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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 01/01/16 to 12/31/16 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: 01/01/16 Ending: 12/31/16

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	14,258	8,921	3,674	26,853	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,258	8,921	3,674	26,853	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.71%

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 80 and days of care provided 3,234

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 12/31/16 Fiscal Year: 1/1 to 12/31/16

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	180,186	13,810	3,969	197,965		197,965	(729)	197,236			1
2	Food Purchase		166,896		166,896		166,896	(8,500)	158,396			2
3	Housekeeping	115,652	19,129		134,781		134,781		134,781			3
4	Laundry	37,889	12,379		50,268		50,268	(9)	50,259			4
5	Heat and Other Utilities			90,754	90,754		90,754	166	90,920			5
6	Maintenance	29,069	30,352	36,335	95,756		95,756	(4,334)	91,422			6
7	Other (specify):* see trial balance			12,613	12,613		12,613		12,613			7
8	TOTAL General Services	362,796	242,566	143,671	749,033		749,033	(13,406)	735,627			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	1,782,117	131,274	17,210	1,930,601		1,930,601	(60,646)	1,869,955			10
10a	Therapy		4,269	713,406	717,675		717,675	(69,456)	648,219			10a
11	Activities	40,425	2,204	1,712	44,341		44,341		44,341			11
12	Social Services	33,724	2,267	1,712	37,703		37,703	(269)	37,434			12
13	CNA Training											13
14	Program Transportation			16,468	16,468		16,468	(12)	16,456			14
15	Other (specify):* see trial balance			10,945	10,945		10,945	(4,313)	6,632			15
16	TOTAL Health Care and Programs	1,856,266	140,014	780,653	2,776,933		2,776,933	(134,696)	2,642,237			16
	C. General Administration											
17	Administrative	198,342		270,192	468,534		468,534	(98,437)	370,097			17
18	Directors Fees											18
19	Professional Services			30,403	30,403		30,403	(8,738)	21,665			19
20	Dues, Fees, Subscriptions & Promotions			16,723	16,723		16,723	(6,586)	10,137			20
21	Clerical & General Office Expenses	49,268	36,662	39,167	125,097		125,097	(7,157)	117,940			21
22	Employee Benefits & Payroll Taxes			333,288	333,288		333,288	(8,100)	325,188			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,663	16,663		16,663	349	17,012			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,480	46,480		46,480	(2,600)	43,880			26
27	Other (specify):* see trial balance			44,288	44,288		44,288	(40,830)	3,458			27
28	TOTAL General Administration	247,610	36,662	797,204	1,081,476		1,081,476	(172,099)	909,377			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,466,672	419,242	1,721,528	4,607,442		4,607,442	(320,201)	4,287,241			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: 01/01/16 Ending: 12/31/16

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			29,396	29,396		29,396	89,329	118,725			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			86,831	86,831		86,831		86,831			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(312,000)				34
35	Rent-Equipment & Vehicles			24,769	24,769		24,769		24,769			35
36	Other (specify):* **Off site Storage**			1,137	1,137		1,137		1,137			36
37	**TOTAL Ownership**			454,133	454,133		454,133	(222,671)	231,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		16	216	232		232		232			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,609	187,609		187,609		187,609			42
43	Other (specify):* **see trial balance**			203,414	203,414		203,414	(63,930)	139,484			43
44	**TOTAL Special Cost Centers**		16	391,239	391,255		391,255	(63,930)	327,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,466,672	419,258	2,566,900	5,452,830		5,452,830	(606,802)	4,846,028			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: 01/01/16 Ending: 12/31/16

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				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,240)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(113)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(251)	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	(37)	21		18
19	Entertainment				19
20	Contributions	(200)	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	(40,640)	27		24
25	Fund Raising, Advertising and Promotional	(4,425)	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	(192,517)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (246,423)		$	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)	(360,379)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (360,379)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (606,802)		37

