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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0046888

Facility Name: Calhoun Nursing & Rehab Ctr

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	X	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) 972-2392
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 1/1/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) 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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	29,280	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,796	8,751	3,681	25,228	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,796	8,751	3,681	25,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.16%

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 01/01/2005

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 _____ and days of care provided 3,446

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

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

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	153,369	12,083	13,429	178,881		178,881	(200)	178,681			1
2	Food Purchase		149,424		149,424		149,424	(245)	149,179			2
3	Housekeeping	119,962	16,798		136,760		136,760		136,760			3
4	Laundry	11,572	11,610		23,182		23,182		23,182			4
5	Heat and Other Utilities			74,245	74,245		74,245		74,245			5
6	Maintenance	25,806	12,241	36,439	74,486		74,486	(5,236)	69,250			6
7	Other (specify):* see trial balance			8,969	8,969		8,969		8,969			7
8	**TOTAL General Services**	310,709	202,156	133,082	645,947		645,947	(5,681)	640,266			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,540,437	105,465	22,560	1,668,462		1,668,462	(6,374)	1,662,088			10
10a	Therapy		4,010	680,023	684,033		684,033	(104,590)	579,443			10a
11	Activities	33,156	1,364	1,738	36,258		36,258		36,258			11
12	Social Services	30,952	1,356	1,738	34,046		34,046		34,046			12
13	CNA Training											13
14	Program Transportation			7,453	7,453		7,453		7,453			14
15	Other (specify):* see trial balance			8,449	8,449		8,449	(2,068)	6,381			15
16	**TOTAL Health Care and Programs**	1,604,545	112,195	738,761	2,455,501		2,455,501	(113,032)	2,342,469			16
	C. General Administration											
17	Administrative	176,081		251,592	427,673		427,673	(70,106)	357,567			17
18	Directors Fees											18
19	Professional Services			6,005	6,005		6,005	(2,709)	3,296			19
20	Dues, Fees, Subscriptions & Promotions			14,036	14,036		14,036	(5,375)	8,661			20
21	Clerical & General Office Expenses	19,013	30,000	35,832	84,845		84,845	(3,824)	81,021			21
22	Employee Benefits & Payroll Taxes			247,643	247,643		247,643	(416)	247,227			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,841	25,841		25,841	(112)	25,729			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,053	69,053		69,053	(2,600)	66,453			26
27	Other (specify):* see trial balance			81,553	81,553		81,553	(47,801)	33,752			27
28	**TOTAL General Administration**	195,094	30,000	731,555	956,649		956,649	(132,943)	823,706			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,110,348	344,351	1,603,398	4,058,097		4,058,097	(251,656)	3,806,441			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 & Rehab Ctr #0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			19,112	19,112		19,112	107,726	126,838			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,711	3,711		3,711	37,086	40,797			32
33	Real Estate Taxes			76,173	76,173		76,173		76,173			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(312,000)				34
35	Rent-Equipment & Vehicles			30,739	30,739		30,739		30,739			35
36	Other (specify):* see trial balance											36
37	**TOTAL Ownership**			441,735	441,735		441,735	(167,188)	274,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			144	144		144		144			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,574	176,574		176,574		176,574			42
43	Other (specify):* see trial balance			153,227	153,227		153,227	(28,874)	124,353			43
44	**TOTAL Special Cost Centers**			329,945	329,945		329,945	(28,874)	301,071			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,110,348	344,351	2,375,078	4,829,777		4,829,777	(447,718)	4,382,059			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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(57,360)	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	(3,716)	32		10
11	Discounts, Allowances, Rebates & Refunds	(338)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(245)	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	(17)	21		18
19	Entertainment				19
20	Contributions	(425)	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	(63,986)	27		24
25	Fund Raising, Advertising and Promotional	(5,375)	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	(16,456)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (147,918)		$	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)	(299,800)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (299,800)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (447,718)		37

