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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nursing Home

Address: 500 South Art Bartell Rd. (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:

#REF!

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2010 to 11/30/2011 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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	26,631	9,773	7,395	43,799	8
9	SNF/PED					9
10	ICF	13,401	13,013	431	26,845	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,032	22,786	7,826	70,644	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.65%

#REF!

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

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 2,984

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: 11/30/2011 Fiscal Year: 11/30/2011

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	504,751	80,675	60,429	645,855		645,855	(4,252)	641,603			1
2	Food Purchase		439,026		439,026		439,026	(18,126)	420,900			2
3	Housekeeping	362,667	67,671		430,338		430,338	(2,337)	428,001			3
4	Laundry	111,200	33,831		145,031		145,031		145,031			4
5	Heat and Other Utilities			486,125	486,125		486,125	(16,790)	469,335			5
6	Maintenance	57,969	53,756	165,260	276,985		276,985	(7,565)	269,420			6
7	Other (specify):*											7
8	TOTAL General Services	1,036,587	674,959	711,814	2,423,360		2,423,360	(49,070)	2,374,290			8
	B. Health Care and Programs											
9	Medical Director			40,000	40,000		40,000		40,000			9
10	Nursing and Medical Records	4,302,477	391,246	1,208,973	5,902,696		5,902,696		5,902,696			10
10a	Therapy	80,161		1,072,823	1,152,984		1,152,984		1,152,984			10a
11	Activities	141,914	2,953	1,488	146,355		146,355		146,355			11
12	Social Services	160,168		1,488	161,656		161,656		161,656			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Adult Day Care	150,115	13,245	66,662	230,022		230,022	(230,022)				15
16	TOTAL Health Care and Programs	4,834,835	407,444	2,391,434	7,633,713		7,633,713	(230,022)	7,403,691			16
	C. General Administration											
17	Administrative	96,761		371,537	468,298		468,298		468,298			17
18	Directors Fees											18
19	Professional Services			242,282	242,282		242,282	(6,454)	235,828			19
20	Dues, Fees, Subscriptions & Promotions			98,454	98,454		98,454	(15,728)	82,726			20
21	Clerical & General Office Expenses	248,270	38,794	98,116	385,180		385,180	(212)	384,968			21
22	Employee Benefits & Payroll Taxes			2,057,461	2,057,461		2,057,461		2,057,461			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,337	18,337		18,337	(389)	17,948			24
25	Other Admin. Staff Transportation			4,540	4,540		4,540	(25)	4,515			25
26	Insurance-Prop.Liab.Malpractice			385,853	385,853		385,853	(9,497)	376,356			26
27	Other (specify):*											27
28	TOTAL General Administration	345,031	38,794	3,276,580	3,660,405		3,660,405	(32,305)	3,628,100			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,216,453	1,121,197	6,379,828	13,717,478		13,717,478	(311,397)	13,406,081			29

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

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: 12/01/2010 Ending: 11/30/2011

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			724,873	724,873		724,873	(17,583)	707,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,323	150,323		150,323	(533)	149,790			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68,281	68,281		68,281		68,281			35
36	Other (specify):*											36
37	TOTAL Ownership			943,477	943,477		943,477	(18,116)	925,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,492		188,492		188,492		188,492			39
40	Barber and Beauty Shops	52,301	938		53,239		53,239		53,239			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,043	133,043		133,043		133,043			42
43	Other (specify):* Non-Allow Costs			196,973	196,973		196,973	(196,973)				43
44	TOTAL Special Cost Centers	52,301	189,430	330,016	571,747		571,747	(196,973)	374,774			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,268,754	1,310,627	7,653,321	15,232,702		15,232,702	(526,486)	14,706,216			45

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

#REF!

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	$ (230,022)	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	(28,312)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,453	30		9
10	Interest and Other Investment Income	(533)	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	(71,148)	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	(1,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(15,478)	20		28
29	Other-Attach Schedule See Pg 5A	(187,084)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (526,486)		$	30

BHF USE ONLY									
48		49		50		51		52	

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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))**	$ (526,486)		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