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

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

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

Calhoun Nsg & Rehab Center

ID# 0046888

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues&Subscriptions	$ (2,084)	20	1
2	Remove Non-allowable Legal Fees	(3,400)	19	2
3	Remove Non-allowable Admissions Other Supplies	(6,852)	21	3
4	Remove Non-allowable Finance Charges	(19)	21	4
5	Remove Non-allowable Insurance Cost	(2,600)	26	5
6	Remove Non-allowable Admin Other Supplies	(133)	21	6
7	Remove Non-allowable NRS Admin- Res Transport	(12)	14	7
8	Remove Non-allowable HR-EE background checks	(77)	20	8
9	Remove Non-allowable BO Tax Preperation Fees	(5,338)	19	9
10	Remove Non-allow Outpatient Svcs-consol billing	(224)	43	10
11	Additional Allowable Dietary	217	1	11
12	Additional Allowable Food	(9)	2	12
13	Additional Allowable Maintenance	2,211	6	13
14	Additional Allowable Laundry	(9)	4	14
15	Additional Allowable Nursing and Med. Records	272	10	15
16	Additional Allowable Heat and Other Utilities	166	5	16
17	Additional Allowable Travel	349	24	17
18	Additional Allowable ADR submission	10	27	18
19	Offset Outpatient Physical Therapy Revenue	(85,915)	10a	19
20	Offset Outpatient Occupational Therapy Revenue	(3,693)	10a	20
21	Offset Outpatient Speech Therapy Revenue	(86)	10a	21
22	Remove Non-allowable IV Rx Drugs Cost	(2,092)	43	22
23	Remove Non-allowable Prior Year Costs	(3,068)	43	23
24	Offset Interco Sold Services Revenue	(58,741)	10	24
25	Offset Interco Sold Services Revenue	(946)	1	25
26	Offset Interco Sold Services Revenue	(269)	12	26
27	Offset Interco Sold Services Revenue	(8,266)	22	27
28	Offset Misc. Revenue Med Surg	(1,127)	10	28
29	Offset Misc. Revenue Food Sup.	(106)	10	29
30	Offset Misc. Revenue Non-Med Equip	(87)	6	30
31	Offset Misc. Revenue Incontinent	(612)	10	31
32	Offset Misc. Revenue Equip	(43)	10	32
33	Offset Misc. Revenue Other	(3)	21	33
34	Capitalize repairs & Maintenance & Equipment	(4,206)	10	34
35	Capitalize repairs & Maintenance & Equipment	(3,825)	6	35
36	Capitalize repairs & Maintenance & Equipment	(2,633)	6	36
37	Depreciation/Amort LHI	1,740	30	37
38	Depreciation/Amort MME	6,278	30	38
39	Current Year Depreciation Audit Adjustments LHI	(7,285)	30	39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(192,517)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calhoun Nsg & Rehab Center **#** 0046888 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(729)	0	0	0	0	0	0	0	0	0	0	(729)	1
2	Food Purchase	(8,500)	0	0	0	0	0	0	0	0	0	0	(8,500)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(9)	0	0	0	0	0	0	0	0	0	0	(9)	4
5	Heat and Other Utilities	166	0	0	0	0	0	0	0	0	0	0	166	5
6	Maintenance	(4,334)	0	0	0	0	0	0	0	0	0	0	(4,334)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,406)	0	0	0	0	0	0	0	0	0	0	(13,406)	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	(64,563)	3,917	0	0	0	0	0	0	0	0	0	(60,646)	10
10a	Therapy	(89,694)	20,238	0	0	0	0	0	0	0	0	0	(69,456)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(269)	0	0	0	0	0	0	0	0	0	0	(269)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(12)	0	0	0	0	0	0	0	0	0	0	(12)	14
15	Other (specify):*	0	(4,313)	0	0	0	0	0	0	0	0	0	(4,313)	15
16	**TOTAL Health Care and Programs**	(154,538)	19,842	0	0	0	0	0	0	0	0	0	(134,696)	16
	C. General Administration													
17	Administrative	0	(98,437)	0	0	0	0	0	0	0	0	0	(98,437)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,738)	0	0	0	0	0	0	0	0	0	0	(8,738)	19
20	Fees, Subscriptions & Promotions	(6,586)	0	0	0	0	0	0	0	0	0	0	(6,586)	20
21	Clerical & General Office Expenses	(7,157)	0	0	0	0	0	0	0	0	0	0	(7,157)	21
22	Employee Benefits & Payroll Taxes	(8,266)	166	0	0	0	0	0	0	0	0	0	(8,100)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	349	0	0	0	0	0	0	0	0	0	0	349	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):*	(40,830)	0	0	0	0	0	0	0	0	0	0	(40,830)	27
28	**TOTAL General Administration**	(73,828)	(98,271)	0	0	0	0	0	0	0	0	0	(172,099)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,772)	(78,429)	0	0	0	0	0	0	0	0	0	(320,201)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	733	0	88,596	0	0	0	0	0	0	0	0	89,329	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	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**	733	0	(223,404)	0	0	0	0	0	0	0	0	(222,671)	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):*	(5,384)	(58,546)	0	0	0	0	0	0	0	0	0	(63,930)	43
44	**TOTAL Special Cost Centers**	(5,384)	(58,546)	0	0	0	0	0	0	0	0	0	(63,930)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(246,423)	(136,975)	(223,404)	0	0	0	0	0	0	0	0	(606,802)	45