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

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

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

Calhoun Nursing & Rehab Ctr

ID# 0046888

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove non-allowable Admiss-Other Supplies	$ (3,469)	21	1
2	Remove non-allowable Visa Cost	(112)	24	2
3	Remove non-allowable Insurance Cost	(2,600)	26	3
4	Remove non-allowable Outpatient Svcs-Consol Billing	(184)	43	4
5	Remove non-allowable BO-Tax Prep Fees	(2,709)	19	5
6	Remove non-allowable Admin-Other Purch Svcs	(63)	27	6
7	Offset Misc. Revenue Sch XVII line 28a	(1,003)	10	7
8	Offset Misc. Revenue Sch XVII line 28a	(25)	10	8
9	Offset Misc. Revenue Sch XVII line 28a	(111)	6	9
10	Offset Misc. Revenue Sch XVII line 28a	(564)	10	10
11	Offset Misc. Revenue Sch XVII line 28a	(37)	10	11
12	Offset Interco Sold Service Rev Sch XVII ln 28a	(1,030)	10	12
13	Offset Interco Sold Service Rev Sch XVII ln 28a	(389)	10	13
14	Offset Interco Sold Service Rev Sch XVII ln 28a	(489)	10	14
15	Offset Interco Sold Service Rev Sch XVII ln 28a	(265)	22	15
16	Remove non-allowable IV Prescription Drugs	(18,106)	43	16
17	Remove non-allowable Prior Year Costs	28,359	43	17
18	Offset Outpatient Occupational Therapy Revenue	(10,422)	10a	18
19	Offset Outpatient Speech Therapy Revenue	(3,106)	10a	19
20	Capitalize repairs&maint for Medicaid	(5,125)	6	20
21	Capitalize repairs&maint for Medicaid	(200)	1	21
22	Amort/Depreciate Repair/Maint Captl. For Medicaid	5,194	30	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,456)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(200)	0	0	0	0	0	0	0	0	0	0	(200)	1
2	Food Purchase	(245)	0	0	0	0	0	0	0	0	0	0	(245)	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	(5,236)	0	0	0	0	0	0	0	0	0	0	(5,236)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,681)	0	0	0	0	0	0	0	0	0	0	(5,681)	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	(3,537)	(2,837)	0	0	0	0	0	0	0	0	0	(6,374)	10
10a	Therapy	(70,888)	(33,702)	0	0	0	0	0	0	0	0	0	(104,590)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(2,068)	0	0	0	0	0	0	0	0	0	(2,068)	15
16	TOTAL Health Care and Programs	(74,425)	(38,607)	0	0	0	0	0	0	0	0	0	(113,032)	16
	C. General Administration													
17	Administrative	0	(70,106)	0	0	0	0	0	0	0	0	0	(70,106)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,709)	0	0	0	0	0	0	0	0	0	0	(2,709)	19
20	Fees, Subscriptions & Promotions	(5,375)	0	0	0	0	0	0	0	0	0	0	(5,375)	20
21	Clerical & General Office Expenses	(3,824)	0	0	0	0	0	0	0	0	0	0	(3,824)	21
22	Employee Benefits & Payroll Taxes	(265)	(151)	0	0	0	0	0	0	0	0	0	(416)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(112)	0	0	0	0	0	0	0	0	0	0	(112)	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):*	(64,474)	0	16,673	0	0	0	0	0	0	0	0	(47,801)	27
28	TOTAL General Administration	(79,359)	(70,257)	16,673	0	0	0	0	0	0	0	0	(132,943)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,465)	(108,864)	16,673	0	0	0	0	0	0	0	0	(251,656)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nursing & Rehab Ctr **#** 0046888 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,194	0	102,532	0	0	0	0	0	0	0	0	107,726	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,716)	0	40,802	0	0	0	0	0	0	0	0	37,086	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(312,000)	0	0	0	0	0	0	0	0	(312,000)	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	1,478	0	(168,666)	0	0	0	0	0	0	0	0	(167,188)	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):*	10,069	(38,943)	0	0	0	0	0	0	0	0	0	(28,874)	43
44	TOTAL Special Cost Centers	10,069	(38,943)	0	0	0	0	0	0	0	0	0	(28,874)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(147,918)	(147,807)	(151,993)	0	0	0	0	0	0	0	0	(447,718)	45

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DTD HC, LLC	50%	Granite Nursing and Rehabilitation Center, LLC	Granite City	Colonnades Property C	Granite City	Property Company
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Stearns Property Com	Granite City	Property Company
		White Hall Nursing and Rehabilitation Center, LLC	White Hall	Hardin Property Com	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Herculaneum Property	Herculaneum	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Jefferson City Propert	Jefferson City	Property Company
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Riverside Property Co	Kansas City	Property Company
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Terrace Square (Doug	Douglasville	Property Company

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	$ 251,592	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 181,486	$ (70,106)	1
2	V	34							2
3	V	10	Pharmacy Consulting Services	17,280	Tara Pharmacy SE, LLC	0.00%	16,502	(778)	3
4	V	43	Flu Vac/Prescription Drug-Resident	145,545	Tara Pharmacy SE, LLC	0.00%	106,602	(38,943)	4
5	V	22	Flu/TB Vaccines for Employees	1,683	Tara Pharmacy SE, LLC	0.00%	1,532	(151)	5
6	V	10	Medication Administration Records	5,280	Tara Pharmacy SE, LLC	0.00%	3,221	(2,059)	6
7	V	10a	Physical Therapy Fees	377,801	Tara Therapy, LLC	0.00%	400,021	22,220	7
8	V	10a	Occupational Therapy Fees	225,886	Tara Therapy, LLC	0.00%	175,117	(50,769)	8
9	V	10a	Speech Therapy Fees	76,336	Tara Therapy, LLC	0.00%	71,183	(5,153)	9
10	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,532	(2,068)	10
11	V	1	Dietary Service	10,567	Stearns Nursing and Rehabilitation Center, LLC	0.00%	10,567		11
12	V	6	Maintenance Services	570	Stearns Nursing and Rehabilitation Center, LLC	0.00%	570		12
13	V	15	Nursing Services	182	Granite Nursing and Rehabilitation Center, LLC		182		13
14	Total			$ 1,116,322			$ 968,515	$ * (147,807)	14

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

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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)	
15	V	34	Rent	$ 312,000	Hardin Property Company, LLC	0.00%	$	$ (312,000)	15
16	V	27	Admin-Other Purch Svcs		Hardin Property Company, LLC	0.00%	60	60	16
17	V	30	Depreciation Leasehold Imp		Hardin Property Company, LLC	0.00%	71,775	71,775	17
18	V	30	Depreciation Major Moveable		Hardin Property Company, LLC	0.00%	20,838	20,838	18
19	V	30	Depreciation Bldg & Improve		Hardin Property Company, LLC	0.00%	9,919	9,919	19
20	V	27	Amort Loan Acquisition Costs		Hardin Property Company, LLC	0.00%	16,613	16,613	20
21	V	32	Interest-Capital/Long-Term Debt		Hardin Property Company, LLC	0.00%	40,802	40,802	21
22	V	1	Dietary Services	384	White Hall Nursing and Rehabilitation Center, LLC	0.00%	384		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 312,384			$ 160,391	$ * (151,993)	39

