FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0046888

Facility Name: Calhoun Nursing & Rehabilitation Center

Address: 1 Myrtle Lane (Number) Hardin (City) 62047 (Zip Code)

County: Calhoun

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) 4/30/2011 (Date)
(Type or Print Name) Gary F. Eye
(Title) Senior VP of Finance of Tara Cares

Paid Preparer

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,756	7,938	3,008	24,702	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,756	7,938	3,008	24,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.60%

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)
Outpatient therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 2,999

Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	140,276	10,320	4,415	155,011		155,011	(1,948)	153,063			1
2	Food Purchase		129,477		129,477		129,477	(171)	129,306			2
3	Housekeeping	100,908	14,950		115,858		115,858		115,858			3
4	Laundry	23,539	8,944		32,483		32,483		32,483			4
5	Heat and Other Utilities			73,782	73,782		73,782		73,782			5
6	Maintenance	24,770	8,040	40,128	72,938		72,938	(12,999)	59,939			6
7	Other (specify):* see trial balance			6,239	6,239		6,239		6,239			7
8	**TOTAL General Services**	289,493	171,731	124,564	585,788		585,788	(15,118)	570,670			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,362,553	81,242	22,560	1,466,355		1,466,355	3,361	1,469,716			10
10a	Therapy		2,579	983,742	986,321		986,321	(297,021)	689,300			10a
11	Activities	30,519	800	2,066	33,385		33,385		33,385			11
12	Social Services	29,411	603	2,003	32,017		32,017		32,017			12
13	CNA Training											13
14	Program Transportation			5,161	5,161		5,161		5,161			14
15	Other (specify):* see trial balance			5,430	5,430		5,430	(1,275)	4,155			15
16	**TOTAL Health Care and Programs**	1,422,483	85,224	1,037,762	2,545,469		2,545,469	(294,935)	2,250,534			16
	C. General Administration											
17	Administrative	187,622		234,852	422,474		422,474	(57,664)	364,810			17
18	Directors Fees											18
19	Professional Services			5,473	5,473		5,473	(2,151)	3,322			19
20	Dues, Fees, Subscriptions & Promotions			13,105	13,105		13,105	(4,857)	8,248			20
21	Clerical & General Office Expenses	40,647	24,925	36,336	101,908		101,908	(4,102)	97,806			21
22	Employee Benefits & Payroll Taxes			281,624	281,624		281,624	(3,293)	278,331			22
23	Inservice Training & Education											23
24	Travel and Seminar			28,188	28,188		28,188	(58)	28,130			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			140,038	140,038		140,038	(2,600)	137,438			26
27	Other (specify):* see trial balance			26,308	26,308		26,308	(17,907)	8,401			27
28	**TOTAL General Administration**	228,269	24,925	765,924	1,019,118		1,019,118	(92,632)	926,486			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,940,245	281,880	1,928,250	4,150,375		4,150,375	(402,685)	3,747,690			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: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			56,438	56,438		56,438	2,655	59,093			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			77,580	77,580		77,580	(745)	76,835			33
34	Rent-Facility & Grounds			317,308	317,308		317,308		317,308			34
35	Rent-Equipment & Vehicles			26,099	26,099		26,099		26,099			35
36	Other (specify):*											36
37	**TOTAL Ownership**			477,425	477,425		477,425	1,910	479,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			656	656		656		656			39
40	Barber and Beauty Shops			306	306		306		306			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**			114,842	114,842		114,842	(19,010)	95,832			43
44	**TOTAL Special Cost Centers**			159,604	159,604		159,604	(19,010)	140,594			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,940,245	281,880	2,565,279	4,787,404		4,787,404	(419,785)	4,367,619			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: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(61,864)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(164)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(171)	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	(463)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(108)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,111)	27		24
25	Fund Raising, Advertising and Promotional	(4,857)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(211)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(31,158)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (115,107)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(304,678)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (304,678)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (419,785)		37

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

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

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

STATE OF ILLINOIS

Calhoun Nursing & Rehabilitation Center

ID# 0046888

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admiss- Other Supplies	$ (3,727)	21	1
2	Remove Non-allowable EE Recognition Program	(1,447)	22	2
3	Remove Non-allowable Employee Benefits	(293)	22	3
4	Remove Non-allowable Visa Costs	(58)	24	4
5	Remove Non-allowable Visa Costs	(323)	22	5
6	Remove Non-allowable Insurance Costs	(2,600)	26	6
7	Remove Non-allowable Outpatient-Consol Billing	(875)	43	7
8	Remove Non-allowable Acctg- Tax Fees	(2,043)	19	8
9	Remove Non-allowable Admin. - Other Purch Svcs	(1,333)	27	9
10	Remove Non-allowable Nrsg Admin - Purch Svcs	(1,080)	15	10
11	Offset Outpatient Occupational Therapy Revenue	(5,922)	10a	11
12	Remove Non-allowable IV Prescription Drugs	(4,383)	43	12
13	Remove Prior Year Costs	8,616	43	13
14	Offset Interco Sold Services Revenue	(360)	10	14
15	Offset Interco Sold Services Revenue	(467)	10	15
16	Offset Interco Sold Services Revenue	(222)	10	16
17	Offset Interco Sold Services Revenue	(81)	6	17
18	Offset Interco Sold Services Revenue	(205)	1	18
19	Offset Interco Sold Services Revenue	(1,286)	1	19
20	Offset Interco Sold Services Revenue	(787)	22	20
21	Remove Interco Purchased Services Mark-up	(457)	1	21
22	Remove Capitalized Repairs & Maintenance	(9,897)	6	22
23	Remove Capitalized Repairs & Maintenance	(3,021)	6	23
24	Amort/Depreciate Repair/Maint Captl. For Medicaid	2,655	30	24
25	Remove Real estate Tax Under/(Over) Accrual	(745)	33	25
26	Offset Misc. Revenue	(467)	10	26
27	Offset Misc. Revenue	(42)	10	27
28	Offset Misc. Revenue	(282)	10	28
29	Offset Misc. Revenue	(26)	10	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**	(31,158)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center **#** 0046888 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(1,948)	0	0	0	0	0	0	0	0	0	0	(1,948)	1
2	Food Purchase	(171)	0	0	0	0	0	0	0	0	0	0	(171)	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	(12,999)	0	0	0	0	0	0	0	0	0	0	(12,999)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,118)	0	0	0	0	0	0	0	0	0	0	(15,118)	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	(1,866)	5,227	0	0	0	0	0	0	0	0	0	3,361	10
10a	Therapy	(67,786)	(229,235)	0	0	0	0	0	0	0	0	0	(297,021)	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):*	(1,080)	(195)	0	0	0	0	0	0	0	0	0	(1,275)	15
16	**TOTAL Health Care and Programs**	(70,732)	(224,203)	0	0	0	0	0	0	0	0	0	(294,935)	16
	C. General Administration													
17	Administrative	0	(57,664)	0	0	0	0	0	0	0	0	0	(57,664)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,151)	0	0	0	0	0	0	0	0	0	0	(2,151)	19
20	Fees, Subscriptions & Promotions	(4,857)	0	0	0	0	0	0	0	0	0	0	(4,857)	20
21	Clerical & General Office Expenses	(4,102)	0	0	0	0	0	0	0	0	0	0	(4,102)	21
22	Employee Benefits & Payroll Taxes	(2,850)	(443)	0	0	0	0	0	0	0	0	0	(3,293)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(58)	0	0	0	0	0	0	0	0	0	0	(58)	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):*	(17,907)	0	0	0	0	0	0	0	0	0	0	(17,907)	27
28	**TOTAL General Administration**	(34,525)	(58,107)	0	0	0	0	0	0	0	0	0	(92,632)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,375)	(282,310)	0	0	0	0	0	0	0	0	0	(402,685)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	2,655	0	0	0	0	0	0	0	0	0	0	2,655	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(745)	0	0	0	0	0	0	0	0	0	0	(745)	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**	1,910	0	0	0	0	0	0	0	0	0	0	1,910	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):*	3,358	(22,368)	0	0	0	0	0	0	0	0	0	(19,010)	43
44	**TOTAL Special Cost Centers**	3,358	(22,368)	0	0	0	0	0	0	0	0	0	(19,010)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(115,107)	(304,678)	0	0	0	0	0	0	0	0	0	(419,785)	45