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	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/l	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. ☐ 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	$ 270,192	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 171,755	$ (98,437)	1
2	V	10	Pharmacy Consulting Services	17,280	Tara Pharmacy SE, LLC	0.00%	21,197	3,917	2
3	V	43	Flu Vac/Prescription Drug-Resident	172,298	Tara Pharmacy SE, LLC	0.00%	113,752	(58,546)	3
4	V	22	Flu/TB Vaccines for Employees	2,689	Tara Pharmacy SE, LLC	0.00%	2,855	166	4
5	V	15	Misc. Sales & Delivery Charges	561	Tara Pharmacy SE, LLC	0.00%		(561)	5
6	V	10a	Physical Therapy Fees	336,356	Tara Therapy, LLC	0.00%	350,129	13,773	6
7	V	10a	Occupational Therapy Fees	223,428	Tara Therapy, LLC	0.00%	204,822	(18,606)	7
8	V	10a	Speech Therapy Fees	153,622	Tara Therapy, LLC	0.00%	178,693	25,071	8
9	V	15	Patient Care Software	408	Raimax Healthcare Solutions Group, LLC	0.00%	468	60	9
10	V	15	Wireless Access Points License Fee	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	(212)	(3,812)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,180,434			$ 1,043,459	$ * (136,975)	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: 01/01/16 Ending: 12/31/16

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%	70,135	70,135	16
17	V	30	Depreciation Major Moveable		Hardin Property Company, LLC	0.00%	8,542	8,542	17
18	V	30	Depreciation Bldg & Improve		Hardin Property Company, LLC	0.00%	9,919	9,919	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	1	Dietary Services	570	Stearns Nursing and Rehabilitation Center, LLC	0.00%	570		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			$ 312,570			$ 89,166	$ * (223,404)	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: 01/01/16 Ending: 12/31/16

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, LLC					1
2			Lake City Nursing and Rehabilitation Center, LLC					2
3			Mobile Nursing and Rehabilitation Center, LLC					3
4			Florence Nursing and Rehabilitation Center, LLC					4
5			Birmingham Nrs&Rehab Center East, LLC					5
6			Birmingham Nursing and Rehabilitation Center, LLC					6
7			Eight Mile Nursing and Rehabilitation Center, LLC					7
8			North Hill Nursing and Rehabilitation Center, LLC					8
9			Elba Nursing and Rehabilitation Center, LLC					9
10			Quince Nursing and Rehabilitation Center, LLC					10
11			Allenbrooke Nursing and Rehabilitation Center, LLC					11
12			Tupelo Nursing and Rehabilitation Center, LLC					12
13			Brandon Nursing and Rehabilitation Center, LLC					13
14			Lakeland Nursing and Rehabilitation Center, LLC					14
15			McComb Nursing and Rehabilitation Center, LLC					15
16			Cleveland Nursing and Rehabilitation Center, LLC					16
17			Chadwick Nursing and Rehabilitation Center, LLC					17
18			Manhattan Nursing and Rehabilitation Center, LLC					18
19			Ruleville Nursing and Rehabilitation Center, LLC					19
20			Farmerville Nursing and Rehabilitation Center, LLC					20
21			Bernice Nursing and Rehabilitation Center, LLC					21
22			Ruston Nursing and Rehabilitation Center, LLC					22
23			Natchitoches Nursing and Rehabilitation Center, LLC					23
24			Winnfield Nursing and Rehabilitation Center, LLC					24
25			Ringgold Nursing and Rehabilitation Center, LLC					25
26			Arcadia Nursing and Rehabilitation Center, LLC					26
27			Jena Nursing and Rehabilitation Center, LLC					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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	DTD HC, LLC	Owner		50.00	0	0	0.00		$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.55	1.38	Fin/ Adm. of TC	4,176	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.55	1.38	Fin/ Adm. of TC	4,176	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President	Admin SVS of	0.00	***	0.55	1.38	VP of TC	3,730	17	7
8			Tara Cares								8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	$ 12,082		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: 01/01/16 Ending: 12/31/16

