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Architect Drawings	\$ 2,047	92
93			93
94			94
95		\$ 2,047	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1996</u>	<u>80</u>	<u>1/1/05</u>	\$ <u>382,714</u>	<u>13.5 yrs</u>	<u>1-15 yr</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		80		\$ 382,714			7

10. Effective dates of current rental agreement:

Beginning 12/31/04

Ending 6/30/18

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

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

12.	<u>12/31/2007</u>	\$ <u>382,714</u>
13.	<u>12/31/2008</u>	\$ <u>382,714</u>
14.	<u>12/31/2009</u>	\$ <u>382,714</u>

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease 13.5 yrs.

1,145,101

84,822

9. Option to Buy: YES NO Terms: 60 day notice *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 17,043 Description: _____

(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.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 checked="" type="checkbox"/> YES <input 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 checked="" 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 515	\$	\$ 515
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	\$	\$ 515	\$	\$ 515
10	SUM OF line 9, col. 1 and 2 (e)	\$	515		

C. CONTRACTUAL INCOME

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

\$ n/a

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (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	\$ 142,937	\$	1
2	Cash-Patient Deposits	4,183		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 31,088)	632,357		3
4	Supply Inventory (priced at cost)	6,929		4
5	Short-Term Investments			5
6	Prepaid Insurance	417		6
7	Other Prepaid Expenses	992,580		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,779,403	\$	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	10,966		15
16	Equipment, at Historical Cost	95,241		16
17	Accumulated Depreciation (book methods)	(20,939)		17
18	Deferred Charges	13,401		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Long Term Deposits	25		22
23	Other(specify): <u>Construction in Progress</u>	2,047		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 100,741	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,880,144	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 173,849	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,183		28
29	Short-Term Notes Payable	190,281		29
30	Accrued Salaries Payable	144,734		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,428		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,020		32
33	Accrued Interest Payable	2,714		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benefits Payable</u>	6,161		36
37	<u>Accrued Expenses</u>	72,200		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 670,570	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,324,782		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)	\$ 1,324,782	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,995,352	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (115,208)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,880,144	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 29,205	1
2	Restatements (describe):		2
3	Prior Year Adjustments	(79,005)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (49,800)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(65,408)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (65,408)	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)	\$ (115,208)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center# 0046888Report Period Beginning: 1/1/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,463,895	1
2	Discounts and Allowances for all Levels	689,289	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,153,184	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	141,138	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 141,138	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	510	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 510	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,473	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,473	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	296	28
28a	PrchDisc/VendComm/SoldSrvcs Rev/Med Rec Copies	2,156	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,452	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,304,757	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	490,277	31
32	Health Care	1,426,618	32
33	General Administration	728,847	33
B. Capital Expense			
34	Ownership	581,957	34
C. Ancillary Expense			
35	Special Cost Centers	98,666	35
36	Provider Participation Fee	43,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,370,165	40
41	Income before Income Taxes (line 30 minus line 40)**	(65,408)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (65,408)	43

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

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

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning: 1/1/06

Ending: 12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,820	2,092	\$ 54,611	\$ 26.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,551	7,005	142,406	20.33	3
4	Licensed Practical Nurses	16,820	17,836	302,842	16.98	4
5	CNAs & Orderlies	39,539	42,138	398,658	9.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,839	2,023	18,896	9.34	9
10	Activity Assistants	786	786	5,734	7.30	10
11	Social Service Workers	2,034	2,309	22,344	9.68	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	23,717	11.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,715	5,299	50,978	9.62	15
16	Dishwashers	5,600	6,032	44,179	7.32	16
17	Maintenance Workers	2,000	2,080	26,674	12.82	17
18	Housekeepers	8,232	8,809	65,841	7.47	18
19	Laundry	2,407	2,604	20,465	7.86	19
20	Administrator	1,944	2,080	64,870	31.19	20
21	Assistant Administrator					21
22	Other Administrative	2,000	2,080	29,113	14.00	22
23	Office Manager	1,935	2,109	20,981	9.95	23
24	Clerical	1,158	1,158	8,996	7.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS Coordinator	1,913	2,083	44,677	21.45	32
33	Other(specify) Nrsng Adm Clerical	1,838	2,014	19,246	9.56	33
34	TOTAL (lines 1 - 33)	104,971	112,617	\$ 1,365,228 *	\$ 12.12	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	26	\$ 1,282	1-3 35
36	Medical Director	contract	7,200	9-3 36
37	Medical Records Consultant	\$1/bed	960	10-3 37
38	Nurse Consultant			38
39	Pharmacist Consultant	\$10/bed	9,600	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	28	1,695	11-3 44
45	Social Service Consultant	42	2,484	12-3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	96	\$ 23,221	49

C. CONTRACT NURSES

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

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 \$2,941 net of non-allowable
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,945 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,800
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. \$ 510
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? n/a
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.