FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nursing Home

Address: 500 South Art Bartell Drive (Number) Urbana (City) 61802 (Zip Code)

County: Champaign

Telephone Number: (217) 384-3784 **Fax #** (217) 337-0120

HFS ID Number:

Date of Initial License for Current Owners: 4/26/1905

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
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 12/1/09 to 11/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

III. STATISTICAL DATA

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

	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	187	Skilled (SNF)	187	68,255	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,695	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	25,350	18,174	9,232	52,756	8
9	SNF/PED					9
10	ICF	13,256	5,306	476	19,038	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,606	23,480	9,708	71,794	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.94%

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)
Adult Day Care; Child Day Care

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 2006

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 187 and days of care provided 4,903

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 11/30/10 Fiscal Year: 11/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	500,825	69,191	24,661	594,677		594,677	(2,949)	591,728			1
2	Food Purchase		396,385		396,385		396,385	(18,169)	378,216			2
3	Housekeeping	388,410	64,224		452,634		452,634	(2,218)	450,416			3
4	Laundry	116,754	31,813		148,567		148,567		148,567			4
5	Heat and Other Utilities			524,708	524,708		524,708	(18,123)	506,585			5
6	Maintenance	66,239	27,793	113,634	207,666		207,666	(4,885)	202,781			6
7	Other (specify):*											7
8	TOTAL General Services	1,072,228	589,406	663,003	2,324,637		2,324,637	(46,344)	2,278,293			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,268,487	413,385	1,439,166	6,121,038		6,121,038		6,121,038			10
10a	Therapy	80,541	2,100	1,235,637	1,318,278		1,318,278		1,318,278			10a
11	Activities	147,795	3,754	1,473	153,022		153,022		153,022			11
12	Social Services	136,691		32,539	169,230		169,230		169,230			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Adult Day Care	164,542	11,904	66,174	242,620		242,620	(242,620)				15
16	TOTAL Health Care and Programs	4,798,056	431,143	2,774,989	8,004,188		8,004,188	(242,620)	7,761,568			16
	C. General Administration											
17	Administrative	88,150		346,505	434,655		434,655		434,655			17
18	Directors Fees											18
19	Professional Services			190,980	190,980		190,980	(14,548)	176,432			19
20	Dues, Fees, Subscriptions & Promotions			70,572	70,572		70,572	(15,577)	54,995			20
21	Clerical & General Office Expenses	260,558	34,898	78,208	373,664		373,664	(4,648)	369,016			21
22	Employee Benefits & Payroll Taxes			1,887,538	1,887,538		1,887,538		1,887,538			22
23	Inservice Training & Education			8,616	8,616		8,616	(937)	7,679			23
24	Travel and Seminar			25,905	25,905		25,905	(1,703)	24,202			24
25	Other Admin. Staff Transportation			2,556	2,556		2,556	(18)	2,538			25
26	Insurance-Prop.Liab.Malpractice			231,143	231,143		231,143	(9,447)	221,696			26
27	Other (specify):*											27
28	TOTAL General Administration	348,708	34,898	2,842,023	3,225,629		3,225,629	(46,878)	3,178,751			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,218,992	1,055,447	6,280,015	13,554,454		13,554,454	(335,842)	13,218,612			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Champaign County Nursing Home #0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			725,694	725,694		725,694	(29,615)	696,079			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,051	155,051		155,051	(3,548)	151,503			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			47,312	47,312		47,312		47,312			35
36	Other (specify):*											36
37	TOTAL Ownership			928,057	928,057		928,057	(33,163)	894,894			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,851		257,851		257,851		257,851			39
40	Barber and Beauty Shops	35,804	844		36,648		36,648		36,648			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,043	133,043		133,043		133,043			42
43	Other (specify):* Non-Allowable Cos			145,279	145,279		145,279	(145,279)				43
44	TOTAL Special Cost Centers	35,804	258,695	278,322	572,821		572,821	(145,279)	427,542			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,254,796	1,314,142	7,486,394	15,055,332		15,055,332	(514,284)	14,541,048			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$ (245,260)	15	$	1
2	Other Care for Outpatients				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	(4,550)	30		9
10	Interest and Other Investment Income	(3,548)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(36,270)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(15,330)	20		28
29	Other-Attach Schedule See Pg 5A	(209,326)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (514,284)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (514,284)		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		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

