

		FOR BHF USE				

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

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.

I. IDPH License ID Number: 0034934

Facility Name: Champaign Terrace

Address: 808 North 3rd St Joseph 61873
Number City Zip Code

County: Champaign

Telephone Number: (217) 469-8006 **Fax #** (217) 398-0944

HFS ID Number: _____

Date of Initial License for Current Owners: 02/03/89

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Sherry Newton **Telephone Number:** (217) 398-0754
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 10/01/09 to 9/30/10 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) Sherry Newton
 (Title) Chief Executive Officer

Paid Preparer
 (Signed) See Attached Compilation Report (Date) _____
 (Print Name and Title) James B. Eisenmenger, MS, CPA
Member
 (Firm Name & Address) Martin, Hood, Frieze & Associates, LLC
2507 S. Neil Street, Champaign, IL 61820
 (Telephone) (217) 351-2000 **Fax #** (217) 351-7726

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 Terrace

0034934 Report Period Beginning: 10/01/09 Ending: 9/30/10

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,126			5,126	13
14	TOTALS	5,126			5,126	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.77%

D. How many bed-hold days during this year were paid by the Department? 122 (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)
None

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

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

I. On what date did you start providing long term care at this location?
Date started 02/03/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/03/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/10 Fiscal Year: 9/30/10

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

Facility Name & ID Number

Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	40,600		2,236	42,836		42,836		42,836		1
2	Food Purchase		31,395		31,395		31,395		31,395		2
3	Housekeeping	32,479	4,432		36,911		36,911	48	36,959		3
4	Laundry	16,240	1,459		17,699		17,699		17,699		4
5	Heat and Other Utilities			15,866	15,866		15,866	1,856	17,722		5
6	Maintenance			21,848	21,848		21,848	12,500	34,348		6
7	Other (specify):*										7
8	TOTAL General Services	89,319	37,286	39,950	166,555		166,555	14,404	180,959		8
	B. Health Care and Programs										
9	Medical Director		5,996	5,600	11,596		11,596		11,596		9
10	Nursing and Medical Records	164,928	49	26,067	191,044		191,044	(13,133)	177,911		10
10a	Therapy										10a
11	Activities	16,240	8,112		24,352		24,352		24,352		11
12	Social Services										12
13	CNA Training	1,334			1,334		1,334		1,334		13
14	Program Transportation			3,840	3,840		3,840	1,462	5,302		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	182,502	14,157	35,507	232,166		232,166	(11,671)	220,495		16
	C. General Administration										
17	Administrative	34,654		105,929	140,583		140,583	(67,156)	73,427		17
18	Directors Fees							415	415		18
19	Professional Services			5,811	5,811		5,811	2,181	7,992		19
20	Dues, Fees, Subscriptions & Promotions			1,902	1,902		1,902	444	2,346		20
21	Clerical & General Office Expenses	16,240	3,138	576	19,954		19,954	12,955	32,909		21
22	Employee Benefits & Payroll Taxes			95,689	95,689		95,689	14,421	110,110		22
23	Inservice Training & Education			133	133		133	85	218		23
24	Travel and Seminar							407	407		24
25	Other Admin. Staff Transportation			1,646	1,646		1,646	4,262	5,908		25
26	Insurance-Prop.Liab.Malpractice			4,937	4,937		4,937	1,907	6,844		26
27	Other (specify):*										27
28	TOTAL General Administration	50,894	3,138	216,623	270,655		270,655	(30,079)	240,576		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	322,715	54,581	292,080	669,376		669,376	(27,346)	642,030		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 Terrace

#0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			12,235	12,235		12,235	8,150	20,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,031	4,031		4,031	7,638	11,669			32
33	Real Estate Taxes			7,929	7,929		7,929	2,263	10,192			33
34	Rent-Facility & Grounds			51,600	51,600		51,600		51,600			34
35	Rent-Equipment & Vehicles							470	470			35
36	Other (specify):*											36
37	TOTAL Ownership			75,795	75,795		75,795	18,521	94,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,447	40,447		40,447		40,447			42
43	Other (specify):* IL Repl Tax			2,165	2,165		2,165	(2,165)				43
44	TOTAL Special Cost Centers			42,612	42,612		42,612	(2,165)	40,447			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	322,715	54,581	410,487	787,783		787,783	(10,990)	776,793			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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	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				9
10	Interest and Other Investment Income				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				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	(2,165)	43-3		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,165)		\$	30

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	2	
		Amount	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 Schedule VIII	(8,825)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (8,825)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (10,990)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign Terrace

ID# 0034934

Report Period Beginning: 10/01/09

Ending: 9/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			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			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	0	49

