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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0046888

Facility Name: Calhoun Nsg & Rehab 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	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 1/1/13 to 12/31/13 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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	12,039	8,267	3,778	24,084	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,039	8,267	3,778	24,084	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.48%

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)

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 80 and days of care provided 3,755

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 12/31/13 Fiscal Year: 1/1 to 12/31/13

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,072	13,993	11,793	183,858		183,858		183,858			1
2	Food Purchase		145,904		145,904		145,904	(780)	145,124			2
3	Housekeeping	114,089	15,450	51	129,590		129,590		129,590			3
4	Laundry	14,136	10,752		24,888		24,888		24,888			4
5	Heat and Other Utilities			72,912	72,912		72,912		72,912			5
6	Maintenance	28,035	16,676	31,382	76,093		76,093	(3,486)	72,607			6
7	Other (specify):* see trial balance			10,740	10,740		10,740		10,740			7
8	**TOTAL General Services**	314,332	202,775	126,878	643,985		643,985	(4,266)	639,719			8
	B. Health Care and Programs											
9	Medical Director			17,600	17,600		17,600		17,600			9
10	Nursing and Medical Records	1,509,865	96,273	18,275	1,624,413		1,624,413	(8,257)	1,616,156			10
10a	Therapy		4,397	663,433	667,830		667,830	(121,692)	546,138			10a
11	Activities	32,845	1,088	1,780	35,713		35,713		35,713			11
12	Social Services	31,242	2,093	1,730	35,065		35,065		35,065			12
13	CNA Training											13
14	Program Transportation			20,465	20,465		20,465		20,465			14
15	Other (specify):* see trial balance			8,805	8,805		8,805	(1,035)	7,770			15
16	**TOTAL Health Care and Programs**	1,573,952	103,851	732,088	2,409,891		2,409,891	(130,984)	2,278,907			16
	C. General Administration											
17	Administrative	178,407		254,040	432,447		432,447	(93,146)	339,301			17
18	Directors Fees											18
19	Professional Services			8,998	8,998		8,998	(2,333)	6,665			19
20	Dues, Fees, Subscriptions & Promotions			16,518	16,518		16,518	(10,165)	6,353			20
21	Clerical & General Office Expenses	23,236	32,840	33,717	89,793		89,793	(7,586)	82,207			21
22	Employee Benefits & Payroll Taxes			400,554	400,554		400,554	(732)	399,822			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,214	19,214		19,214	(18)	19,196			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			66,003	66,003		66,003	(2,600)	63,403			26
27	Other (specify):* see trial balance			116,543	116,543		116,543	(94,145)	22,398			27
28	**TOTAL General Administration**	201,643	32,840	915,587	1,150,070		1,150,070	(210,725)	939,345			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,089,927	339,466	1,774,553	4,203,946		4,203,946	(345,975)	3,857,971			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 Nsg & Rehab Center #0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,111	27,111		27,111	100,390	127,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,432	6,432		6,432	(6,432)				32
33	Real Estate Taxes			72,284	72,284		72,284		72,284			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(312,000)				34
35	Rent-Equipment & Vehicles			29,248	29,248		29,248		29,248			35
36	Other (specify):*											36
37	**TOTAL Ownership**			447,075	447,075		447,075	(218,042)	229,033			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			180	180		180		180			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			167,945	167,945		167,945		167,945			42
43	Other (specify):* **see trial balance**			186,705	186,705		186,705	(70,005)	116,700			43
44	**TOTAL Special Cost Centers**			354,830	354,830		354,830	(70,005)	284,825			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,089,927	339,466	2,576,458	5,005,851		5,005,851	(634,022)	4,371,829			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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	(56,259)	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	(6,432)	32		10
11	Discounts, Allowances, Rebates & Refunds	(340)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(238)	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	(372)	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	(93,773)	27		24
25	Fund Raising, Advertising and Promotional	(10,165)	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	(51,240)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (218,819)		$	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)	(415,203)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (415,203)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (634,022)		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