ID# 0046664

Report Period Beginning: 12/1/09

Ending: 11/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset miscellaneous revenue	$ (4,407)	21	1
2	Offset meal revenue against food cost	(5,565)	2	2
3	Cable TV expense	(25,936)	43	3
4	Non-allowable dues	(246)	20	4
5	Laboratory fees	(30,496)	43	5
6	Medicare ancillary expense	(42,626)	43	6
7	Disallow Out-Of-Period Legal Expenses	(12,874)	19	7
8	Non-allowable Transfers to General Corporate F	(7,970)	43	8
9	Public relations expense	(1,981)	43	9
10	Disallow Indirect Adult Day Care Costs:			10
11	Dietary	(2,949)	1	11
12	Food	(12,604)	2	12
13	Housekeeping	(2,218)	3	13
14	Utilities	(18,123)	5	14
15	Maintenance	(4,885)	6	15
16	Professional Fees	(1,674)	19	16
17	Office	(241)	21	17
18	Staff Transportation	(18)	25	18
19	Insurance - Auto	(7,853)	26	19
20	Insurance - Other	(1,594)	26	20
21	Depreciation - Other	(25,065)	30	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(209,326)		49

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Champaign County	100	N/A	N/A	Champaign County	Urbana	Government

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 [X] 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			N/A	$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	See Attached List	Board of Directors	Administrative	0.00	None	<1	<1%		None	N/A	3
4											4
5											5
6											6
7											7
8											8
9	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										9
10	transactions with the nursing home during the reporting period.										10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Champaign County Day Care Cost
Street Address: 1776 East Washington
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3776
Fax Number: (217) 337-0120

	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	Dietary	Meals	223,892		$ 92,752	$	7,119	$ 2,949	1
2	2	Food	Meals	223,892		396,385		7,119	12,604	2
3	3	Housekeeping	Square Feet	135,500		64,224		4,680	2,218	3
4	5	Utilities	Square Feet	135,500		524,708		4,680	18,123	4
5	6	Maintenance	Square Feet	135,500		141,430		4,680	4,885	5
6	19	Professional Fees	Revenue	15,245,759		242,675		105,165	1,674	6
7	21	Office Expense	Revenue	15,245,759		34,898		105,165	241	7
8	25	Staff Transportation	Revenue	15,245,759		2,556		105,165	18	8
9	26	Insurance - Auto	Direct	1		7,853		1	7,853	9
10	26	Insurance - Other	Revenue	15,245,759		231,143		105,165	1,594	10
11	30	Depreciation - Other	Square Feet	135,500		725,694		4,680	25,065	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	TOTALS					$ 2,464,318	$		$ 77,224	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	Interest - Bonds Payable		X	Construction	Varies	06/30/2006	$ 4,000,000	$ 3,560,000	6/30/2026	Varies	$ 150,509	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interfund Loan		X	Champaign County							4,542	6
7												7
8												8
9	TOTAL Facility Related						$ 4,000,000	$ 3,560,000			$ 155,051	9
	B. Non-Facility Related*											
10												10
11									Offset interest income		(3,548)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,548)	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 3,560,000			$ 151,503	15

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

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 Champaign County Nursing Home # 0046664 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	**2009**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	N/A	8
	2006		9
	2007		10
	2008		11
	2009		12

County nursing home. Exempt from real estate tax.

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0046664

CONTACT PERSON REGARDING THIS REPORT Andrew Buffenbarger, Administrator

TELEPHONE (217) 384-3784 FAX #: (217) 337-0120

A. **Summary of Real Estate Tax Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 135,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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

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

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

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

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

Adults Day Care Services
4,680 Square Feet

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(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	Facility	670,000	2007	$ 253,543	1
2					2
3	TOTALS	670,000		$ 253,543	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	243		2007	2007	$ 23,227,193	$ 577,728	40	$ 580,680	$ 2,952	$ 2,226,033	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New NH parking lot			2007	189,924	36,155	20	22,173	(13,982)	96,915	9
10	Masonry sign			2008	16,741	670	25	670		1,675	10
11	Smoke Barriers			2010	89,879	1,215	37	1,215		1,215	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
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 Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 23,523,737	$ 615,768		$ 604,738	$ (11,030)	$ 2,325,838	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 983,871	$ 92,622	$ 98,966	$ 6,344	10	$ 562,414	71
72	Current Year Purchases	17,907	368	368		5-10	368	72
73	Fully Depreciated Assets							73
74	Disallowed by Day Care Depreciation			(25,065)	(25,065)			74
75	TOTALS	$ 1,001,778	$ 92,990	$ 74,269	$ (18,721)		$ 562,782	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	See Sch 13A	See Sch 13A	See Sch 13A	156,853	16,936	17,072	136	5-10	90,283	77
78	Disposal	94 Ford Van Repair	2005	(2,484)				3	(2,484)	78
79										79
80	TOTALS			$ 154,369	$ 16,936	$ 17,072	$ 136		$ 87,799	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)	$ 24,933,427	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 725,694	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 696,079	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,615)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,976,419	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	N/A	$	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.

Champaign County Nursing Home
Provider #: 0001636
12/1/2009 to 11/30/2010 **Schedule 13A**

XI. OWNERSHIP COSTS (continued)

D. Vehicle Depreciation (See instructions.)*

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Life in Years	Accumulated Depreciation
Resident Use	96 Ford Bus	1996	36,532			0	10	36,532
Resident Use	98 Dodge Van	1998	33,746			0	10	33,746
Resident Use	Lift for Van	2001	537			0	5	537
Resident Use	97 Ford	2002	1,358		136	136	10	1,120
Resident Use	Mini Van Paratransit w/ ramp	2009	33,104	6,621	6,621	0	5	7,173
Resident Use	09 Ford Eldorado Van	2009	51,576	10,315	10,315	0	5	11,175
			156,853	**16,936**	**17,072**	**136**		**90,283**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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			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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 47,312 Description: See PG 14A
(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			N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home
Provider #: 0001636
12/1/2009 to 11/30/2010 **Schedule 14A**

XII. RENTAL COSTS

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

16. Rental Amount for movable equipment:

Description	Amount
Trash Compactor	2,948
Cleaner	35
Wound Vac	18,617
Oxygen Cylinders	2,148
ACP	7,790
Miscellaneous	209
Mattresses	4,038
Orthomotion Tech	255
CPM	7,004
Dishwasher	4,268
	47,312