Champaign County Nursing Home

ID# 0046664

Report Period Beginning: 12/01/2010

Ending: 11/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Offset meal revenue against food cost	(4,896)	2	2
3	Non-Allowable Travel & Seminar	(389)	24	3
4	Non-allowable dues	(250)	20	4
5	Laboratory fees	(20,502)	43	5
6	Medicare ancillary expense	(67,336)	43	6
7	Disallow Out-Of-Period Legal Expenses	(1,194)	19	7
8	Non-allowable Transfers to General Corporate F	(8,313)	43	8
9	Public relations expense	(3,333)	19	9
10	Disallow Indirect Adult Day Care Costs:			10
11	Dietary	(4,252)	1	11
12	Food	(13,230)	2	12
13	Housekeeping	(2,337)	3	13
14	Utilities	(16,790)	5	14
15	Maintenance	(7,565)	6	15
16	Professional Fees	(1,327)	19	16
17	Office	(212)	21	17
18	Staff Transportation	(25)	25	18
19	Insurance - Auto	(7,384)	26	19
20	Insurance - Other	(2,113)	26	20
21	Depreciation - Other	(25,036)	30	21
22	Non-Allowable Photography	(600)	19	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**	(187,084)		49

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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 ☐ 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			$			$	$ * 0	14

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

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Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										8
9	transactions with the nursing home during the reporting period.										9
10											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

#REF!

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 1/30/2011

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: 5600 South Are Bartell Rd.
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	219,174		$ 141,104	$	6,605	$ 4,252	1
2	2	Food	Meals	219,174		439,026		6,605	13,230	2
3	3	Housekeeping	Square Feet	135,500		67,671		4,680	2,337	3
4	5	Utilities	Square Feet	135,500		486,125		4,680	16,790	4
5	6	Maintenance	Square Feet	135,500		219,016		4,680	7,565	5
6	19	Professional Fees	Revenue	16,280,116		242,282		89,162	1,327	6
7	21	Office Expense	Revenue	16,280,116		38,794		89,162	212	7
8	25	Staff Transportation	Revenue	16,280,116		4,540		89,162	25	8
9	26	Insurance - Auto	Direct	1		7,384		1	7,384	9
10	26	Insurance - Other	Revenue	16,280,116		385,853		89,162	2,113	10
11	30	Depreciation - Other	Square Feet	135,500		724,873		4,680	25,036	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					$ 2,756,668	$		$ 80,271	25

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Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	$ 3,400,000	6/30/2026	Varies	$ 143,909	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interfund Loan		X	Champaign County							6,414	6
7												7
8												8
9	TOTAL Facility Related						$ 4,000,000	$ 3,400,000			$ 150,323	9
	B. Non-Facility Related*											
10												10
11									Offset interest income		(533)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (533)	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 3,400,000			$ 149,790	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.) #REF!

** 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:** 12/01/2010 **Ending:** 11/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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.)	**2010**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 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:			
	2006	N/A	**8**
	2007		**9**
	2008		**10**
	2009		**11**
	2010		**12**

County nursing home. Exempt from real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	**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.

#REF!

2010 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 Charles S.Schuette, 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 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 12/01/2010 Ending: 11/30/2011

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

#REF!

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	243		2007	2007	$ 23,227,193	$ 577,728	40	$ 580,680	$ 2,952	$ 2,806,713	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)	119,088	9
10	Masonry sign			2008	16,741	670	25	670		2,345	10
11	Smoke Barriers			2010	89,879	2,429	37	2,429		3,644	11
12	Smoke Barriers			2011	3,900	37	36	54	17	54	12
13	Boiler Repair			2011	4,990	1,871	2	1,248	(623)	1,248	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

#REF!

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		$ 23,532,627	$ 618,890		$ 607,254	$ (11,636)	$ 2,933,092	70

#REF!

**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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,001,778	$ 81,568	$ 99,334	$ 17,766	5-10	$ 662,116	71
72	Current Year Purchases	60,581	7,044	6,058	(986)	3-10	6,058	72
73	Fully Depreciated Assets							73
74	Disallowed Day Care Depreciation			(25,036)	(25,036)			74
75	TOTALS	$ 1,062,359	$ 88,612	$ 80,356	$ (8,256)		$ 668,174	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	See Sch 13A	See Sch 13A	See Sch 13A	209,013	17,371	19,680	2,309	5-10	109,963	77
78										78
79										79
80	TOTALS			$ 209,013	$ 17,371	$ 19,680	$ 2,309		$ 109,963	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)	$ 25,057,542	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 724,873	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 707,290	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,583)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,711,229	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	N/A				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.

#REF!

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

Champaign County Nursing Home
Provider #: 0001636
12/1/2010 to 11/30/2011 **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	1,256
Resident Use	Mini Van Paratransit w/ ramp	2009	33,104	6,621	6,621	0	5	13,794
Resident Use	09 Ford Eldorado Van	2009	51,576	10,315	10,315	0	5	21,490
Resident Use	2011 Ford Van	2011	52,160	435	2,608	2,173	10	2,608
			209,013	**17,371**	**19,680**	**2,309**		**109,963**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 68,281 Description: See Schedule 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			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

###

Champaign County Nursing Home **Schedule 14A**
Provider #: 0001636
12/1/2010 to 11/30/2011

XII. RENTAL COSTS

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

16. Rental Amount for movable equipment:

Description	Amount
Trash Compactor	3,374
Wound Vac	15,919
Oxygen Cylinders	213
ACP	11,400
Mattresses	11,110
Orthomotion Tech	11,898
Oxygen Concentrators	2,526
Dishwasher	4,559
Medical Equipments	7,115
Construction vehicles	167
	68,281

To PG14, Ln 16

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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.

###

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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, C3	hrs	$	6,123	$	459,201	$	6,123	$ 459,201	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,507		188,016		2,507	188,016	2
3	Licensed Recreational Therapist		hrs		5,675		425,606		5,675	425,606	3
4	Licensed Physical Therapist	L10A, C3	hrs								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					188,492		188,492	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			$	14,305	$	1,072,823	$ 188,492	14,305	$ 1,261,315	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.

#REF!

STATE OF ILLINOIS

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2011 (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	$ 451,613	$ 451,613	1
2	Cash-Patient Deposits	8,880	8,880	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,450)	1,156,893	1,156,893	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	32,482	32,482	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Other Funds	4,790,600	4,790,600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,440,468	$ 6,440,468	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	23,194,982	23,227,194	14
15	Leasehold Improvements, at Historical Cost	463,526	305,433	15
16	Equipment, at Historical Cost	1,287,189	1,271,372	16
17	Accumulated Depreciation (book methods)	(3,626,652)	(3,711,229)	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)**	$ 21,319,045	$ 21,346,313	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 27,759,513	$ 27,786,781	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,686,592	$ 3,686,592	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,880	8,880	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	700,336	700,336	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	58,612	58,612	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to General Corporate Fund	333,142	333,142	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,787,562	$ 4,787,562	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,400,000	3,400,000	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)**	$ 3,400,000	$ 3,400,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,187,562	$ 8,187,562	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 19,571,951	$ 19,599,219	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 27,759,513	$ 27,786,781	48

#REF!

*(See instructions.)

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,515,856	1
2	Restatements (describe):		2
3	**Prior period adjustment**	8,681	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,524,537	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,047,414	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)**	$ 1,047,414	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 19,571,951	24 *

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

#REF!

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	$ 14,748,162	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,748,162	3
	B. Ancillary Revenue		
4	Day Care	89,162	4
5	Other Care for Outpatients	34,798	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 123,960	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	169,398	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	46,584	13
14	Non-Patient Meals	4,896	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	76,289	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 297,167	23
	D. Non-Operating Revenue		
24	Contributions	13,473	24
25	Interest and Other Investment Income***	533	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,006	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	1,096,821	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,096,821	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,280,116	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,423,360	31
32	Health Care	7,633,713	32
33	General Administration	3,660,405	33
	B. Capital Expense		
34	Ownership	943,477	34
	C. Ancillary Expense		
35	Special Cost Centers	438,704	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)***	$ 15,232,702	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,047,414	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,047,414	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. #REF!**

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

Champaign County Nursing Home **Schedule 19A**
Provider #: 0001636
12/1/2010 to 11/30/2011

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

Description	Amount
Taxes - Current Operating	1,003,519
Other Operating Taxes	373
Mobile Home Tax	1,092
Payment in Lieu of Taxes	612
Resident Transportation	16,310
Late charges	16,084
Misc Income	58,831
Total - Line 28	1,096,821