STATE OF ILLINOIS **Page 5A**

Calhoun Nsg & Rehab Center

ID# **0046888**

Report Period Beginning: **1/1/13**

Ending: **12/31/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove non-allowable Admiss Other Supplies	$ (7,239)	21	1
2	Remove non-allowable Visa Costs	(18)	24	2
3	Remove non-allowable Insurance Costs	(2,600)	26	3
4	Remove non-allowable Tax Prep Fees	(2,333)	19	4
5	Offset Misc. Revenue Sch XVII line 28a	(1,021)	10	5
6	Offset Misc. Revenue Sch XVII line 28a	(38)	10	6
7	Offset Misc. Revenue Sch XVII line 28a	(106)	6	7
8	Offset Misc. Revenue Sch XVII line 28a	(562)	10	8
9	Offset Misc. Revenue Sch XVII line 28a	(35)	10	9
10	Offset Misc. Revenue Sch XVII line 28a	(7)	21	10
11	Offset Interco Sold Service Rev Sch XVII line 28a	(2,351)	10	11
12	Offset Interco Sold Service Rev Sch XVII line 28a	(1,333)	10	12
13	Offset Interco Sold Service Rev Sch XVII line 28a	(312)	17	13
14	Offset Interco Sold Service Rev Sch XVII line 28a	(306)	10	14
15	Offset Interco Sold Service Rev Sch XVII line 28a	(512)	22	15
16	Remove non-allow IV Prescription Drug Costs	(14,955)	43	16
17	Remove Prior Year Costs	(10,848)	43	17
18	Offset Outpatient Occupational Therapy Revenue	(4,554)	10a	18
19	Offset Outpatient Speech Therapy Revenue	(1,868)	10a	19
20	Capitalize repairs & maintenance for Medicaid	(1,400)	6	20
21	Capitalize repairs & maintenance for Medicaid	(500)	6	21
22	Capitalize repairs & maintenance for Medicaid	(1,960)	6	22
23	Amortization on LHI capitalized for Medicaid	4,571	30	23
24	Accrue Additional Plant Ops Purchased Svcs	480	6	24
25	Remove Non-allowable Dietary Raw Food	(542)	2	25
26	Remove Non-allowable Depreciation on LHI	(891)	30	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**	(51,240)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nsg & Rehab Center **#** 0046888 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(780)	0	0	0	0	0	0	0	0	0	0	(780)	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	(3,486)	0	0	0	0	0	0	0	0	0	0	(3,486)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,266)	0	0	0	0	0	0	0	0	0	0	(4,266)	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	(5,646)	(2,611)	0	0	0	0	0	0	0	0	0	(8,257)	10
10a	Therapy	(62,681)	(59,011)	0	0	0	0	0	0	0	0	0	(121,692)	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	(1,035)	0	0	0	0	0	0	0	0	0	(1,035)	15
16	**TOTAL Health Care and Programs**	(68,327)	(62,657)	0	0	0	0	0	0	0	0	0	(130,984)	16
	C. General Administration													
17	Administrative	(312)	(92,834)	0	0	0	0	0	0	0	0	0	(93,146)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,333)	0	0	0	0	0	0	0	0	0	0	(2,333)	19
20	Fees, Subscriptions & Promotions	(10,165)	0	0	0	0	0	0	0	0	0	0	(10,165)	20
21	Clerical & General Office Expenses	(7,586)	0	0	0	0	0	0	0	0	0	0	(7,586)	21
22	Employee Benefits & Payroll Taxes	(512)	(220)	0	0	0	0	0	0	0	0	0	(732)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(18)	0	0	0	0	0	0	0	0	0	0	(18)	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):*	(94,145)	0	0	0	0	0	0	0	0	0	0	(94,145)	27
28	**TOTAL General Administration**	(117,671)	(93,054)	0	0	0	0	0	0	0	0	0	(210,725)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(190,264)	(155,711)	0	0	0	0	0	0	0	0	0	(345,975)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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	3,680	0	96,710	0	0	0	0	0	0	0	0	100,390	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,432)	0	0	0	0	0	0	0	0	0	0	(6,432)	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**	(2,752)	0	(215,290)	0	0	0	0	0	0	0	0	(218,042)	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):*	(25,803)	(44,202)	0	0	0	0	0	0	0	0	0	(70,005)	43
44	**TOTAL Special Cost Centers**	(25,803)	(44,202)	0	0	0	0	0	0	0	0	0	(70,005)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(218,819)	(199,913)	(215,290)	0	0	0	0	0	0	0	0	(634,022)	45

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 (	Granite City	Property Company
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Tara Pharmacy SE, LL	Birmingham	Pharmacy
		White Hall Nursing and Rehabilitation Center, LLC	White Hall	Tara Therapy, LLC	Orchard Park	Therapy
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Raimax Healthcare So	Orchard Park	Software
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 Associates, LLC	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Grou	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d/	Orchard Park	Support Office