To PG14, Ln 16

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C2&3	hrs	$	7,529	$ 564,703	$ 1,374	7,529	$ 566,077	1
2	Licensed Speech and Language Development Therapist	L10A, C2&3	hrs		2,421	181,546		2,421	181,546	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2&3	hrs		6,525	489,387	726	6,525	490,113	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				257,851		257,851	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			$	16,475	$ 1,235,636	$ 259,951	16,475	$ 1,495,587	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Champaign County Nursing Home **#** 0046664 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/10 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,008,171	$ 1,008,171	1
2	Cash-Patient Deposits	6,565	6,565	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 45,984)	1,235,415	1,235,415	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	30,336	30,336	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Other Funds	1,105,721	1,105,721	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,386,208	$ 3,386,208	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		253,543	13
14	Buildings, at Historical Cost	23,191,082	23,227,194	14
15	Leasehold Improvements, at Historical Cost	465,853	296,543	15
16	Equipment, at Historical Cost	1,154,791	1,156,147	16
17	Accumulated Depreciation (book methods)	(2,900,457)	(2,976,419)	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 (specify):			22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 21,911,269	$ 21,957,008	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 25,297,477	$ 25,343,216	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,940,040	$ 1,940,040	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,565	6,565	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	690,808	690,808	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	61,912	61,912	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to General Corporate Fund	522,296	522,296	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,221,621	$ 3,221,621	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,560,000	3,560,000	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)**	$ 3,560,000	$ 3,560,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,781,621	$ 6,781,621	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,515,856	$ 18,561,595	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 25,297,477	$ 25,343,216	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 20,964,717	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(2,639,287)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,325,430	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	190,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 190,427	17
	B. Transfers (Itemize):		
18	**Rounding**	(1)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 18,515,856	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,829,974	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,829,974	3
	B. Ancillary Revenue		
4	Day Care	105,165	4
5	Other Care for Outpatients	38,984	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 144,149	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	145,827	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	35,149	13
14	Non-Patient Meals	5,565	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	58,416	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 244,957	23
	D. Non-Operating Revenue		
24	Contributions	22,418	24
25	Interest and Other Investment Income***	3,548	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,966	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	1,000,713	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,000,713	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,245,759	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,324,637	31
32	Health Care	8,004,188	32
33	General Administration	3,225,629	33
	B. Capital Expense		
34	Ownership	928,057	34
	C. Ancillary Expense		
35	Special Cost Centers	439,778	35
36	Provider Participation Fee	133,043	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,055,332	40
41	**Income before Income Taxes (line 30 minus line 40)****	190,427	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 190,427	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
Government Entity - part of county

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

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

Champaign County Nursing Home
Provider #: 0001636
12/1/2009 to 11/30/2010 **Schedule 19A**

XVII. Income Statement
Line 28 Other Income(specify):

Description	Amount
Taxes - Current Operating	963,749
Other Operating Taxes	436
Mobile Home Tax	1,074
Payment in Lieu of Taxes	895
Resident Transportation	10,013
Sale of Fixed Assets	2,032
Late charges	18,106
Misc Income	4,407
Total - Line 28	1,000,713

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,974	2,086	$ 96,797	$ 46.40	1
2	Assistant Director of Nursing	1,861	2,090	81,549	39.02	2
3	Registered Nurses	15,437	16,678	644,131	38.62	3
4	Licensed Practical Nurses	29,564	31,376	1,005,768	32.06	4
5	CNAs & Orderlies	133,279	137,627	2,440,241	17.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,600	6,167	80,541	13.06	8
9	Activity Director	2,009	2,089	94,653	45.31	9
10	Activity Assistants	1,881	2,086	53,142	25.48	10
11	Social Service Workers	6,802	7,734	136,691	17.67	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,086	135,186	64.81	13
14	Head Cook	7,435	721	44,366	61.53	14
15	Cook Helpers/Assistants	7,435	8,574	321,273	37.47	15
16	Dishwashers					16
17	Maintenance Workers	5,455	6,147	66,239	10.78	17
18	Housekeepers	28,936	31,830	388,410	12.20	18
19	Laundry	9,075	10,425	116,754	11.20	19
20	Administrator	2,080	2,080	88,150	42.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,093	17,259	260,558	15.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Adult Day Care	9,384	10,938	164,542	15.04	32
33	Other(specify) Barber & Beauty	2,619	2,941	35,805	12.17	33
34	TOTAL (lines 1 - 33)	286,883	300,934	$ 6,254,796 *	$ 20.78	34

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	413	$ 24,661	1(3)	35
36	Medical Director				36
37	Medical Records Consultant	44	3,369	10(3)	37
38	Nurse Consultant	1,742	155,734	10(3)	38
39	Pharmacist Consultant	Monthly	7,686	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	24	1,453	L11 C3	44
45	Social Service Consultant	298	32,539	L12 C3	45
46	Other(specify) Quality Assurance	Monthly	3,850	L19 C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,521	$ 229,292		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8,363	$ 409,390	10(3)	50
51	Licensed Practical Nurses	8,084	311,548	10(3)	51
52	Certified Nurse Assistants/Aides	23,239	551,439	10(3)	52
53	TOTAL (lines 50 - 52)	39,686	$ 1,272,377		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Andrew Buffenbarger	Administrator	0	$ 88,150
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,150

B. Administrative - Other

Description	Amount
Management Performance (Management Fees)	$ 346,505
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 346,505

C. Professional Services

Vendor/Payee	Type	Amount
See Sch21A	See Sch21A	$ 190,980
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 190,980

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 218,619
Unemployment Compensation Insurance	93,140
FICA Taxes	457,850
Employee Health Insurance	505,762
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	583,264
Employee Morale	6,160
Employee Labs & Physicals	22,743
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,887,538

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

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	37,385
Health Care Worker Background Check	
(Indicate # of checks performed 136)	1,360
Patient Background Checks 483	4,830
See Sch21A	25,007
Less: Public Relations Expense	(246)
Non-allowable advertising	(0)
Yellow page advertising	(15,331)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,995

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	25,905
Entertainment Expense	(1,703)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,202

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home
Provider #: 0001636
12/1/2009 to 11/30/2010 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Brought forward from page 21		190,980
Vendor	Type	Amount
Aaron S. Wolff Total	LTC Issues - Legal	490
Evans, Froehlich, Beth & Chamley	LTC Issues - Legal	2,750
Fletcher, John c.	LTC Issues - Legal	3,623
Kelley, Elvidge	LTC Issues - Legal	2,652
Management Performance Associates	LTC Issues - Legal	2,586
Meyer Capel Law Office, P.C.	LTC Issues - Legal	11,814
Polsinelli Shughart	LTC Issues - Legal	49,069
Champaign County Treasurer	Legal	-
Champaign County Treasurer	Accounting	42,231
Champaign County Treasurer	Financial Services	1,518
Govig & Associates, Inc.	S.S. Director	10,000
Thomas L. Yaeger	Arbitrator	1,736
McGladrey & Pullen , LLP	Cost Report	11,030
Herman Torosian	Grievance	2,420
Jeffrey Jacobs	Arbitration	598
Kelly Services, Inc.	Clerical Services	8,848
Kohn, Lisa Salkovitz	Hearing Cancellation	675
L-1 Identity Solutions	Fingerprint	30
Lifecycle Systems	Aviary Delivery	350
Oliver Group	Predictive Index	7,900
Activity Connection Com	Computer Services	143
Allscripts Healthcare, LLC	Computer Services	250
AT&T	Computer Services	698
C.C. Administrative Services	Computer Services	33
Comcast Cable	Computer Services	903
E-Health Data Solutions	Computer Services	4,140
Ivans, Inc.	Computer Services	671
MDI Achieve	Computer Services	22,124
AccountTemps	Employment Services	805
Marvin F. Hill Jr	Employment Services	-
Matthew W. Finkin	Employment Services	-
Deborah M. Brodsky	Employment Services	-
AFSCME Council 31	Employment Services	893
Total agreeing to Schedule V, Line 19		190,980 To PG21

SEE ACCOUNTANTS' COMPILATION REPORT

Allocated to Day Care and eliminated	(1,674)
To Disallow OOP Legal Expenses	(12,874)
Total (agree to Schedule V, line 20, column 8)	176,432

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
Illinois Health Care Association	-
Life Services Network	6,177
Yellow Page Advertising	15,331
Public Relations	245
Miscellaneous Dues	1,279
Miscellaneous Publications	1,975
TOTAL (agree to Sch. V, line 20, col. 8	25,007

To PG21

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/1/09 Ending: 11/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN-$6,177**

(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? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **96,555** 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. $ **133,043**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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-See Pg 8A** 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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,565**

(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? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **N/A**
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? **Yes**
Firm Name: **Bray, Drake, Liles & Richardson LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.