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	$ 234,852	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 177,313	$ (57,664)	1
2	V	34	Sublease Building & Equip	317,308	Tara Midwest, LLC	0.00%	317,308		2
3	V	10	Pharmacy Consulting Services	17,280	Tara Pharmacy SE, LLC	0.00%	21,984	4,704	3
4	V	43	Flu Vac/Prescription Drug-Resident	101,223	Tara Pharmacy SE, LLC	0.00%	78,855	(22,368)	4
5	V	22	Flu/TB Vaccines for Employees	1,776	Tara Pharmacy SE, LLC	0.00%	1,333	(443)	5
6	V	10	Medication Administration Records	5,280	Tara Pharmacy SE, LLC	0.00%	5,803	523	6
7	V	10a	Physical Therapy Fees	516,002	Tara Therapy, LLC	0.00%	459,473	(56,529)	7
8	V	10a	Occupational Therapy Fees	377,381	Tara Therapy, LLC	0.00%	218,801	(158,580)	8
9	V	10a	Speech Therapy Fees	90,359	Tara Therapy, LLC	0.00%	76,233	(14,126)	9
10	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	3,405	(195)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,665,061			$ 1,360,508	$ * (304,678)	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: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	DTD HC, LLC	Owner		50.00	0	0	0	0	$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/Admin	0.00	***	0.59	0.01	Fin/Adm. TC	3,936	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/Admin	0.00	***	0.59	0.01	Fin/Adm. TC	3,936	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.59	0.01	VP	3,212	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	$ 11,084		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: 1/1/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Administrative Services Costs	Days	1,418,531	36	$ 253,727	$ 241,032	24,698	$ 4,418	1
2	5	Administrative Services Costs	Days	1,418,531	36	36,729	0	24,698	639	2
3	6	Administrative Services Costs	Days	1,418,531	36	57,523	1,453	24,698	1,002	3
4	10	Administrative Services Costs	Days	1,418,531	36	879,684	771,995	24,698	15,316	4
5	17	Administrative Services Costs	Days	1,418,531	36	6,601,121	6,601,121	24,698	114,931	5
6	19	Administrative Services Costs	Days	1,418,531	36	106,999	0	24,698	1,863	6
7	20	Administrative Services Costs	Days	1,418,531	36	10,087	0	24,698	176	7
8	21	Administrative Services Costs	Days	1,418,531	36	287,981	0	24,698	5,014	8
9	22	Administrative Services Costs	Days	1,418,531	36	1,344,595	0	24,698	23,411	9
10	24	Administrative Services Costs	Days	1,418,531	36	100,686	0	24,698	1,753	10
11	26	Administrative Services Costs	Days	1,418,531	36	6,260	0	24,698	109	11
12	27	Administrative Services Costs	Days	1,418,531	36	134,804	0	24,698	2,347	12
13	30	Administrative Services Costs	Days	1,418,531	36	213,053	0	24,698	3,709	13
14	31	Administrative Services Costs	Days	1,418,531	36	10,497	0	24,698	183	14
15	33	Administrative Services Costs	Days	1,418,531	36	27,056	0	24,698	471	15
16	34	Administrative Services Costs	Days	1,418,531	36	105,664	0	24,698	1,840	16
17	35	Administrative Services Costs	Days	1,418,531	36	351	0	24,698	6	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,176,817	$ 7,615,601		$ 177,188	25

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center **#** 0046888 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.	$	74,640	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.)	$	73,895	2
3. Under or (over) accrual (line 2 minus line 1).	$	(745)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	77,580	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	76,835	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	55,258	8
2006	61,044	9
2007	66,455	10
2008	71,090	11
2009	73,895	12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-08-27-200-001-F	PT NE 1/4 S27 T10S R2W	$ 73,895.42	$ 73,895.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,895.42	$ 73,895.42

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	696	70	10	70		383	9
10	Blinds			2006	10,270	2,054	5	2,054		9,243	10
11	Plumbing and Mechanical repairs capitalized for Medicaid			2006	9,738		3			9,738	11
12	Plumbing and Mechanical repairs capitalized for Medicaid			2007	3,009	502	3	502		3,009	12
13	Carpeting			2007	3,360	672	5	672		2,352	13
14	Carpet Flooring			2007	7,038	1,408	5	1,408		4,926	14
15	Air Conditioning Unit (10 ton)			2007	4,650	465	10	465		1,628	15
16	2 Doors			2007	3,319	302	11	302		1,056	16
17	Cilcomm Phone System			2007	14,211	1,421	10	1,421		4,974	17
18	Nurse Station			2008	40,675	4,068	10	4,068		10,169	18
19	Roof Replacement			2009	73,323	8,147	9	8,147		12,221	19
20	Front Doors (2)			2009	3,457	384	9	384		576	20
21	Water Heater			2009	10,508	1,168	9	1,168		1,751	21
22	Satellite TV Equipment			2009	15,752	1,750	9	1,750		2,625	22
23	Air Compressor			2009	6,339	704	9	704		1,056	23
24	A/C Unit			2010	573	57	5	57		57	24
25	Hot Water Pump			2010	1,216	76	8	76		76	25
26	A/C Unit			2010	573	57	5	57		57	26
27	Air Compressor			2010	3,000	188	8	188		188	27
28	A/C Unit (Rooftop 5 - ton)			2010	4,900	306	8	306		306	28
29	A/C Unit			2010	573	57	5	57		57	29
30	Panic Bars (for Fire Door - 2)			2010	3,730	233	8	233		233	30
31	Repairs to Generator, Sprinkler and Fire Alarm Panel										31
32	capitalized for Medicaid each rpr over $2,500			2010	12,918	2,152	3	2,152		2,152	32
33											33
34	Note: See additional building improvements made by property										34
35	owner Healthcare REIT, Inc. on supplemental schedule										35
36	included as Page 24 of the cost report.										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: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		$ 233,826	$ 26,241		$ 26,241	$	$ 68,833	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: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 173,746	$ 23,244	$ 23,244	$	various	$ 95,642	71
72	Current Year Purchases	22,922	2,208	2,208		various	2,208	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 196,668	$ 25,452	$ 25,452	$		$ 97,850	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	Long Term Care	2009 Ford E250 Extended	2009	$ 36,998	$ 7,400	$ 7,400	$	5	$ 11,099	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			$ 36,998	$ 7,400	$ 7,400	$		$ 11,099	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)	$ 467,492	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 59,093	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 59,093	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)	$ 177,782	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	Repl Sprinkler System	$ 294,623	92
93			93
94			94
95		$ 294,623	95

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1996	80	1/1/05	$ 317,308	13.5	1-15 yrs.	3
4	Additions							4
5								5
6								6
7	TOTAL		80		$ 317,308 **			7

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

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2011	$ 317,308
13.	12/31/2012	$ 317,308
14.	12/31/2013	$ 317,308

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: 60 day notice - see attached *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 26,237 Description: See separate schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See separate schedule		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 166,975	$	1
2	Cash-Patient Deposits	8,624		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	307,088		3
4	Supply Inventory (priced at cost)	5,951		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,757		6
7	Other Prepaid Expenses	3,973		7
8	Accounts Receivable (owners or related parties)	(2,010,909)		8
9	Other(specify): Non resident A/R (see TB)	6,342		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,510,199)	$	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	208,161		15
16	Equipment, at Historical Cost	233,666		16
17	Accumulated Depreciation (book methods)	(162,883)		17
18	Deferred Charges			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 **Deposits long term**	1,025		22
23	Other(specify): Construction in progress	294,623		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 574,592	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (935,607)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,733	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,547		28
29	Short-Term Notes Payable	3,654		29
30	Accrued Salaries Payable	186,103		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,535		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,580		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	11,956		36
37	Accrued Expenses	(175,712)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 217,396	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To/From HC REIT	286,857		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 286,857	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 504,253	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,439,860)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (935,607)	$	48

*(See instructions.)

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (859,218)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (859,218)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(48,742)	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	(531,900)	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)**	$ (580,642)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,439,860)	24 *

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,766,022	1
2	Discounts and Allowances for all Levels	985,966	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,751,988	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	67,786	5
6	Therapy	892,314	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 960,100	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	8,952	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)**	$ 8,952	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,583	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,583	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	9,117	28
28a	Prch Disc / Vending Commissions / Sold Srvcs Rev	4,922	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,039	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,738,662	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	585,788	31
32	Health Care	2,545,469	32
33	General Administration	1,019,118	33
	B. Capital Expense		
34	Ownership	477,425	34
	C. Ancillary Expense		
35	Special Cost Centers	115,804	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)***	$ 4,787,404	40
41	**Income before Income Taxes (line 30 minus line 40)****	(48,742)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (48,742)	43

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

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

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,080	$ 68,421	$ 32.89	1
2	Assistant Director of Nursing	1,584	1,816	44,195	24.34	2
3	Registered Nurses	13,514	14,606	325,363	22.28	3
4	Licensed Practical Nurses	11,342	13,119	243,016	18.52	4
5	CNAs & Orderlies	46,277	51,280	570,040	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,059	22,401	10.88	9
10	Activity Assistants	923	955	8,118	8.50	10
11	Social Service Workers	2,008	2,080	29,411	14.14	11
12	Dietician					12
13	Food Service Supervisor	1,940	2,080	27,585	13.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,080	11,459	102,542	8.95	15
16	Dishwashers	999	1,269	10,149	8.00	16
17	Maintenance Workers	1,871	2,054	24,770	12.06	17
18	Housekeepers	10,147	11,044	100,908	9.14	18
19	Laundry	2,472	2,720	23,539	8.65	19
20	Administrator	1,928	2,185	102,769	47.03	20
21	Assistant Administrator					21
22	Other Administrative	1,880	2,080	35,226	16.94	22
23	Office Manager	1,952	2,080	32,115	15.44	23
24	Clerical	5,672	6,028	58,159	9.65	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 C: MDS Coordinator	3,272	3,737	88,489	23.68	32
33	Other(specify) Nrsg Admin Cleri	1,878	2,065	23,029	11.15	33
34	TOTAL (lines 1 - 33)	123,627	136,796	$ 1,940,245 *	$ 14.18	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	98	16,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18/bed	17,280	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	2,003	11-3	44
45	Social Service Consultant	30	2,003	12-3	45
46	Other(specify)				46
47	Medical Records Preparation	$5.50/bed	5,280	10-3	47
48					48
49	TOTAL (lines 35 - 48)	158	$ 43,366		49

C. CONTRACT NURSES

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Ledder	Administrator	0	$ 103,553
Catherine Clowers	Bus. Office Mgr	0	31,590
Christine Akers	Payroll	0	712
Mary Brangenberg	Bus. Office Asst.	0	16,727
Mary Kirn	Admiss Coordinator	0	35,040
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 187,622

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 234,852
TOTAL (agree to Schedule V, line 17, col. 3)	$ 234,852
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,379
Freed, Maxick & Battaglia	Tax Fees	2,043
Various Legal Fees - See Attached detailed listing		1,051
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,473

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,104
Unemployment Compensation Insurance	15,243
FICA Taxes	141,317
Employee Health Insurance	95,855
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Benefits - other	2,894
Employee Benefits - Hep B Vaccination	55
Employee Benefits - WC safety rec. program	1,200
Employee Benefits - Short Term Disability	663
TOTAL (agree to Schedule V, line 22, col.8)	$ 278,331

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

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

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,106
Advertising: Employee Recruitment	2,757
Health Care Worker Background Check	
(Indicate # of checks performed 175)	2,579
Facility Advertising	2,097
IL. Health Care Association	4,416
Non Allowable IL Health Care Assn	(2,760)
Notary Fees	40
AANAC Membership Dues	110
Less: Public Relations Expense	( )
Non-allowable advertising	(2,097)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,248

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	23,415
Seminar Expense	4,715
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,130

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $1,655 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. $ **24,214** 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? **Yes, outpatient therap** 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? **None** 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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No personal use**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) 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 and Rehabilitation Center, LLC # 0046888 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 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	
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	640	5	640		6,400	4
5	Maglocks (7), Keypads (6)			2005	4,560	456	10	456		2,508	5
6	Water Heater - A.O. Smith 100 Gl			2005	2,275	228	10	228		1,251	6
7	Dining Room Lights (62)			2006	6,470	647	10	647		2,912	7
8	Nurse Station			2006	3,691	308	12	308		1,384	8
9	Metal Storage Building			2006	525	53	10	53		236	9
10	Window Treatments/Valances			2006	3,942	788	5	788		3,548	10
11	Windows (2)			2006	34,125	2,844	12	2,844		12,797	11
12	Paint Facility (hallway, dining room, nurse station)			2006	22,050	4,410	5	4,410		19,845	12
13											13
14											14
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31											31
32											32
33											33
34	TOTAL (lines 1 thru 33)				$ 84,038	$ 10,373		$ 10,373	$ 0	$ 50,881	34

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