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

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Jonesboro Nursing and Rehabilitation Center, L	Jonesboro	Jonesboro Property Co	Jonesboro	Property Company	1
2			Lake City Nursing and Rehabilitation Center, L	Lake City	Rex Road Property Co	Lake City	Property Company	2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile	Mobile Property Comp	Mobile	Property Company	3
4			Fairfield Nursing and Rehabilitation Center, LL	Fairfield	Fairfield Property Cor	Fairfield	Property Company	4
5			Florence Nursing and Rehabilitation Center, LL	Florence	Florence Property Cor	Florence	Property Company	5
6			Birmingham Nrs&Rehab Center East, LLC	Birmingham	Birmingham East Prop	Birmingham	Property Company	6
7			Birmingham Nursing and Rehabilitation Center	Birmingham	Birmingham Property	Birmingham	Property Company	7
8			Eight Mile Nursing and Rehabilitation Center, L	Eight Mile	Eight Mile Property C	Eight Mile	Property Company	8
9			Quince Nursing and Rehabilitation Center, LLC	Memphis	Quince Property Comp	Memphis	Property Company	9
10			Allenbrooke Nursing and Rehabilitation Center,	Memphis	Allenbrooke Property	Memphis	Property Company	10
11			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo	Tupelo Property Comp	Tupelo	Property Company	11
12			Brandon Nursing and Rehabilitation Center, LL	Brandon	Brandon Property Cor	Brandon	Property Company	12
13			Lakeland Nursing and Rehabilitation Center, LI	Jackson	Lakeland Property Co	Jackson	Property Company	13
14			McComb Nursing and Rehabilitation Center, LI	McComb	McComb Property Co	McComb	Property Company	14
15			Cleveland Nursing and Rehabilitation Center, L	Cleveland	Cleveland Property Co	Cleveland	Property Company	15
16			Chadwick Nursing and Rehabilitation Center, L	Jackson	Chadwick (Jackson) P	Jackson	Property Company	16
17			Manhattan Nursing and Rehabilitation Center, I	Jackson	Manhattan Property C	Jackson	Property Company	17
18			Ruleville Nursing and Rehabilitation Center, LL	Ruleville	Ruleville Property Cor	Ruleville	Property Company	18
19			Farmerville Nursing and Rehabilitation Center,	Farmerville	Farmerville Property (	Farmerville	Property Company	19
20			Bernice Nursing and Rehabilitation Center, LLC	Bernice	Bernice Property Com	Bernice	Property Company	20
21			Ruston Nursing and Rehabilitation Center, LLC	Ruston	Longleaf (Ruston) Pro	Ruston	Property Company	21
22			Natchitoches Nursing and Rehabilitation Center	Natchitoches	Natchitoches Property	Natchitoches	Property Company	22
23			Winnfield Nursing and Rehabilitation Center, L	Winnfield	Winnfield Property Co	Winnfield	Property Company	23
24			Ringgold Nursing and Rehabilitation Center, LI	Ringgold	Ringgold Property Cor	Ringgold	Property Company	24
25			Arcadia Nursing and Rehabilitation Center, LL	Arcadia	Willow Ridge (Arcadia	Arcadia	Property Company	25
26			Jena Nursing and Rehabilitation Center, LLC	Jena	Aimwell (Jena) Proper	Jena	Property Company	26
27					Aurora Cares Property	Orchard Park	Property Company	27
28			** The above listed facilites are related by		Aurora Cares, LLC d/	Orchard Park	Support Office	28
29			common ownership		Tara Midwest, LLC	Orchard Park	Clearing Account fo	29
30					Tara Healthcare, LLC	Orchard Park	Clearing Account fo	30

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Tara Pharmacy SE, LI	Birmingham	Pharmacy	1
2					Tara Therapy, LLC	Orchard Park	Therapy	2
3					Raimax Healthcare So	Orchard Park	Software	3
4					White Hall Property C	White Hall	Property Company	4
5					3690 N. H. Associates,	Orchard Park	Clearing Account fo	5
6					3690 Associates, LLC	Orchard Park	Clearing Account fo	6
7					Health Care Risk Grou	Orchard Park	Insurance	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.54	1.35	Fin/ Adm. TC	3,793	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.54	1.35	Fin/ Adm. TC	3,793	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.54	1.35	VP	3,147	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	$ 10,733		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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,473,669	35	$ 257,223	$ 220,671	25,224	$ 4,402	1
2	5	Administrative Services Costs	Days	1,473,669	35	36,825	0	25,224	630	2
3	6	Administrative Services Costs	Days	1,473,669	35	55,513	0	25,224	949	3
4	10	Administrative Services Costs	Days	1,473,669	35	2,440,929	2,173,122	25,224	41,777	4
5	17	Administrative Services Costs	Days	1,473,669	35	5,663,604	5,663,604	25,224	96,939	5
6	19	Administrative Services Costs	Days	1,473,669	35	9,265	0	25,224	159	6
7	20	Administrative Services Costs	Days	1,473,669	35	14,781	0	25,224	253	7
8	21	Administrative Services Costs	Days	1,473,669	35	305,257	0	25,224	5,225	8
9	22	Administrative Services Costs	Days	1,473,669	35	1,272,672	0	25,224	21,784	9
10	24	Administrative Services Costs	Days	1,473,669	35	113,930	0	25,224	1,952	10
11	26	Administrative Services Costs	Days	1,473,669	35	5,104	0	25,224	86	11
12	27	Administrative Services Costs	Days	1,473,669	35	133,549	0	25,224	2,286	12
13	30	Administrative Services Costs	Days	1,473,669	35	154,779	0	25,224	2,649	13
14	31	Administrative Services Costs	Days	1,473,669	35	4,919	0	25,224	84	14
15	32	Administrative Services Costs	Days	1,473,669	35	91	0	25,224	2	15
16	33	Administrative Services Costs	Days	1,473,669	35	28,086	0	25,224	481	16
17	34	Administrative Services Costs	Days	1,473,669	35	106,649	0	25,224	1,825	17
18	35	Administrative Services Costs	Days	1,473,669	35	173	0	25,224	3	18
19										19
20										20
21		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								21
22		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								22
23		considered a Home Office by CMS and as defined in 42 CRF 421.404.								23
24										24
25	TOTALS					$ 10,603,349	$ 8,057,397		$ 181,486	25

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	M&T BANK		X	Purchase of Physical Plant	$1,636.00	6/22/11	$ 549,494	$	6/20/12	libor+3.5%	$ 8,178	1
2	M&T BANK		X	Refinance Purchase of Plant	$4,661.00	6/20/12	1,480,118		12/20/12	libor+3.5%	32,624	2
3												3
4												4
5												5
	Working Capital											
6	M&T BANK		X	Working Capital-Floating Balar	$269.00	6/26/09	3,654	152,714	demand not	0.0450	3,233	6
7												7
8												8
9	TOTAL Facility Related				$6,566.00		$ 2,033,266	$ 152,714			$ 44,035	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,033,266	$ 152,714			$ 44,035	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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 & Rehab Ctr # 0046888 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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 2011 report.	$	80,800	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.)	$	76,573	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,227)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	80,400	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.	$	76,173	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	66,455	8
	2008	71,090	9
	2009	73,895	10
	2010	76,955	11
	2011	76,573	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calhoun Nursing & Rehab Ctr 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 2011 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 2011.

	(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	$ 76,572.94	$ 76,572.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,572.94	$ 76,572.94

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 [X] (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 [X] (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).

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: 131,730
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.CapitalizedPre-openingSalaries,Benefits&OtherCostsIncurred2007,2009&2010.AllocatedViaRelatedOrgCost&ReportedSchVII B
(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	Long Term Care	199,940	2011	$ 19,577	1
2					2
3	TOTALS	199,940		$ 19,577	3

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	80		2011	1996	$ 396,764	$ 9,919	40	$ 9,919	$	$ 14,879	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	696	70	10	70		523	9
10	Blinds			2006	10,270		5			10,270	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		3			3,009	12
13	Carpeting			2007	3,360	336	5	336		3,360	13
14	Carpet Flooring			2007	7,038	704	5	704		7,038	14
15	Air Conditioning Unit (10 ton)			2007	4,650	465	10	465		2,558	15
16	2 Doors			2007	3,319	302	11	302		1,660	16
17	Cilcomm Phone System			2007	14,211	1,421	10	1,421		7,816	17
18	Nurse Station			2008	40,675	4,068	10	4,068		18,305	18
19	Roof Replacement			2009	73,323	8,147	9	8,147		28,515	19
20	Front Doors (2)			2009	3,457	384	9	384		1,344	20
21	Water Heater			2009	10,508	1,168	9	1,168		4,087	21
22	Satellite TV Equipment			2009	15,752	1,750	9	1,750		6,125	22
23	Air Compressor			2009	6,339	704	9	704		2,465	23
24	A/C Unit			2010	573	114	5	114		285	24
25	Hot Water Pump			2010	1,216	152	8	152		380	25
26	A/C Unit			2010	573	114	5	114		285	26
27	Air Compressor			2010	3,000	375	8	375		938	27
28	A/C Unit (Rooftop 5 - ton)			2010	4,900	613	8	613		1,532	28
29	A/C Unit			2010	573	114	5	114		285	29
30	Panic Bars (for Fire Door - 2)			2010	3,730	466	8	466		1,165	30
31	Repairs to Generator - Capitalized for Medicaid			2010	3,061	1,020	3	1,020		2,550	31
32	Sprinkler System Repair - Capitalized for Medicaid			2010	6,836	2,279	3	2,279		5,697	32
33	Fire Alarm Panel Repair-Capitalized for Medicaid			2010	3,021	1,007	3	1,007		2,518	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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	A/C Unit	2011	$ 573	$ 115	5	$ 115	$	$ 172	37
38	Sprinkler System Conversion	2011	3,000	429	7	429		643	38
39	Sprinkler System	2011	334,136	47,734	7	47,734		71,601	39
40	Lighting (Dining Room)	2011	1,206	172	7	172		258	40
41	A/C Unit	2011	646	129	5	129		194	41
42	A/C Unit	2011	648	130	5	130		195	42
43	Water Heater (91 gallon-Laundry)	2011	11,200	1,600	7	1,600		2,400	43
44	A/C Unit	2011	646	129	5	129		194	44
45	A/C Unit (10 ton Central NRS Station)	2011	10,000	667	15	667		1,000	45
46	Heaters (9 w/panel Attic)	2011	21,000	4,200	5	4,200		6,300	46
47	A/C Units	2012	632	63	5	63		63	47
48	PTAC Unit	2012	632	63	5	63		63	48
49	Walk in Freezer and water line repair - Capitalized for Medicaid	2012	4,800	800	3	800		800	49
50	Addtl Freezer Rpr-Drain&Heater (posted after 6/30/12)	2012	525	88	3	88		88	50
51	PTAC Unit	2012	632	63	5	63		63	51
52	PSRO Door	2012	1,344	45	15	45		45	52
53	Smoke Detectors (4, required additional)	2012	4,717	236	10	236		236	53
54	Chair-rail in Dining Room	2012	1,026	51	10	51		51	54
55									55
56									56
57									57
58									58
59									59
60									60
61	Note: See additional building improvements made by former								61
62	property owner Healthcare REIT, Inc. on supplemental								62
63	schedule included as page 24 of the cost report.								63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,027,955	$ 92,406		$ 92,406	$	$ 221,693	70

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

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 159,380	$ 23,471	$ 23,471	$	various	$ 93,466	71
72	Current Year Purchases	49,626	3,561	3,561		various	3,561	72
73	Fully Depreciated Assets	52,052					52,052	73
74								74
75	TOTALS	$ 261,058	$ 27,032	$ 27,032	$		$ 149,079	75

D. Vehicle Costs. (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	$ 25,899	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			$ 36,998	$ 7,400	$ 7,400	$		$ 25,899	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,345,588	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,838	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 126,838	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)	$ 396,671	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Therapy Renovation	$ 10,252	92
93			93
94			94
95		$ 10,252	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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:	N/A	N/A	N/A	$ N/A	N/A	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$ N/A
13.	/2014	$ N/A
14.	/2015	$ N/A

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: $ 29,046 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			$	$	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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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.

Facility Name & ID Number Calhoun Nursing & Rehab Ctr **#** 0046888 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/12 **(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	$ 204,160	$	1
2	Cash-Patient Deposits	4,717		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	901,033		3
4	Supply Inventory (priced at cost)	5,697		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,493		6
7	Other Prepaid Expenses	2,398		7
8	Accounts Receivable (owners or related parties)	(2,638,562)		8
9	Other(specify): Non Resident A/R (see TB)	2,467		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,516,597)	$	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	40,629		15
16	Equipment, at Historical Cost	98,765		16
17	Accumulated Depreciation (book methods)	(41,426)		17
18	Deferred Charges	1,425		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,125		22
23	Other(specify): Construction in Progress	10,252		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 110,770	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,405,827)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 37,882	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,105		28
29	Short-Term Notes Payable	152,714		29
30	Accrued Salaries Payable	242,502		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,942		31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,400		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	9,094		36
37	Accrued Expenses	82,600		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 639,239	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 639,239	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,045,066)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,405,827)	$	48

***(See instructions.)**

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,792,125)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,792,125)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(21,940)	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	(231,001)	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)**	$ (252,941)	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)**	$ (2,045,066)	24 *

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

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,035,164	1
2	Discounts and Allowances for all Levels	1,089,715	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,124,879	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	70,888	5
6	Therapy	543,731	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 614,619	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	2,617	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,442	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,059	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,716	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,716	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	50,814	28
28a	Purchase Discounts/Sold Srvcs/Rebates&Refunds	5,750	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 56,564	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,807,837	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	645,947	31
32	Health Care	2,455,501	32
33	General Administration	956,649	33
	B. Capital Expense		
34	Ownership	441,735	34
	C. Ancillary Expense		
35	Special Cost Centers	153,371	35
36	Provider Participation Fee	176,574	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,829,777	40
41	**Income before Income Taxes (line 30 minus line 40)****	(21,940)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (21,940)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,356,922	44
45	Private Pay - Net Inpatient Revenue	1,082,814	45
46	Medicare - Net Inpatient Revenue	1,664,830	46
47	Other-(specify) Hospice Contract	20,313	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,124,879	49