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)662-2629

	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	393,631,114	40	$ 327,613	$ 248,771	5,181,895	$ 4,311	1
2	5	Administrative Services Costs	Days	1,573,569	36	39,084	0	26,847	666	2
3	6	Administrative Services Costs	Days	1,573,569	36	73,458	0	26,847	1,253	3
4	10	Administrative Services Costs	Total Costs	393,631,114	40	2,792,167	2,199,184	5,181,895	36,752	4
5	17	Administrative Services Costs	Days	1,573,569	36	5,935,931	5,935,931	26,847	101,274	5
6	19	Administrative Services Costs	Days	1,573,569	36	10,996	0	26,847	188	6
7	20	Administrative Services Costs	Days	1,573,569	36	13,064	0	26,847	224	7
8	21	Administrative Services Costs	Days	1,573,569	36	280,112	0	26,847	4,779	8
9	22	Administrative Services Costs	Days	1,573,569	36	874,230	0	26,847	14,915	9
10	24	Administrative Services Costs	Days	1,573,569	36	142,490	0	26,847	2,431	10
11	26	Administrative Services Costs	Days	1,573,569	36	5,764	0	26,847	98	11
12	27	Administrative Services Costs	Days	1,573,569	36	92,390	0	26,847	1,577	12
13	30	Administrative Services Costs	Days	1,573,569	36	83,854	0	26,847	1,430	13
14	31	Administrative Services Costs	Days	1,573,569	36	10,324	0	26,847	176	14
15	33	Administrative Services Costs	Days	1,573,569	36	30,404	0	26,847	519	15
16	34	Administrative Services Costs	Days	1,573,569	36	66,534	0	26,847	1,135	16
17	35	Administrative Services Costs	Days	1,573,569	36	1,606	0	26,847	27	17
18										18
19		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								19
20		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								20
21		considered a Home Office by CMS and as defined in 42 CRF 421.404.								21
22										22
23										23
24										24
25	TOTALS					$ 10,780,021	$ 8,383,886		$ 171,755	25

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	88,200	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.)	$	87,511	2
3. Under or (over) accrual (line 2 minus line 1).	$	(689)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	87,520	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.	$	86,831	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	76,573	8
	2012	76,573	9
	2013	79,930	10
	2014	86,774	11
	2015	87,511	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(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	$ 87,511.14	$ 87,511.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 87,511.14	$ 87,511.14

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,969 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).

None

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: 63,995
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&OtherCostsIncurred2009&2010. AllocatedViaRelatedOrgCost&Reported Sch VII 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: 01/01/16 Ending: 12/31/16

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	$	$ 54,555	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	696		10			696	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		4,418	15
16	2 Doors			2007	3,318	302	11	302		2,866	16
17	Cilcomm Phone System - Reduced on Audit			2007	9,716	972	10	972		9,231	17
18	Nurse Station			2008	40,675	4,068	10	4,068		34,574	18
19	Roof Replacement			2009	73,323	8,147	9	8,147		61,103	19
20	Front Doors (2)			2009	3,457	384	9	384		2,881	20
21											21
22											22
23											23
24	Air Compressor			2010	3,000	375	8	375		2,438	24
25	A/C Unit Rooftop 5 Ton			2010	4,900	613	8	613		3,982	25
26	Panic Bars (for Fire Door - 2)			2010	3,730	466	8	466		3,030	26
27	Repairs to Generator - Capitalized for Medicaid			2010	3,061		3			3,061	27
28	Sprinkler System Repair - Capitalized for Medicaid			2010	6,836		3			6,836	28
29	Fire Alarm Panel Repair-Capitalized for Medicaid			2010	3,021		3			3,021	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Sprinkler System Conversion	2011	$ 3,000	$ 428	7	$ 428	$	$ 2,357	37
38	Sprinkler System	2011	334,136	47,734	7	47,734		262,536	38
39									39
40									40
41									41
42	A/C Unit (10 ton Central NRS Station)	2011	10,000	667	15	667		3,667	42
43	Heaters (9 w/panel Attic)	2011	21,000	2,100	5	2,100		21,000	43
44									44
45									45
46	Walk in Freezer and water line repair - Capitalized for Medicaid	2012	4,800		3			4,800	46
47									47
48									48
49									49
50	Smoke Detectors (4, required additional)	2012	4,717	472	10	472		2,123	50
51									51
52									52
53									53
54									54
55	(3) Rooftop A/C Units	2013	38,000	2,533	15	2,533		8,866	55
56	Repairs fo AC -compressor, recharge freon-Cap for Medicaid	2013	3,860	643	3	643		3,860	56
57	Water Heater 100 Gallon for Showers	2014	12,500	1,250	10	1,250		3,125	57
58	A/C Unit (5 ton rooftop)	2014	14,000	1,400	10	1,400		3,500	58
59	Water Heater 100 Gallon for Laundry - Capitalized for Medicaid	2014	4,884	488	10	488		1,220	59
60	Shower Room Renovation - East hall install tile,cabintry	2014	60,570	3,029	20	3,029		7,571	60
61	drywall, paint,framing, electric and plumbing								61
62	Storage Shed	2015	6,719	336	20	336		504	62
63	Kitchen Floor (Quarry Tile)	2015	16,717	836	20	836		1,254	63
64	Fire Panel	2015	26,181	2,618	10	2,618		3,927	64
65	Labor and materials to tie in two commercial water heaters - Capitalized	2015	2,940	118	25	118		177	65
66	Labor and materials to replace kitchen water lines & shut-offs - Capitaliz	2015	2,804	112	25	112		168	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,157,390	$ 90,475		$ 90,475	$	$ 556,762	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: 01/01/16 Ending: 12/31/16

