

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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: January 1, 2005

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 1/1/07 to 12/31/07 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: 1/1/07 Ending: 12/31/07

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	<u>80</u>	Skilled (SNF)	<u>80</u>	<u>29,200</u>	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	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	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	<u>15,710</u>	<u>7,649</u>	<u>4,063</u>	<u>27,422</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,710</u>	<u>7,649</u>	<u>4,063</u>	<u>27,422</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.91%

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

3 (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)

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

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

YES NO

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

YES NO

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

Date started 01/1/05

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 3,823Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 1/1 to 12/31/07 Fiscal Year: 1/1 to 12/31/07

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	126,415	12,868	6,937	146,220		146,220	(760)	145,460		1
2	Food Purchase		117,012		117,012		117,012	(180)	116,832		2
3	Housekeeping	82,276	13,627	173	96,076		96,076	(391)	95,685		3
4	Laundry	21,553	6,638		28,191		28,191		28,191		4
5	Heat and Other Utilities			79,374	79,374		79,374		79,374		5
6	Maintenance	25,021	12,555	25,856	63,432		63,432	(3,009)	60,423		6
7	Other (specify):* see trial balance			3,224	3,224		3,224		3,224		7
8	TOTAL General Services	255,265	162,700	115,564	533,529		533,529	(4,340)	529,189		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,137,767	77,186	11,678	1,226,631		1,226,631	528	1,227,159		10
10a	Therapy		2,657	589,544	592,201		592,201	(24,413)	567,788		10a
11	Activities	30,566	763	2,093	33,422		33,422		33,422		11
12	Social Services	26,162		2,013	28,175		28,175		28,175		12
13	CNA Training			515	515		515		515		13
14	Program Transportation			785	785		785		785		14
15	Other (specify):* see trial balance			3,117	3,117		3,117		3,117		15
16	TOTAL Health Care and Programs	1,194,495	80,606	616,945	1,892,046		1,892,046	(23,885)	1,868,161		16
	C. General Administration										
17	Administrative	159,573		175,836	335,409		335,409	12,545	347,954		17
18	Directors Fees										18
19	Professional Services			15,419	15,419		15,419	(3,627)	11,792		19
20	Dues, Fees, Subscriptions & Promotions			13,852	13,852		13,852	(4,356)	9,496		20
21	Clerical & General Office Expenses	9,443	21,735	26,980	58,158		58,158	(6,539)	51,619		21
22	Employee Benefits & Payroll Taxes			272,487	272,487		272,487	(3,307)	269,180		22
23	Inservice Training & Education										23
24	Travel and Seminar			30,624	30,624		30,624	(170)	30,454		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,172	10,172		10,172	(2,600)	7,572		26
27	Other (specify):* see trial balance			34,628	34,628		34,628	(18,311)	16,317		27
28	TOTAL General Administration	169,016	21,735	579,998	770,749		770,749	(26,365)	744,384		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,618,776	265,041	1,312,507	3,196,324		3,196,324	(54,590)	3,141,734		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: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			21,798	21,798	21,798	3,747	25,545			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			92,612	92,612	92,612	(3,981)	88,631			32
33	Real Estate Taxes			70,310	70,310	70,310		70,310			33
34	Rent-Facility & Grounds			373,662	373,662	373,662		373,662			34
35	Rent-Equipment & Vehicles			24,581	24,581	24,581		24,581			35
36	Other (specify):* Amtz Customer Rights			3,658	3,658	3,658		3,658			36
37	TOTAL Ownership			586,621	586,621	586,621	(234)	586,387			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			1,534	1,534	1,534		1,534			39
40	Barber and Beauty Shops			193	193	193		193			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			116,266	116,266	116,266	(17,823)	98,443			43
44	TOTAL Special Cost Centers			161,793	161,793	161,793	(17,823)	143,970			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,618,776	265,041	2,060,921	3,944,738	3,944,738	(72,647)	3,872,091			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: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(31)	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	(3,981)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,509)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	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	(1,221)	21		18
19	Entertainment				19
20	Contributions	(350)	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	(17,892)	27		24
25	Fund Raising, Advertising and Promotional	(4,356)	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	(36,965)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,454)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (66,454)		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: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Remove Non Allowable Prior Year Costs	\$ (12,003)	43	1
2	Remove Employee Recognition Program >\$25/EE	(2,245)	22	2
3	Remove Non Allowable Admiss-Other Supplies	(3,809)	21	3
4	Remove Non Allowable Outpatient Svcs	(4,241)	43	4
5	Remove Non Allowable Insurance Costs	(2,600)	26	5
6	Remove Non Allowable Admin Other Fees	(69)	27	6
7	Capitalize Repairs & Maintenance for Medicaid	(3,009)	6	7
8	Amortization of LHI Capitalized for Medicaid	3,747	30	8
9	Remove Restricted Work.Comp. Interest Income	(1,323)	22	9
10	Remove Non Allowable Visa Costs	(170)	24	10
11	Remove Non Allowable IV Prescription Drug Costs	(1,570)	43	11
12	Offset Interco Sold Services Revenue	(2,584)	10	12
13	Offset Interco Sold Services Revenue	(1,585)	22	13
14	Offset Interco Sold Services Revenue	(631)	17	14
15	Offset Interco Sold Services Revenue	(169)	1	15
16	Offset Interco Sold Services Revenue	(391)	3	16
17	Remove Interco Purchased Services Mark Up	(591)	1	17
18	Remove Interco Purchased Services Mark Up	(95)	10	18
19	Remove Non Allowable Acctg Tax Fees E&Y	(3,627)	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	(36,965)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	(760)	0	0	0	0	0	0	0	0	0	0	(760)	1
2	Food Purchase	(180)	0	0	0	0	0	0	0	0	0	0	(180)	2
3	Housekeeping	(391)	0	0	0	0	0	0	0	0	0	0	(391)	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	(3,009)	0	0	0	0	0	0	0	0	0	0	(3,009)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,340)	0	0	0	0	0	0	0	0	0	0	(4,340)	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	(2,679)	3,207	0	0	0	0	0	0	0	0	0	528	10
10a	Therapy	0	(24,413)	0	0	0	0	0	0	0	0	0	(24,413)	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	(2,679)	(21,206)	0	(23,885)	16								
	C. General Administration													
17	Administrative	(631)	13,176	0	0	0	0	0	0	0	0	0	12,545	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,627)	0	0	0	0	0	0	0	0	0	0	(3,627)	19
20	Fees, Subscriptions & Promotions	(4,356)	0	0	0	0	0	0	0	0	0	0	(4,356)	20
21	Clerical & General Office Expenses	(6,539)	0	0	0	0	0	0	0	0	0	0	(6,539)	21
22	Employee Benefits & Payroll Taxes	(5,153)	1,846	0	0	0	0	0	0	0	0	0	(3,307)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(170)	0	0	0	0	0	0	0	0	0	0	(170)	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):*	(18,311)	0	0	0	0	0	0	0	0	0	0	(18,311)	27
28	TOTAL General Administration	(41,387)	15,022	0	(26,365)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,406)	(6,184)	0	(54,590)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	3,747	0	0	0	0	0	0	0	0	0	0	3,747	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,981)	0	0	0	0	0	0	0	0	0	0	(3,981)	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	(234)	0	0	0	0	0	0	0	0	0	0	(234)	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):*	(17,814)	(9)	0	0	0	0	0	0	0	0	0	(17,823)	43
44	TOTAL Special Cost Centers	(17,814)	(9)	0	(17,823)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(66,454)	(6,193)	0	(72,647)	45								