Facility Name & ID Number

Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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
See Schedule VII C		See Attached Schedule		Health Services Consul	Champaign, IL	Consulting
				Cobblestone Rehabilita	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long-Term Care
				Developmental Founda	Champaign, IL	Long-Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Schedule VIII	\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Ryle	Chairman	Administrative	0.50	All related party wages are allocations from HSC. See attached allocation spreadsheet and explanation. These individuals receive no compensation from entities other than HSC.			Administrative	\$ 1,159	17-7	1
2	Lynn Ryle	Director	Administrative	0.50				Administrative	1,159	17-7	2
3											
4	Alan Ryle	Chairman	Directors Fees	0.50				Directors Fees	207	18-7	4
5	Lynn Ryle	Director	Directors Fees	0.50				Directors Fees	208	18-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,733		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending: 9/30/10

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 NO

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

Name of Related Organization Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing	Reverse actual amounts paid and accrued to HSC for		\$	\$		(24,492)	1
2	17	Administrative	services provided in order to allocate HSC's actual expenses.					(105,929)	2
3									3
4	3	Housekeeping	Beds	370	207	1,110	16	48	4
5	5	Heat & Utilities	Beds	370	207	42,909	16	1,856	5
6	6	Maintenance	Beds	370	207	267,766	16	12,500	6
7	10	Nursing	Beds	370	207	192,582	16	11,359	7
8	14	Program Transportation	Beds	370	207	33,812	16	1,462	8
9	17	Administrative	Beds	370	207	950,956	16	38,773	9
10	18	Director Fees	Beds	370	207	9,600	16	415	10
11	19	Professional Fees	Beds	370	207	50,435	16	2,181	11
12	20	Dues & Subscriptions	Beds	370	207	10,279	16	444	12
13	21	Clerical	Beds	370	207	297,827	16	12,955	13
14	22	P/R Taxes & Benefits	Beds	370	207	523,534	16	14,421	14
15	23	Inservice	Beds	370	207	1,963	16	85	15
16	24	Travel & Seminar	Beds	370	207	9,410	16	407	16
17	25	Administrative Transportation	Beds	370	207	98,562	16	4,262	17
18	26	Insurance	Beds	370	207	44,102	16	1,907	18
19	30	Depreciation	Beds	370	207	188,461	16	8,150	19
20	32	Interest	Beds	370	207	176,631	16	7,638	20
21	33	Real Estate Tax	Beds	370	207	52,340	16	2,263	21
22	35	Equipment Lease	Beds	370	207	10,860	16	470	22
23	N/A	Salaries and Wages	Beds	370	207	959,105	16	0	23
24									24
25	TOTALS				\$ 3,922,244	\$ 2,535,094		\$ (8,825)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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										
										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					\$	\$			\$	1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Busey Bank	X	Working Capital	N/A	11/1/2008	N/A	78,429	11/30/2009	5.0000	4,031	6								
7	Schedule VIII Allocation	X								7,638	7								
8											8								
9	TOTAL Facility Related				\$	\$ 78,429				\$ 11,669	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related				\$	\$				\$	14								
15	TOTALS (line 9+line14)				\$	\$ 78,429				\$ 11,669	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2009 report.		\$	6,736		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.)		\$	7,925		2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	1,189		3																			
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	6,740		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.		\$	7,929		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	7,133	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		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
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																					
	2006	7,483	9																					
	2007	7,639	10																					
	2008	8,030	11																					
	2009	7,925	12																					
Real estate tax accrual is based on estimated 2010 tax																								

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign Terrace COUNTY Champaign
 FACILITY IDPH LICENSE NUMBER 0034934
 CONTACT PERSON REGARDING THIS REPORT Sherry Newton
 TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>28-22-11-329-002</u>	<u>Facility</u>	\$ <u>7,580.00</u>	\$ <u>7,580.00</u>
2.	<u>28-22-11-329-003</u>	<u>Facility</u>	\$ <u>345.00</u>	\$ <u>345.00</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>7,925.00</u>	\$ <u>7,925.00</u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? (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? (a) Own the Equipment (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).

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	4	
5									5	
6									6	
7									7	
8									8	
	Improvement Type**									
9	Leasehold Improvements	1994		1,380	35	39	35		558	9
10	Leasehold Improvements	1995		3,470	129	27	129		1,925	10
11	Carpet	1997		9,788	363	27	363		4,955	11
12	Alarm System Upgrade	1999		1,435	53	27	53		605	12
13	Bathroom Repairs	1999		982	36	27	36		402	13
14	Carpet	2000		5,981	222	27	222		2,107	14
15	Plumbing	2002		560	21	27	21		174	15
16	Sheeting	2004		853	31	27.5	31		207	16
17	Air Conditioner	2004		1,800	65	27.5	65		407	17
18	Tile	2005		2,351	118	5	118		2,351	18
19	Furnace/Ductwork	2005		10,814	393	27.5	393		6,187	19
20	Water Heater	2006		650	93	7	93		442	20
21	Remodel Bathroom	2006		1,978	72	27.5	72		306	21
22	Remodel Bathroom	2006		4,564	166	27.5	166		692	22
23	Remodel Bathroom	2006		4,479	163	27.5	163		666	23
24	Oak Flooring	2006		1,369	274	5	274		1,279	24
25	Birchwood Door	2006		1,115	159	7	159		623	25
26	Kitchen Remodel	2010		5,550	793	7	793		793	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)	\$	\$		\$	\$	\$	70
			59,119		3,186		3,186	24,679