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	
1	Totals from Page 12A, Carried Forward		$ 1,157,390	$ 90,475		$ 90,475	$	$ 556,762	1
2	A/C Unit (5 ton rooftop)	2016	3,825	191	10	191		191	2
3	Water Heater - Kitchen	2016	8,496	425	10	425		425	3
4	Repairs to Frozen Fire Suppression System for the building	2016	2,633	188	7	188		188	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Note: See additional building improvements made by former		59,713	3,501		3,501		54,986	26
27	property owner Healthcare REIT, Inc. on supplemental								27
28	schedule included as page 24 of the cost report.								28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,232,057	$ 94,780		$ 94,780	$	$ 612,552	34

**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: 01/01/16 Ending: 12/31/16

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	$ 243,988	$ 26,009	$ 26,009	$	various	$ 124,905	71
72	Current Year Purchases	4,206	421	421		various	421	72
73	Fully Depreciated Assets	135,768	1,015	1,015		various	135,769	73
74								74
75	TOTALS	$ 383,962	$ 27,445	$ 27,445	$		$ 261,095	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	$	$	$	5	$ 36,998	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			$ 36,998	$	$	$		$ 36,998	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)	$ 1,672,594	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 122,225	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 122,225	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)	$ 910,645	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	None	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:				$			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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 25,182 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: 01/01/16 Ending: 12/31/16

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 Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Calhoun Nsg & Rehab Center **#** 0046888 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 17,615	$	1
2	Cash-Patient Deposits	8,320		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	862,960		3
4	Supply Inventory (priced at cost)	4,594		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,990		6
7	Other Prepaid Expenses	7,893		7
8	Accounts Receivable (owners or related parties)	(80,955)		8
9	Other(specify): Non Resident A/R (see TB)	7,368		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 830,785	$	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	228,378		15
16	Equipment, at Historical Cost	152,368		16
17	Accumulated Depreciation (book methods)	(158,808)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deposits long Term	1,506		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 223,444	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,054,229	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,873	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,594		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,328		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,743		31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,520		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	37,743		36
37	Accrued Expenses	169,074		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 682,875	$	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)**	$ 682,875	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 371,354	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,054,229	$	48

***(See instructions.)**

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 54,651	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 54,651	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	63,403	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	391,400	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(138,100)	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)**	$ 316,703	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)**	$ 371,354	24 *

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

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 3,707,774	1
2	Discounts and Allowances for all Levels	1,103,397	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,811,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	89,694	5
6	Therapy	502,657	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 592,351	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	8,240	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,218	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,346	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,804	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	744	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 744	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Prior Year Net Revenue**	27,850	28
28a	**Purchase Discounts & Misc Revenue**	70,313	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 98,163	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,516,233	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	749,033	31
32	Health Care	2,776,933	32
33	General Administration	1,081,476	33
	B. Capital Expense		
34	Ownership	454,133	34
	C. Ancillary Expense		
35	Special Cost Centers	203,646	35
36	Provider Participation Fee	187,609	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,452,830	40
41	**Income before Income Taxes (line 30 minus line 40)****	63,403	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 63,403	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,793,865	44
45	Private Pay - Net Inpatient Revenue	1,243,516	45
46	Medicare - Net Inpatient Revenue	1,770,571	46
47	Other-(specify) **Hospice**	3,219	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,811,171	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: 01/01/16 Ending: 12/31/16