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning:

1/1/07

Ending:

12/31/07

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	Administrative Services Costs	\$ 175,836	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 189,012	\$ 13,176	1
2	V	34	Sublease Building & Equip	373,662	Tara Midwest, LLC	0.00%	373,662		2
3	V	10	Consulting Pharmacy Services	9,600	Tara Pharmacy SE, LLC	0.00%	12,807	3,207	3
4	V	43	Flu Vaccines for Residents	802	Tara Pharmacy SE, LLC	0.00%	793	(9)	4
5	V	22	Flu Vaccines for Employees	1,204	Tara Pharmacy SE, LLC	0.00%	1,190	(14)	5
6	V	22	Medical Transcription	1,120	Tara Pharmacy SE, LLC	0.00%	2,980	1,860	6
7	V	10a	Physical Therapy Fees	342,411	Tara Therapy, LLC	0.00%	338,946	(3,465)	7
8	V	10a	Occupational Therapy Fees	186,177	Tara Therapy, LLC	0.00%	139,613	(46,564)	8
9	V	10a	Speech Therapy Fees	60,956	Tara Therapy, LLC	0.00%	86,572	25,616	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,151,768			\$ 1,145,575	\$ * (6,193)		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: 1/1/07 Ending: 12/31/07

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	***	0.77	1.92	Fin/Oper	\$ 4,310	17	1
2	Norbert A. Bennett	Co-CEO	See attachment	45.00	***	0.77	1.92	Fin/Oper	4,310	17	2
3	Gail M. Polanski	SVP Quality	See attachment	10.00	***	0.77	1.92	Qual. Assur.	5,203	17	3
4		Assurance									4
5	Suzette Wilson	Vice President	See attachment	0.00	***	0.77	1.92	VP	3,419	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	\$ 17,242		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: 1/1/07 Ending: 12/31/07

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	17	Administrative Services Costs Days			\$	\$		\$	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: 1/1/07 Ending: 12/31/07

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 Rights	Interest Only	12/31/04	\$ 1,191,300	\$ 1,191,300	6/30/2018	5.7500	\$ 68,472	1								
2					until Maturity							2								
3	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	1/23/06	233,951	137,337	1/23/2010	9.3800	15,929	3								
4					with add'l 25 basis points each year							4								
5												5								
Working Capital																				
6	Health Care REIT, Inc.		X	Working Capital	Interest Only	12/31/2004	131,793		12/31/2007	Prime +3	8,211	6								
7					with balance to amortize down					10.6500		7								
8					evenly in 2007 thru 12/31/07				effective rate at 12/31/07			8								
9	TOTAL Facility Related						\$ 1,557,044	\$ 1,328,637			\$ 92,612	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,557,044	\$ 1,328,637			\$ 92,612	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>61,044.28</u>	\$ <u>61,044.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>61,044.28</u>	\$ <u>61,044.28</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

1/1/07 Ending:

12/31/07

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: 849,335 2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8 4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc. capitalized pre-opening salaries, fringe benefits & other costs incurred prior 1/1/05. Costs allocated via related org cost & reported on Sch V.
(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:

1/1/07

Ending:

12/31/07

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	70	10	70		174	9
10		Blinds		2006	10,270	2,050	5	2,050		3,080	10
11		Plumbing and Mechanical repairs capitalized for Medicaid		2006	9,738	3,247	3	3,247		4,868	11
12		Plumbing and Mechanical repairs capitalized for Medicaid		2007	3,009	502	3	502		502	12
13		Carpeting		2007	3,360	336	5	336		336	13
14		Carpet Flooring		2007	7,038	704	5	704		704	14
15		Air Conditioning Unit (10 ton)		2007	4,650	233	10	233		233	15
16		2 Doors		2007	3,319	151	11	151		151	16
17		Cilcomm Phone System		2007	14,210	711	10	711		711	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:

1/1/07

Ending:

12/31/07

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)	\$ 56,289	\$ 8,004		\$ 8,004	\$	\$ 10,759	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: 1/1/07 Ending: 12/31/07

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	\$ 95,241	\$ 16,566	\$ 16,566	\$		\$ 36,374	71
72	Current Year Purchases	15,553	975	975			975	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 110,794	\$ 17,541	\$ 17,541	\$		\$ 37,349	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)	\$ 167,083	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,545	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,545	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)	\$ 48,108	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	\$ 2,704	92
93			93
94			94
95		\$ 2,704	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.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

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>373,662</u>	<u>13.5 yrs</u>	<u>1-15 yr</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		80		\$ 373,662			7

10. Effective dates of current rental agreement:

Beginning 12/31/04 midnight

Ending 6/30/18 midnight

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>373,662</u>
13.	<u>12/31/2008</u>	\$ <u>373,662</u>
14.	<u>12/31/2009</u>	\$ <u>373,662</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.

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: \$ 27,904 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	<u>See Separate Schedule</u>		\$ _____	\$ <u>58</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 58	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: 1/1/07 Ending: 12/31/07

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
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	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	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: 1/1/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ 745,102	\$	1
2	Cash-Patient Deposits	9,764		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	573,597		3
4	Supply Inventory (priced at <u>cost</u>)	4,407		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,149		6
7	Other Prepaid Expenses	906,417		7
8	Accounts Receivable (owners or related parties)	(662,628)		8
9	Other(specify):	549		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,579,357	\$	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	43,542		15
16	Equipment, at Historical Cost	110,794		16
17	Accumulated Depreciation (book methods)	(42,738)		17
18	Deferred Charges	8,714		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 <u>Long Term Deposits</u>)	25		22
23	Other(specify): <u>Construction in Progress</u>	2,704		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 123,041	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,702,398	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 32,349	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,764		28
29	Short-Term Notes Payable	58,488		29
30	Accrued Salaries Payable	171,994		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,193		31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,310		32
33	Accrued Interest Payable	1,072		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benefits Payable</u>	(1,153)		36
37	<u>Accrued Expenses</u>	(443)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 362,574	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,270,150		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)	\$ 1,270,150	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,632,724	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 69,674	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,702,398	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (115,208)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (115,208)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	184,882	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)	\$ 184,882	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)	\$ 69,674	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center# 0046888Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 2,656,187	1
2	Discounts and Allowances for all Levels	982,290	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,638,477	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	454,785	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 454,785	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	31	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,410	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)	\$ 21,441	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,615	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,615	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	1,009	28
28a	PrchDisc/VendComm/SoldSrvcs Rev/Med Rec Copies	8,293	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,302	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,129,620	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	533,529	31
32	Health Care	1,892,046	32
33	General Administration	770,749	33
B. Capital Expense			
34	Ownership	586,621	34
C. Ancillary Expense			
35	Special Cost Centers	117,993	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)*	\$ 3,944,738	40
41	Income before Income Taxes (line 30 minus line 40)**	184,882	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 184,882	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: 1/1/07

Ending: 12/31/07

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	1,848	2,070	\$ 64,067	\$ 30.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,139	7,547	162,326	21.51	3
4	Licensed Practical Nurses	19,443	20,725	348,954	16.84	4
5	CNAs & Orderlies	42,400	45,531	449,069	9.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,941	2,163	19,608	9.07	9
10	Activity Assistants	1,353	1,417	10,958	7.73	10
11	Social Service Workers	2,000	2,040	26,162	12.82	11
12	Dietician					12
13	Food Service Supervisor	1,728	2,048	23,252	11.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,251	8,065	72,071	8.94	15
16	Dishwashers	3,665	4,303	31,092	7.23	16
17	Maintenance Workers	1,920	2,080	25,021	12.03	17
18	Housekeepers	9,573	10,156	82,276	8.10	18
19	Laundry	2,524	2,780	21,553	7.75	19
20	Administrator	1,952	2,080	100,693	48.41	20
21	Assistant Administrator					21
22	Other Administrative	2,056	2,160	35,971	16.65	22
23	Office Manager	1,922	2,084	22,909	10.99	23
24	Clerical	1,163	1,195	9,443	7.90	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	3,512	3,824	81,412	21.29	32
33	Other(specify) Nrsng Adm Clerical	2,104	2,296	31,939	13.91	33
34	TOTAL (lines 1 - 33)	115,494	124,564	\$ 1,618,776 *	\$ 13.00	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	8	\$ 404	1-3	35
36	Medical Director	contract	7,200	9-3	36
37	Medical Records Consultant	\$1/bed	2,078	10-3	37
38	Nurse Consultant	0	0	0	38
39	Pharmacist Consultant	\$10/bed	9,600	10-3	39
40	Physical Therapy Consultant	0	0	0	40
41	Occupational Therapy Consultant	0	0	0	41
42	Respiratory Therapy Consultant	0	0	0	42
43	Speech Therapy Consultant	0	0	0	43
44	Activity Consultant	31	2,013	11-3	44
45	Social Service Consultant	31	2,013	12-3	45
46	Other(specify)	0	0	0	46
47					47
48					48
49	TOTAL (lines 35 - 48)	71	\$ 23,308		49

C. CONTRACT NURSES

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

0046888

Report Period Beginning: 1/1/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Barbara Ledder	Administrator	0	\$ 100,693	Workers' Compensation Insurance	\$ 74,649	IDPH License Fee	\$ 663	
Other Administrative Salaries		0	58,880	Unemployment Compensation Insurance	19,634	Advertising: Employee Recruitment	3,873	
				FICA Taxes	121,279	Health Care Worker Background Check		
				Employee Health Insurance	45,500	(Indicate # of checks performed <u>152</u>)	1,800	
				Employee Meals		MIADA	20	
				Illinois Municipal Retirement Fund (IMRF)*		IL. Health Care Association	4,800	
				Employee Benefits - other	6,069	Non Allowable IL Health Care Assn	(1,686)	
				Employee Benefits - Hep B Vaccination	203	Licenses	26	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 159,573					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Tara Cares Administrative Services Fee			\$ 175,836				Out-of-State Travel	\$
							In-State Travel	27,384
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 175,836				Seminar Expense	3,070
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type	Amount					(agree to Sch. V, line 24, col. 8)	
Ernst & Young	Accounting Fees	\$ 11,479						
Ernst & Young	Tax Fees	3,627						
Various - See Attached detailed listing		313						
TOTAL (agree to Schedule V, line 19, column 3)				\$			\$ 30,454	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 15,419					

* Attach copy of IMRF notifications

**See instructions.

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 \$3,114 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. \$ 23,003 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. \$ 31
- (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? _____
- 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.