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	$ 254,040	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 161,206	$ (92,834)	1
2	V	10	Pharmacy Consulting Services	17,280	Tara Pharmacy SE, LLC	0.00%	15,231	(2,049)	2
3	V	43	Flu Vac/Prescription Drug-Resident	141,990	Tara Pharmacy SE, LLC	0.00%	97,788	(44,202)	3
4	V	22	Flu/TB Vaccines for Employees	1,835	Tara Pharmacy SE, LLC	0.00%	1,615	(220)	4
5	V	10	Medication Administration Records	880	Tara Pharmacy SE, LLC	0.00%	318	(562)	5
6	V	10a	Physical Therapy Fees	320,145	Tara Therapy, LLC	0.00%	293,136	(27,009)	6
7	V	10a	Occupational Therapy Fees	203,008	Tara Therapy, LLC	0.00%	172,799	(30,209)	7
8	V	10a	Speech Therapy Fees	140,280	Tara Therapy, LLC	0.00%	138,487	(1,793)	8
9	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,291	(2,309)	9
10	V	15	Wireless Access Points License Fee	560	Raimax Healthcare Solutions Group, LLC	0.00%	1,834	1,274	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,083,618			$ 883,705	$ * (199,913)	14

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	30	Depreciation Leasehold Imp		Hardin Property Company, LLC	0.00%	70,735	70,735	16
17	V	30	Depreciation Major Moveable		Hardin Property Company, LLC	0.00%	16,056	16,056	17
18	V	30	Depreciation Bldg & Improve		Hardin Property Company, LLC	0.00%	9,919	9,919	18
19	V								19
20	V	3	Housekeeping Services	51	White Hall Nursing and Rehabilitaion Center, LLC	0.00%	51		20
21	V	15	Nursing Services	522	Granite Nursing and Rehabilitaion Center, LLC	0.00%	522		21
22	V	27	Administrative Services	1,249	Granite Nursing and Rehabilitaion Center, LLC	0.00%	1,249		22
23	V	1	Dietary Services	8,927	Stearns Nursing and Rehabilitaion Center, LLC	0.00%	8,927		23
24	V	6	Maintenance Services	477	Stearns Nursing and Rehabilitaion Center, LLC	0.00%	477		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			$ 323,226			$ 107,936	$ * (215,290)	39

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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				1
2			Lake City Nursing and Rehabilitation Center, L	Lake City				2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile				3
4			Florence Nursing and Rehabilitation Center, LL	Florence				4
5			Birmingham Nrs&Rehab Center East, LLC	Birmingham				5
6			Birmingham Nursing and Rehabilitation Center	Birmingham				6
7			Eight Mile Nursing and Rehabilitation Center, I	Eight Mile				7
8			North Hill Nursing and Rehabilitation Center, L	North Hill				8
9			Elba Nursing and Rehabilitation Center, LLC	Elba				9
10			Quince Nursing and Rehabilitation Center, LLC	Memphis				10
11			Allenbrooke Nursing and Rehabilitation Center,	Memphis				11
12			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo				12
13			Brandon Nursing and Rehabilitation Center, LL	Brandon				13
14			Lakeland Nursing and Rehabilitation Center, Ll	Jackson				14
15			McComb Nursing and Rehabilitation Center, LI	McComb				15
16			Cleveland Nursing and Rehabilitation Center, L	Cleveland				16
17			Chadwick Nursing and Rehabilitation Center, L	Jackson				17
18			Manhattan Nursing and Rehabilitation Center,	Jackson				18
19			Ruleville Nursing and Rehabilitation Center, LI	Ruleville				19
20			Farmerville Nursing and Rehabilitation Center,	Farmerville				20
21			Bernice Nursing and Rehabilitation Center, LL(	Bernice				21
22			Ruston Nursing and Rehabilitation Center, LLC	Ruston				22
23			Natchitoches Nursing and Rehabilitation Center	Natchitoches				23
24			Winnfield Nursing and Rehabilitation Center, L	Winnfield				24
25			Ringgold Nursing and Rehabilitation Center, LI	Ringgold				25
26			Arcadia Nursing and Rehabilitation Center, LL(	Arcadia				26
27			Jena Nursing and Rehabilitation Center, LLC	Jena				27
28								28
29			** The above listed facilites are related by					29
30			common ownership					30

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	***	0.53	1.33	Fin/ Adm. of TC	3,765	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.53	1.33	Fin/ Adm. of TC	3,765	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.53	1.33	VP of TC	3,057	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	$ 10,587		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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Total Costs	353,161,911	41	$ 346,431	$ 263,368	4,722,025	$ 4,633	1
2	5	Administrative Services Costs	Days	1,476,622	37	41,284	0	24,079	673	2
3	6	Administrative Services Costs	Days	1,476,622	37	71,472	0	24,079	1,165	3
4	10	Administrative Services Costs	Total Costs	353,161,911	41	3,382,826	2,681,559	4,722,025	45,236	4
5	17	Administrative Services Costs	Days	1,476,622	37	5,196,557	5,196,557	24,079	84,742	5
6	19	Administrative Services Costs	Days	1,476,622	37	31,367	0	24,079	511	6
7	20	Administrative Services Costs	Days	1,476,622	37	12,440	0	24,079	203	7
8	21	Administrative Services Costs	Days	1,476,622	37	241,710	0	24,079	3,941	8
9	22	Administrative Services Costs	Days	1,476,622	37	802,842	0	24,079	13,092	9
10	24	Administrative Services Costs	Days	1,476,622	37	105,969	0	24,079	1,727	10
11	26	Administrative Services Costs	Days	1,476,622	37	7,389	0	24,079	121	11
12	27	Administrative Services Costs	Days	1,476,622	37	62,648	0	24,079	1,020	12
13	30	Administrative Services Costs	Days	1,476,622	37	165,080	0	24,079	2,692	13
14	31	Administrative Services Costs	Days	1,476,622	37	10,708	0	24,079	175	14
15	32	Administrative Services Costs	Days	1,476,622	37	278	0	24,079	5	15
16	33	Administrative Services Costs	Days	1,476,622	37	29,222	0	24,079	477	16
17	34	Administrative Services Costs	Days	1,476,622	37	47,896	0	24,079	781	17
18	35	Administrative Services Costs	Days	1,476,622	37	718	0	24,079	12	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					$ 10,556,837	$ 8,141,484		$ 161,206	25

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	M&T BANK		X	Working Capital - Floating Bal	$609.14	6/26/09	3,654		demand not	0.0450	5,482	6
7												7
8												8
9	TOTAL Facility Related				$609.14		$ 3,654	$			$ 5,482	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,654	$			$ 5,482	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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 80,400	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.)		$ 74,484	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,916)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,200	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.		$ 72,284	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	71,090	8
	2009	73,895	9
	2010	76,955	10
	2011	76,573	11
	2012	76,573	12

The 2013 assessment was estimated to be a 5% increase over the 2012 assessment

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calhoun Nsg & Rehab 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 2012 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 2012.

	(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	$ 74,484.46	$ 74,484.46
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,484.46	$ 74,484.46

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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? [X] (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: 136,427
2. Number of Years Over Which it is Being Amortized: 5 Years (60 Months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8
4. Dates Incurred: Various and on the books of 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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$	$ 24,798	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	696	70	10	70		592	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		5			3,360	13
14	Carpet Flooring			2007	7,038		5			7,038	14
15	Air Conditioning Unit (10 ton)			2007	4,650	465	10	465		3,022	15
16	2 Doors			2007	3,318	302	11	302		1,961	16
17	Cilcomm Phone System			2007	14,211	1,421	10	1,421		9,237	17
18	Nurse Station			2008	40,675	4,067	10	4,067		22,371	18
19	Roof Replacement			2009	73,323	8,147	9	8,147		36,661	19
20	Front Doors (2)			2009	3,457	384	9	384		1,728	20
21	Water Heater			2009	10,508	1,167	9	1,167		5,253	21
22	Satellite TV Equipment			2009	15,751	1,750	9	1,750		7,876	22
23	Air Compressor			2009	6,339	704	9	704		3,169	23
24	A/C Unit	Removed on Audit		2010			5				24
25	Hot Water Pump	Removed on Audit		2010			8				25
26	A/C Unit	Removed on Audit		2010			5				26
27	Air Compressor			2010	3,000	375	8	375		1,313	27
28	A/C Unit (Rooftop 5 - ton)			2010	4,900	613	8	613		2,144	28
29	A/C Unit	Removed on Audit		2010			5				29
30	Panic Bars (for Fire Door - 2)			2010	3,730	466	8	466		1,632	30
31	Repairs to Generator - Capitalized for Medicaid			2010	3,061	511	3	511		3,061	31
32	Sprinkler System Repair - Capitalized for Medicaid			2010	6,836	1,139	3	1,139		6,836	32
33	Fire Alarm Panel Repair-Capitalized for Medicaid			2010	3,021	503	3	503		3,021	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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$	$	5	$	$	$	37
38	Sprinkler System Conversion	2011	3,000	428	7	428		1,071	38
39	Sprinkler System	2011	334,136	47,734	7	47,734		119,335	39
40	Lighting (Dining Room)	2011	1,206	172	7	172		430	40
41	A/C Unit	2011			5				41
42	A/C Unit	2011			5				42
43	Water Heater (91 gallon-Laundry)	2011	11,200	1,600	7	1,600		4,000	43
44	A/C Unit	2011	646	129	5	129		323	44
45	A/C Unit (10 ton Central NRS Station)	2011	10,000	667	15	667		1,667	45
46	Heaters (9 w/panel Attic)	2011	21,000	4,200	5	4,200		10,500	46
47	A/C Units	2012	632	126	5	126		189	47
48	PTAC Unit	2012	632	126	5	126		189	48
49	Walk in Freezer and water line repair - Capitalized for Medicaid	2012	4,800	1,600	3	1,600		2,400	49
50	Addtl Freezer Rpr-Drain&Heater (posted after 6/30/12)	2012	525	175	3	175		263	50
51	PTAC Unit	2012	632	126	5	126		190	51
52	PSRO Door	2012	1,344	90	15	90		135	52
53	Smoke Detectors (4, required additional)	2012	4,717	472	10	472		708	53
54	Chair-rail in Dining Room	2012	1,026	103	10	103		154	54
55	Commercial Garbage Disposal	2013	919	92	5	92		92	55
56	GE PTAC A/C Unit	2013	672	67	5	67		67	56
57	Cabling & Install Wireless Access Point	2013	2,145	54	20	54		54	57
58	(3) Rooftop A/C Units	2013	38,000	1,267	15	1,267		1,267	58
59	Repairs fo AC -compressor, recharge freon-Cap for Medicaid	2013	3,860	643	3	643		643	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)		$ 1,068,747	$ 91,874		$ 91,874	$	$ 311,767	70

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 171,886	$ 23,231	$ 23,231	$	various	$ 85,711	71
72	Current Year Purchases	31,732	2,416	2,416		various	2,416	72
73	Fully Depreciated Assets	89,172	2,580	2,580		various	89,172	73
74								74
75	TOTALS	$ 292,790	$ 28,227	$ 28,227	$		$ 177,299	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	$ 33,298	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			$ 36,998	$ 7,400	$ 7,400	$		$ 33,298	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)	$ 1,418,112	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,501	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 127,501	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)	$ 522,364	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	Shower Room Project	$ 6,900	92
93			93
94			94
95		$ 6,900	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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.	/2014	$ N/A
13.	/2015	$ N/A
14.	/2016	$ 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: $ 27,488 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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 ____

*Response to No: Facility required employees to be certified prior to employment.

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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 10,390	$	1
2	Cash-Patient Deposits	6,891		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	895,869		3
4	Supply Inventory (priced at cost)	5,205		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,889		6
7	Other Prepaid Expenses	7,318		7
8	Accounts Receivable (owners or related parties)	(2,982,631)		8
9	Other(specify): Non Resident A/R (see TB)	1,731		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,053,338)	$	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	83,195		15
16	Equipment, at Historical Cost	130,496		16
17	Accumulated Depreciation (book methods)	(68,537)		17
18	Deferred Charges	475		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,125		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	6,900		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 153,654	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,899,684)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 98,714	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,722		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,527		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,012		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,200		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	5,798		36
37	Accrued Expenses	41,257		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 491,230	$	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)**	$ 491,230	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,390,914)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,899,684)	$	48

***(See instructions.)**

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,045,066)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,045,066)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(314,958)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	1,110	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(32,000)	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)**	$ (345,848)	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)**	$ (2,390,914)	24	*

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 3,016,677	1
2	Discounts and Allowances for all Levels	1,096,624	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,113,301	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	62,681	5
6	Therapy	496,835	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 559,516	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	48	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,928	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,054	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,229	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,229	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	(28,130)	28
28a	Purchase Discounts & Misc Revenue	6,923	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (21,207)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,690,893	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	643,985	31
32	Health Care	2,409,891	32
33	General Administration	1,150,070	33
	B. Capital Expense		
34	Ownership	447,075	34
	C. Ancillary Expense		
35	Special Cost Centers	186,885	35
36	Provider Participation Fee	167,945	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,005,851	40
41	**Income before Income Taxes (line 30 minus line 40)****	(314,958)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (314,958)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,264,498	44
45	Private Pay - Net Inpatient Revenue	1,054,760	45
46	Medicare - Net Inpatient Revenue	1,791,753	46
47	Other-(specify) Hospice Contract	2,290	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,113,301	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 Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	1,872	2,080	$ 74,433	$ 35.79	1
2	Assistant Director of Nursing	1,824	2,080	52,027	25.01	2
3	Registered Nurses	10,396	11,915	285,091	23.93	3
4	Licensed Practical Nurses	14,546	16,453	325,863	19.81	4
5	CNAs & Orderlies	45,753	51,517	640,689	12.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,783	1,996	23,123	11.58	9
10	Activity Assistants	922	997	9,722	9.75	10
11	Social Service Workers	1,872	2,080	31,242	15.02	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	33,820	16.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,710	7,498	75,384	10.05	15
16	Dishwashers	4,838	5,342	48,868	9.15	16
17	Maintenance Workers	2,018	2,078	28,035	13.49	17
18	Housekeepers	10,622	11,835	114,089	9.64	18
19	Laundry	1,513	1,561	14,136	9.06	19
20	Administrator	1,888	2,080	86,915	41.79	20
21	Assistant Administrator					21
22	Other Administrative	1,875	2,091	37,001	17.70	22
23	Office Manager	1,952	2,080	35,057	16.85	23
24	Clerical	3,971	4,332	42,670	9.85	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	1,908	2,036	25,594	12.57	31
32	Other Health C: MDS Coordinator	3,731	4,179	106,168	25.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,986	136,310	$ 2,089,927 *	$ 15.33	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	92	17,600	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	1,730	11-3	44
45	Social Service Consultant	28	1,730	12-3	45
46	Other(specify)				46
47	Medical Records Preparation	$5.50 per bed/mo	880	10-3	47
48					48
49	TOTAL (lines 35 - 48)	148	$ 39,220		49

C. CONTRACT NURSES

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Ledder	Administrator	0	$ 86,915
Catherine Clowers	Bus. Office Mgr	0	35,057
Mary Brangenberg	Bus. Office Ast	0	19,434
Mary Kirn	Admis Coordinator	0	37,001
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 178,407

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 254,040
TOTAL (agree to Schedule V, line 17, col. 3)	$ 254,040
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,404
Freed, Maxick & Battaglia	Tax Fees	2,333
Various Legal Fees - See attached detailed listing		4,261
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,998

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,211
Unemployment Compensation Insurance	18,646
FICA Taxes	154,751
Employee Health Insurance	103,351
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Program	2,453
Employee Benefits - Other	4,970
Employee Benefits - Short Term Disability	434
Employee Benefits - Hepatitis B Vaccination	6
Employee Benefits - Tuition Reimbursement	2,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 399,822

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

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

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,552
Health Care Worker Background Check	1,465
(Indicate # of checks performed 126)	
Patient Background Checks 87	
Facility Advertising	6,843
IL Health Care Association	4,416
Non-Allowable Health Care Assn	(3,322)
Illinois Pioneer Coalition	150
Sam's Club/Notary Fees	102
Less: Public Relations Expense	( )
Non-allowable advertising	(6,843)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,353

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,836
Seminar Expense	360
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,196

**See instructions.

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 $1,244 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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,345** 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. $ **167,945**
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. N/A
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 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: 1/1/2013 Ending: 12/31/2013

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		3,876	5
6	Water Heater - A.O. Smith 100 Gl			2005	2,275	227	10	227		1,933	6
7	Dining Room Lights (62)			2006	6,470	647	10	647		4,853	7
8	Nurse Station			2006	3,691	307	12	307		2,306	8
9	Metal Storage Building			2006	525	53	10	53		395	9
10	Window Treatments/Valances			2006	3,942		5			3,942	10
11	Windows (2)			2006	34,125	2,844	12	2,844		21,328	11
12	Paint Facility (hallway, dining room, nurse station)			2006	22,050		5			22,050	12
13											13
14											14
15											15
16											16
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32											32
33											33
34	TOTAL (lines 1 thru 33)				$ 84,038	$ 4,534		$ 4,534	$ 0	$ 67,083	34

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