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	1,864	2,056	$ 72,708	$ 35.36	1
2	Assistant Director of Nursing	1,833	1,985	59,435	29.94	2
3	Registered Nurses	14,543	15,940	456,881	28.66	3
4	Licensed Practical Nurses	17,043	18,461	407,133	22.05	4
5	CNAs & Orderlies	52,542	57,166	758,835	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,734	2,066	26,719	12.93	9
10	Activity Assistants	1,254	1,256	13,706	10.91	10
11	Social Service Workers	1,831	2,023	33,724	16.67	11
12	Dietician					12
13	Food Service Supervisor	1,951	2,159	38,298	17.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,990	5,938	59,598	10.04	15
16	Dishwashers	7,727	8,357	82,290	9.85	16
17	Maintenance Workers	1,951	2,090	29,069	13.91	17
18	Housekeepers	10,270	11,202	115,652	10.32	18
19	Laundry	3,364	3,610	37,889	10.50	19
20	Administrator	1,840	2,080	90,468	43.49	20
21	Assistant Administrator					21
22	Other Administrative	5,681	6,161	92,968	15.09	22
23	Office Manager	2,426	2,930	45,253	15.44	23
24	Clerical	1,253	1,636	18,920	11.56	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	1,770	2,194	27,125	12.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,867	149,310	$ 2,466,671 *	$ 16.52	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	38	$ 2,226	1-3	35
36	Medical Director	147	19,200		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18/bed/month	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	25	1,713		44
45	Social Service Consultant	25	1,712		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	235	$ 42,131		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 Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Ledder	Administrator	0	$ 90,469
Catherine Clowers	Bus. Office Mgr	0	35,358
Mary Eilerman	Bus. Office Mgr	0	9,896
Maggie Vinson	Bus. Office Asst	0	6,002
Mary Eilerman	Bus. Office Asst	0	12,916
Mary Kirn	Dir of Admissions	0	43,701
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 198,342

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 270,192
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 270,192

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,518
Freed, Maxick & Battaglia	Tax Fees	5,338
Various Legal Fees - See attached detailed listing		22,547
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 30,403

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,543
Unemployment Compensation Insurance	17,570
FICA Taxes	180,635
Employee Health Insurance	45,308
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Program	4,005
Employee Benefits - Other	4,720
Employee Benefits - S T Disability	476
Employee Benefits - Hepatitis B Vaccination	
Employee Benefits- Life Insurance (ER)	1,008
Employye Benefits - H.S.A (ER)	7,800
Employee Benefits- Hep B Vac/Dental/Daycare	1,123
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,188

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	958
Health Care Worker Background Check	955
(Indicate # of checks performed 77)	
Patient Background Checks 90	900
Facility Advertising	4,425
IL Health Care Association	5,016
Non-Allowable Health Care Assn/IL Pioneer (	(2,084)
Illinois Pioneer Coalition/Citrix license	1,982
Fingerprinting	420
Less: Public Relations Expense	( )
Non-allowable advertising	(4,425)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,137

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	15,852
Seminar Expense	1,160
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,012

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,082 net of non-allowables**

(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. $ **24,589** 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. $ **187,609**
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 services** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,240**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number Calhoun Nsg & Rehab Center # 0046888 Report Period Beginning: 01/01/16 Ending: 12/31/16

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Made by Healthcare REIT (covered by rent at outset										9
10	of Change of Ownership):										10
11											11
12	A/C Units & Ductwork			2005	6,400		5			6,400	12
13	Maglocks (7), Keypads (6)			2005	4,560		10			4,560	13
14											14
15	Dining Room Lights (62)			2006	6,470	323	10	323		6,470	15
16	Nurse Station			2006	3,691	308	12	308		3,230	16
17	Metal Storage Building			2006	525	26	10	26		525	17
18	Window Treatments/Valances			2006	3,942		5			3,942	18
19	Windows (2)			2006	34,125	2,844	12	2,844		29,859	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTALS (Lines 4 thru 35)				59,713	3,501		3,501		54,986	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