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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	\$ 9,409	\$ 869	\$ 869		5/7	\$ 1,535	71
72	Current Year Purchases	861	158	158		5/7	158	72
73	Fully Depreciated Assets	6,908					6,908	73
74								74
75	TOTALS	\$ 17,178	\$ 1,027	\$ 1,027			\$ 8,601	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	Patient Transportation	Ford Van	2005	\$ 40,111	\$ 8,022	\$ 8,022		5	\$ 31,361	76
77	Patient Transportation	Wheelchair Lift/Tie Down	2005	1,416				5	1,416	77
78										78
79										79
80	TOTALS			\$ 41,527	\$ 8,022	\$ 8,022			\$ 32,777	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)	\$ 117,824	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,235	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,235	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)	\$ 66,057	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Flora Bank & Trust: Trust No. 116

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:	<u>1988</u>	<u>15</u>	<u>02/03/89</u>	\$ <u>51,600</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1991</u>	<u>1</u>					4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>51,600</u>			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: _____ *

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: \$ _____ Description: _____
(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

10. Effective dates of current rental agreement:

Beginning 02/03/04

Ending 02/03/14

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

Fiscal Year Ending Annual Rent

12. 09/30/2011 \$ 51,600

13. 09/30/2012 \$ 51,600

14. _____ \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		445		445
4	Clinical Wages (b)		890		890
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,335	\$	\$ 1,335
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,335		

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF CNAs TRAINED

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

- (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

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

	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 prescripts							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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/09

Ending: 9/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/10 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,133</u>)	222,382		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 222,532	\$	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	59,119		15
16	Equipment, at Historical Cost	58,705		16
17	Accumulated Depreciation (book methods)	(66,057)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 51,767	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 274,299	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	78,429		29
30	Accrued Salaries Payable	11,808		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,740		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 96,977	\$	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)	\$ 96,977	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 177,322	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 274,299	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 208,035	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 208,035	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(66,016)	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)	\$ (66,016)	17
	B. Transfers (Itemize):		
18	Transfers (to) from The Residential Developers. Inc.	35,303	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 35,303	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 177,322	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace# 0034934Report Period Beginning: 10/01/09Ending: 9/30/10

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 721,767	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 721,767	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 721,767	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	166,555	31
32	Health Care	232,166	32
33	General Administration	270,655	33
B. Capital Expense			
34	Ownership	75,795	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,447	36
D. Other Expenses (specify):			
37	<u>IL Repl Tax</u>	2,165	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 787,783	40
41	Income before Income Taxes (line 30 minus line 40)**	(66,016)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (66,016)	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. Tax Return is on a 12/31 fiscal year and is on the cash basis.

*** 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.

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/09

Ending:

9/30/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees	120	1,334	11.12	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	1,460	16,240	11.12	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,095	12,180	11.12	14
15	Cook Helpers/Assistants	2,555	28,420	11.12	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	2,920	32,479	11.12	18
19	Laundry	1,460	16,240	11.12	19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative	2,074	34,654	13.25	22
23	Office Manager				23
24	Clerical	1,460	16,240	11.12	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,344	19,804	12.53	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	12,173	145,124	11.12	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	26,661	322,715 *	\$ 11.40	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 2,236	1-3	35
36	Medical Director	5,600	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	19,896	10-3	38
39	Pharmacist Consultant	240	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	1,074	10-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	3,000	10-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Dentist Consultant	742	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 32,788		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/09

Ending: 9/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sarah Roper	Other Admin	0	\$ 28,053	Workers' Compensation Insurance	\$ 16,229	IDPH License Fee	\$ 1,067	
Jeremy Rieman	QMRP/Admin,	0	2,928	Unemployment Compensation Insurance	2,244	Advertising: Employee Recruitment	610	
Dulcie Vermilion	QMRP/Admin,	0	3,673	FICA Taxes	24,688	Health Care Worker Background Check		
				Employee Health Insurance	40,429	(Indicate # of checks performed <u>11</u>)	225	
				Employee Meals	5,886	Patient Background Checks	<u>3</u>	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other	6,213			
				Schedule VIII Allocation	14,421	Schedule VIII Allocation	444	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 34,654	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,346		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management & Support Staff Fee			\$ 105,929				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 105,929	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
Martin, Hood, Friese & Associates, I	Accounting		\$ 2,354	None		\$	Out-of-State Travel \$	
Thomas, Mamer & Haughey	Legal		255					
Various	Other Prof. Services		3,202				In-State Travel	
							Schedule VIII Allocation 407	
							Seminar Expense	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,811	TOTAL			\$ 407	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace# 0034934Report Period Beginning: 10/01/09Ending: 9/30/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF-\$992
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5/7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,447
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? Yes 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? None
- (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? No 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. \$ 5,886 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? Attached
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? None
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? None
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT