



Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

# 0046888 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	29,280	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	29,280	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	16,024	7,053	3,948	27,025	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,024	7,053	3,948	27,025	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.30%

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 3,457

Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 1/1 to 12/31/08 Fiscal Year: 1/1 to 12/31/08  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/08 Ending: 12/31/08

**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	
	<b>A. General Services</b>											
1	Dietary	129,988	12,428	8,860	151,276		151,276	(860)	150,416			1
2	Food Purchase		123,026		123,026		123,026	(147)	122,879			2
3	Housekeeping	102,555	13,812		116,367		116,367		116,367			3
4	Laundry	22,665	10,499	280	33,444		33,444		33,444			4
5	Heat and Other Utilities			93,255	93,255		93,255		93,255			5
6	Maintenance	23,570	14,063	25,131	62,764		62,764		62,764			6
7	Other (specify):* see trial balance			4,115	4,115		4,115		4,115			7
8	<b>TOTAL General Services</b>	278,778	173,828	131,641	584,247		584,247	(1,007)	583,240			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,253,517	83,199	17,760	1,354,476		1,354,476	2,366	1,356,842			10
10a	Therapy		1,272	696,350	697,622		697,622	(36,500)	661,122			10a
11	Activities	28,309	952	2,123	31,384		31,384		31,384			11
12	Social Services	27,826	282	2,252	30,360		30,360	(7)	30,353			12
13	CNA Training			515	515		515		515			13
14	Program Transportation			370	370		370		370			14
15	Other (specify):* see trial balance			1,722	1,722		1,722	(59)	1,663			15
16	<b>TOTAL Health Care and Programs</b>	1,309,652	85,705	735,492	2,130,849		2,130,849	(34,200)	2,096,649			16
	<b>C. General Administration</b>											
17	Administrative	165,700		205,344	371,044		371,044	(5,501)	365,543			17
18	Directors Fees											18
19	Professional Services			8,509	8,509		8,509	(2,682)	5,827			19
20	Dues, Fees, Subscriptions & Promotions			16,633	16,633		16,633	(6,375)	10,258			20
21	Clerical & General Office Expenses	17,400	26,537	29,645	73,582		73,582	(6,211)	67,371			21
22	Employee Benefits & Payroll Taxes			266,017	266,017		266,017	(4,222)	261,795			22
23	Inservice Training & Education											23
24	Travel and Seminar			32,996	32,996		32,996	(1,341)	31,655			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,505	10,505		10,505	(2,600)	7,905			26
27	Other (specify):* see trial balance			56,666	56,666		56,666	(36,547)	20,119			27
28	<b>TOTAL General Administration</b>	183,100	26,537	626,315	835,952		835,952	(65,479)	770,473			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,771,530	286,070	1,493,448	3,551,048		3,551,048	(100,686)	3,450,362			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: 1/1/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			28,799	28,799	28,799	4,249	33,048			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			78,592	78,592	78,592	(3,273)	75,319			32
33	Real Estate Taxes			69,780	69,780	69,780		69,780			33
34	Rent-Facility & Grounds			288,840	288,840	288,840		288,840			34
35	Rent-Equipment & Vehicles			22,488	22,488	22,488		22,488			35
36	Other (specify):* Amtz Debt Acq Costs			699	699	699		699			36
37	<b>TOTAL Ownership</b>			489,198	489,198	489,198	976	490,174			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops			396	396	396		396			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			43,920	43,920	43,920		43,920			42
43	Other (specify):* see trial balance			114,383	114,383	114,383	(8,572)	105,811			43
44	<b>TOTAL Special Cost Centers</b>			158,699	158,699	158,699	(8,572)	150,127			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,771,530	286,070	2,141,345	4,198,945	4,198,945	(108,282)	4,090,663			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: 1/1/08

Ending: 12/31/08

**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		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	(3,273)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,978)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(147)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,002)	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	(20,856)	27		24
25	Fund Raising, Advertising and Promotional	(5,755)	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	(35,010)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (68,021)		\$	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)	(40,261)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (40,261)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (108,282)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

## Calhoun Nursing &amp; Rehabilitation Center

ID# 0046888

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Remove Restricted WorkersComp. Interest Income	\$ (519)	22	1
2	Remove NonAllowable Admiss-Other Supplies	(4,233)	21	2
3	Remove Employee Recognition Program	(1,075)	22	3
4	Remove Interco Purchased Services Mark-up	(860)	1	4
5	Remove Interco Purchased Services Mark-up	(7)	12	5
6	Remove Interco Purchased Services Mark-up	(59)	15	6
7	Remove Interco Purchased Services Mark-up	(25)	27	7
8	Amort/Depreciation on LHI capital for Medicaid	4,249	30	8
9	Remove NonAllowable Visa Costs	(104)	24	9
10	Remove NonAllowable Visa Costs	(2,213)	22	10
11	Remove NonAllowable IV Prescription Drug Costs	(2,064)	43	11
12	Remove NonAllowable Insurance Costs	(2,600)	26	12
13	Remove NonAllowable Prior Year Costs	(6,297)	43	13
14	Remove NonAllowable Admin- Other Fees	(12,133)	27	14
15	Remove NonAllowable Acctg - Tax Fees	(2,682)	19	15
16	Remove NonAllowable Admin-Other Purch Srvcs	(2,531)	27	16
17	Remove NonAllowable Admissions-Meals/Ent.	(1,195)	24	17
18	Remove NonAllowable Admissions-Lodging	(42)	24	18
19	Remove NonAllowable HR-EE background checks	(620)	20	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	<b>Total</b>	(35,010)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Calhoun Nursing &amp; Rehabilitation Center

# 0046888

Report Period Beginning:

1/1/08

Ending:

12/31/08

## 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)	
	<b>A. General Services</b>													
1	Dietary	(860)	0	0	0	0	0	0	0	0	0	0	(860)	1
2	Food Purchase	(147)	0	0	0	0	0	0	0	0	0	0	(147)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,007)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,007)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,366	0	0	0	0	0	0	0	0	0	2,366	10
10a	Therapy	0	(36,500)	0	0	0	0	0	0	0	0	0	(36,500)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(7)	0	0	0	0	0	0	0	0	0	0	(7)	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):*	(59)	0	0	0	0	0	0	0	0	0	0	(59)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(66)</b>	<b>(34,134)</b>	<b>0</b>	<b>(34,200)</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(5,501)	0	0	0	0	0	0	0	0	0	(5,501)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,682)	0	0	0	0	0	0	0	0	0	0	(2,682)	19
20	Fees, Subscriptions & Promotions	(6,375)	0	0	0	0	0	0	0	0	0	0	(6,375)	20
21	Clerical & General Office Expenses	(6,211)	0	0	0	0	0	0	0	0	0	0	(6,211)	21
22	Employee Benefits & Payroll Taxes	(3,807)	(415)	0	0	0	0	0	0	0	0	0	(4,222)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,341)	0	0	0	0	0	0	0	0	0	0	(1,341)	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):*	(36,547)	0	0	0	0	0	0	0	0	0	0	(36,547)	27
28	<b>TOTAL General Administration</b>	<b>(59,563)</b>	<b>(5,916)</b>	<b>0</b>	<b>(65,479)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(60,636)</b>	<b>(40,050)</b>	<b>0</b>	<b>(100,686)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

# 0046888

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	4,249	0	0	0	0	0	0	0	0	0	0	4,249	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,273)	0	0	0	0	0	0	0	0	0	0	(3,273)	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	<b>TOTAL Ownership</b>	<b>976</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>976</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(8,361)	(211)	0	0	0	0	0	0	0	0	0	(8,572)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(8,361)</b>	<b>(211)</b>	<b>0</b>	<b>(8,572)</b>	<b>44</b>								
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(68,021)</b>	<b>(40,261)</b>	<b>0</b>	<b>(108,282)</b>	<b>45</b>								

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

# 0046888

Report Period Beginning:

1/1/08

Ending:

12/31/08

**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 <u>Administrative Services Costs</u>	\$ 205,344	<u>Aurora Cares, LLC d/b/a Tara Cares</u>	0.00%	\$ 199,843	\$ (5,501)	1
2	V	34 <u>Sublease Building &amp; Equip</u>	288,840	<u>Tara Midwest, LLC</u>	0.00%	288,840		2
3	V	10 <u>Pharmacy Consulting Services</u>	12,480	<u>Tara Pharmacy SE, LLC</u>	0.00%	14,738	2,258	3
4	V	43 <u>Flu Vaccines for Residents</u>	652	<u>Tara Pharmacy SE, LLC</u>	0.00%	441	(211)	4
5	V	22 <u>Flu Vaccines for Employees</u>	1,283	<u>Tara Pharmacy SE, LLC</u>	0.00%	868	(415)	5
6	V	10 <u>Medical Transcription</u>	5,280	<u>Tara Pharmacy SE, LLC</u>	0.00%	5,388	108	6
7	V	10a <u>Physical Therapy Fees</u>	388,851	<u>Tara Therapy, LLC</u>	0.00%	391,324	2,473	7
8	V	10a <u>Occupational Therapy Fees</u>	269,678	<u>Tara Therapy, LLC</u>	0.00%	207,390	(62,288)	8
9	V	10a <u>Speech Therapy Fees</u>	37,821	<u>Tara Therapy, LLC</u>	0.00%	61,136	23,315	9
10	V	32 <u>Capital Interest Expense</u>	78,592	<u>Tara Midwest, LLC</u>	0.00%	78,592		10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,288,821			\$ 1,248,560	\$ * (40,261)	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: 1/1/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	DTD HC, LLC	See Attachment	See Attachment	50.00	See Attachment	See Attached	See Attached	See Attached	\$ See Attachme	17	1	
2	D & N, LLC	See Attachment	See Attachment	50.00	See Attachment	See Attached	See Attached	See Attached	See Attachme	17	2	
3											3	
4											4	
5	Suzette Wilson	Vice President	See attachment	0.00	***			VP		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	\$		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: 1/1/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Administrative Services Costs	Days	1,433,603	35	\$ 331,400	\$ 330,524	27,025	\$ 6,248	1
2	5	Administrative Services Costs	Days	1,433,603	35	54,676	0	27,025	1,031	2
3	6	Administrative Services Costs	Days	1,433,603	35	62,381	1,810	27,025	1,175	3
4	17	Administrative Services Costs	Days	1,433,603	35	7,614,392	7,614,392	27,025	143,535	4
5	19	Administrative Services Costs	Days	1,433,603	35	6,890	0	27,025	130	5
6	20	Administrative Services Costs	Days	1,433,603	35	24,654	0	27,025	465	6
7	21	Administrative Services Costs	Days	1,433,603	35	322,147	0	27,025	6,076	7
8	22	Administrative Services Costs	Days	1,433,603	35	1,019,506	0	27,025	19,218	8
9	24	Administrative Services Costs	Days	1,433,603	35	289,109	0	27,025	5,450	9
10	25	Administrative Services Costs	Days	1,433,603	35	347,091	0	27,025	6,543	10
11	26	Administrative Services Costs	Days	1,433,603	35	5,811	0	27,025	110	11
12	27	Administrative Services Costs	Days	1,433,603	35	77,338	0	27,025	1,458	12
13	30	Administrative Services Costs	Days	1,433,603	35	281,539	0	27,025	5,307	13
14	31	Administrative Services Costs	Days	1,433,603	35	35,842	0	27,025	676	14
15	33	Administrative Services Costs	Days	1,433,603	35	26,254	0	27,025	495	15
16	34	Administrative Services Costs	Days	1,433,603	35	93,028	0	27,025	1,754	16
17	35	Administrative Services Costs	Days	1,433,603	35	9,111	0	27,025	172	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,601,169	\$ 7,946,726		\$ 199,843	25

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/08 Ending: 12/31/08

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
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	77,470	1/23/2010	9.6300	10,120	3								
4					with add'l 25 basis points each year							4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 1,425,251	\$ 1,268,770			\$ 78,592	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,425,251	\$ 1,268,770			\$ 78,592	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 2007 report.	\$	<b>70,310</b>	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.)	\$	<b>66,455</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(3,855)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>73,635</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>69,780</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>52,966</b>	<b>8</b>
	2004	<b>53,066</b>	<b>9</b>
	2005	<b>55,258</b>	<b>10</b>
	2006	<b>61,044</b>	<b>11</b>
	2007	<b>66,455</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>66,454.62</u>	\$ <u>66,454.62</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>66,454.62</u>	\$ <u>66,454.62</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

1/1/08 Ending:

12/31/08

**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

**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
	<b>Improvement Type**</b>										
9		Alumalite Sign		2005	695.94	70	10	70		244	9
10		Blinds		2006	10,270	2,054	5	2,054		5,135	10
11		Plumbing and Mechanical repairs capitalized for Medicaid		2006	9,738	3,246	3	3,246		8,114	11
12		Plumbing and Mechanical repairs capitalized for Medicaid		2007	3,009	1,003	3	1,003		1,505	12
13		Carpeting		2007	3,360	672	5	672		1,008	13
14		Carpet Flooring		2007	7,038	1,408	5	1,408		2,111	14
15		Air Conditioning Unit (10 ton)		2007	4,650	465	10	465		698	15
16		2 Doors		2007	3,319	302	11	302		453	16
17		Cilcomm Phone System		2007	14,211	1,421	10	1,421		2,132	17
18		Nurse Station		2008	40,675	2,034	10	2,034		2,034	18
19		Depreciation on Asset#73-Burnisher Disposed on 5/31/08				68		68			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:

1/1/08

Ending:

12/31/08

**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		\$ 96,964	\$ 12,743		\$ 12,743	\$	\$ 23,434	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: 1/1/08 Ending: 12/31/08

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	\$ 110,115	\$ 18,208	\$ 18,208	\$		\$ 55,490	71
72	Current Year Purchases	25,765	2,097	2,097			2,097	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 135,880	\$ 20,305	\$ 20,305	\$		\$ 57,587	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)	\$ 232,844	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,048	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,048	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)	\$ 81,021	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		\$	92
93			93
94			94
95		\$	95

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

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

**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>288,840</u>	<u>13.5 yrs</u>	<u>1-15yr</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>80</b>		\$ <b>288,840</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 06/30/2018

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2009</u>	\$ <u>288,840</u>
13.	<u>12/31/2010</u>	\$ <u>288,840</u>
14.	<u>12/31/2011</u>	\$ <u>288,840</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 \_\_\_\_\_.

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: \$ 22,655 Description: See separate schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See separate schedule</u>		\$ _____	\$ <u>50</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <b>50</b>	<b>21</b>

\* 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: 1/1/08 Ending: 12/31/08

**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 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.

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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# 0046888Report Period Beginning: 1/1/08Ending: 12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,634,822	\$	1
2	Cash-Patient Deposits	19,243		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	578,361		3
4	Supply Inventory (priced at <u>cost</u> )	5,568		4
5	Short-Term Investments			5
6	Prepaid Insurance	946		6
7	Other Prepaid Expenses	9,225		7
8	Accounts Receivable (owners or related parties)	(1,487,995)		8
9	Other(specify):	300		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 760,470	\$	10
	<b>B. Long-Term Assets</b>			
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	84,217		15
16	Equipment, at Historical Cost	135,880		16
17	Accumulated Depreciation (book methods)	(71,400)		17
18	Deferred Charges	699		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>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 149,421	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 909,891	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 61,363	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,243		28
29	Short-Term Notes Payable	65,853		29
30	Accrued Salaries Payable	184,465		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,869		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,780		32
33	Accrued Interest Payable	622		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Employee Benefits Payable</u>	3,583		36
37	<u>Accrued Expenses</u>	(90,391)		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 334,387	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,202,917		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,202,917	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,537,304	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (627,413)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 909,891	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 69,674	1
2	Restatements (describe):		2
3	Prior Period Adjustment Operating Rights Impairment	(897,950)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (828,276)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	200,863	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)	\$ 200,863	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (627,413)	24 *

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center# 0046888Report Period Beginning: 1/1/08Ending: 12/31/08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,752,390	1
2	Discounts and Allowances for all Levels	1,088,540	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,840,930	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	546,232	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 546,232	8
<b>C. Other Operating Revenue</b>			
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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,128	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 11,128	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,890	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,890	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Prior Year Net Revenue</b>	(4,593)	28
28a	<b>PrchDisc/VendComm/SoldSrvcs Rev/Med Rec Copies</b>	2,221	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (2,372)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,399,808	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	584,247	31
32	Health Care	2,130,849	32
33	General Administration	835,952	33
<b>B. Capital Expense</b>			
34	Ownership	489,198	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	114,779	35
36	Provider Participation Fee	43,920	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,198,945	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	200,863	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 200,863	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: 1/1/08

Ending:

12/31/08

**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	1,768	2,074	\$ 57,144	\$ 27.55	1
2	Assistant Director of Nursing	8	8	216	27.00	2
3	Registered Nurses	8,394	9,144	202,089	22.10	3
4	Licensed Practical Nurses	17,902	19,513	349,597	17.92	4
5	CNAs & Orderlies	47,162	50,576	540,060	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,563	1,760	16,213	9.21	9
10	Activity Assistants	1,438	1,556	12,096	7.77	10
11	Social Service Workers	2,008	2,072	27,826	13.43	11
12	Dietician					12
13	Food Service Supervisor	752	800	21,895	27.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,709	12,257	101,372	8.27	15
16	Dishwashers	852	1,017	6,721	6.61	16
17	Maintenance Workers	1,758	1,959	23,570	12.03	17
18	Housekeepers	11,803	12,627	102,555	8.12	18
19	Laundry	2,448	2,804	22,665	8.08	19
20	Administrator	1,944	2,080	103,646	49.83	20
21	Assistant Administrator					21
22	Other Administrative	1,928	2,080	34,092	16.39	22
23	Office Manager	2,079	2,391	27,962	11.69	23
24	Clerical	2,089	2,154	17,400	8.08	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	3,896	4,327	83,825	19.37	32
33	Other(specify) Nrsng Adm Clerical	1,833	2,183	20,586	9.43	33
34	TOTAL (lines 1 - 33)	123,334	133,382	\$ 1,771,530 *	\$ 13.28	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	0	\$ 0	1-3	35
36	Medical Director	110	14,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$13/bed	12,480	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	2,123	11-3	44
45	Social Service Consultant	31	2,124	12-3	45
46	Other(specify)	0	0	0	46
47	Medical Records Preparation	\$5.50/bed	5,280	10-3	47
48					48
49	TOTAL (lines 35 - 48)	172	\$ 36,407		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)	0	\$ 0	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 \$1,406 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. \$ 22,813 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. \$ 43,920  
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. \$ 0
- (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.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center

# 0046888

Report Period Beginning:

1/1/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Improvements Made by Landlord (covered by rent at outset									1
2	of Change of Ownership):									2
3										3
4	A/C Units & Ductwork		2005	6,400	1,280	5	1,280		4,480	4
5	Maglocks (7), Keypads (6)		2005	4,560	456	10	456		1,596	5
6	Water Heater - A.O. Smith 100 GI		2005	2,275	228	10	228		796	6
7	Dining Room Lights (62)		2006	6,470	647	10	647		1,618	7
8	Nurse Station		2006	3,691	308	12	308		769	8
9	Metal Storage Building		2006	525	53	10	53		131	9
10	Window Treatments/Valances		2006	3,942	788	5	788		1,971	10
11	Windows (2)		2006	34,125	2,844	12	2,844		7,109	11
12	Paint Facility (hallway, dining room, nurse station)		2006	22,050	4,410	5	4,410		11,025	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	<b>TOTAL (lines 1 thru 33)</b>			\$ 84,038	\$ 11,013		\$ 11,013	\$ 0	\$ 29,495	34

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