* **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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,936	2,080	$ 69,218	$ 33.28	1
2	Assistant Director of Nursing	1,767	1,942	48,555	25.00	2
3	Registered Nurses	12,659	14,254	340,862	23.91	3
4	Licensed Practical Nurses	13,187	14,646	288,111	19.67	4
5	CNAs & Orderlies	49,799	54,779	664,568	12.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,897	2,026	23,262	11.48	9
10	Activity Assistants	975	1,046	9,894	9.46	10
11	Social Service Workers	1,912	2,080	30,952	14.88	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,088	28,092	13.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,741	5,568	52,271	9.39	15
16	Dishwashers	7,283	7,702	73,006	9.48	16
17	Maintenance Workers	1,922	2,175	25,806	11.86	17
18	Housekeepers	11,784	12,757	119,962	9.40	18
19	Laundry	1,147	1,280	11,572	9.04	19
20	Administrator	1,928	2,080	83,718	40.25	20
21	Assistant Administrator					21
22	Other Administrative	1,928	2,080	37,533	18.04	22
23	Office Manager	1,944	2,080	34,074	16.38	23
24	Clerical	3,922	4,236	39,769	9.39	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(specify)	3,842	4,160	103,292	24.83	32
33	Other(specify)	1,965	2,101	25,831	12.29	33
34	TOTAL (lines 1 - 33)	128,538	141,160	$ 2,110,348 *	$ 14.95	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	80	16,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18 per bed/mo	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	28	1,738	11-3	44
45	Social Service Consultant	28	1,738	12-3	45
46	Other(specify)				46
47	Medical Records Preparation	$5.50 per bed/mo	5,280	10-3	47
48					48
49	TOTAL (lines 35 - 48)	135	$ 42,836		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 & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Ledder	Administrator	0	$ 83,718
Catherine Clowers	Bus Office Mgr	0	34,074
Mary Brangenberg	Bus Office Ast.	0	20,756
Mary Kirn	Admis Coordinator	0	37,533
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 176,081

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 251,592
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 251,592

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,437
Freed, Maxick & Battaglia	Tax Fees	2,709
Various Legal Fees- See attached detailed listing		859
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,005

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ (28,592)
Unemployment Compensation Insurance	14,159
FICA Taxes	156,392
Employee Health Insurance	97,637
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Progam	1,650
Employee Benefits - Other	2,872
Employee Benefit - Short Term Disability	721
Employee Benefit - Hepatitis B Vaccination	640
Employee Benefit - Tuition Rimbursement	1,748
TOTAL (agree to Schedule V, line 22, col.8)	$ 247,227

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	$ 1,990
Advertising: Employee Recruitment	2,627
Health Care Worker Background Check	2,557
(Indicate # of checks performed 165)	
Patient Background Checks 71	
Facility Advertising	2,256
IL Health Care Association	4,416
Non-Allowable Health Care Assn	(3,119)
Illinois Power Coalition	150
Sam's Club	40
Less: Public Relations Expense	( )
Non-allowable advertising	(2,256)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,661

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	21,242
Seminar Expense	4,487
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,729

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

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

Facility Name & ID Number Calhoun Nursing & Rehab Ctr # 0046888 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 $1,647 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. $ **26,856** 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. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **176,574**
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 therapy** 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? **N/A**
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: 1/1/2012 Ending: 12/31/2012

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 Healthcare REIT (covered by rent at outset										1
2	of Change of Ownership):										2
3											3
4	A/C Units & Ductwork			2005	6,400		5			6,400	4
5	Maglocks (7), Keypads (6)			2005	4,560	456	10	456		3,420	5
6	Water Heater - A.O. Smith 100 Gl			2005	2,275	227	10	227		1,706	6
7	Dining Room Lights (62)			2006	6,470	647	10	647		4,206	7
8	Nurse Station			2006	3,691	307	12	307		1,999	8
9	Metal Storage Building			2006	525	53	10	53		342	9
10	Window Treatments/Valances			2006	3,942		5			3,942	10
11	Windows (2)			2006	34,125	2,844	12	2,844		18,484	11
12	Paint Facility (hallway, dining room, nurse station)			2006	22,050		5			22,050	12
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32											32
33											33
34	TOTAL (lines 1 thru 33)				$ 84,038	$ 4,534		$ 4,534	$ 0	$ 62,549	34

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