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	2,416	2,640	$ 94,926	$ 35.96	1
2	Assistant Director of Nursing	2,316	2,640	79,875	30.26	2
3	Registered Nurses	20,797	22,102	664,914	30.08	3
4	Licensed Practical Nurses	58,632	60,468	1,237,378	20.46	4
5	CNAs & Orderlies	200,789	204,166	2,225,384	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,697	6,625	80,161	12.10	8
9	Activity Director					9
10	Activity Assistants	10,904	11,944	141,914	11.88	10
11	Social Service Workers	7,909	9,660	160,168	16.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,233	42,542	504,751	11.86	15
16	Dishwashers					16
17	Maintenance Workers	4,894	5,373	57,969	10.79	17
18	Housekeepers	26,070	30,644	362,667	11.83	18
19	Laundry	8,728	9,977	111,200	11.15	19
20	Administrator	2,005	2,253	96,761	42.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,075	17,021	248,270	14.59	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	8,612	10,178	150,115	14.75	32
33	Other(specify) Barber & Beauty	3,733	4,323	52,301	12.10	33
34	TOTAL (lines 1 - 33)	415,810	442,556	$ 6,268,754 *	$ 14.16	34 ###

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	413	$ 60,429	1(3)	35
36	Medical Director	200	40,000	9(3)	36
37	Medical Records Consultant	44	9,319	10(3)	37
38	Nurse Consultant	1,742	170,334	10(3)	38
39	Pharmacist Consultant	Monthly	6,378	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	1,488	11(3)	44
45	Social Service Consultant	298	1,488	12(3)	45
46	Other(specify) Resident Transport	Monthly	14,451	10(3)	46
47	MDS Consultant	Monthly	9,776	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	2,721	$ 313,663		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,586	$ 159,820	10(3)	50
51	Licensed Practical Nurses	5,665	200,385	10(3)	51
52	Certified Nurse Assistants/Aides	27,140	638,510	10(3)	52
53	TOTAL (lines 50 - 52)	36,391	$ 998,715		53

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Andrew Buffenbarger	Administrator	0	$ 88,150
Charles S.Schuette	Administrator	0	8,611
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,761

B. Administrative - Other

Description	Amount
Management Performance (Management Fees)	$ 371,537
TOTAL (agree to Schedule V, line 17, col. 3)	$ 371,537
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch21A	See Sch21A	$ 242,282
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 242,282

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 277,414
Unemployment Compensation Insurance	134,167
FICA Taxes	459,093
Employee Health Insurance	540,736
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	614,509
Employee Morale	1,532
Employee Labs & Physicals	30,010
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,057,461

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	57,382
Health Care Worker Background Check	
(Indicate # of checks performed 211)	2,998
Patient Background Checks 409	4,094
Life Services Network	13,982
Yellow Page Advertising	15,478
Miscellaneous Dues	1,104
Miscellaneous Publications	1,176
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(15,478)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,726

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,337
Seminar Expense	
Entertainment Expense	(389)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,948

* Attach copy of IMRF notifications

** See instructions.

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Champaign County Nursing Home
Provider #: 0001636
12/1/2010 to 11/30/2011 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor	Type	Amount
Evans, Froehlich, Beth & Chamley	LTC Issues - Legal	2,750
Kelley, Elvidge	LTC Issues - Legal	(152)
Meyer Capel Law Office, P.C.	LTC Issues - Legal	39,587
Polsinelli Shughart	LTC Issues - Legal	13,861
Champaign County Treasurer	Legal	638
Champaign County Treasurer	Accounting	42,510
Champaign County Treasurer	Computer Services	830
McGladrey & Pullen , LLP	Cost Report	19,825
Herman Torosian	Grievance	940
Lifecycle Systems	Aviary Delivery	530
Activity Connection Com	Computer Services	143
Allscripts Healthcare, LLC	Computer Services	3,000
AT&T	Computer Services	813
Comcast Cable	Computer Services	802
E-Health Data Solutions	Computer Services	4,140
Ivans, Inc.	Computer Services	1,348
MDI Achieve	Computer Services	21,068
AFSCME Council 31	Employment Services	25
Area Wide Reporting & Video Conf.	Court Reporting / Deposition	400
Accountemps	Accounting Services	6,025
Discovery Health Record Solution	Electronic Medical Records	150
Federal Mediation & Conciliation	Arbitration / Mediation	25
Healthport	Health Audit Technology	3,221
Pinnacle Consulting	IT Consulting	4,200
Sarah Bush, Lincoln Health Center	Medical Services	246
Stephen Hayford	Photography - Disallow	600
Stricklin & Associates	Public Relations - Disallow	3,333
The Oliver Group	Predictive Index	7,900
University of Illinois	Medical Services	839
Bierig, Steven M.	Arbitration	711
Cipolla, Thomas A.	Arbitration	450
Dichter, Fredric R.	Arbitration	936
Heyl, Royster, Voelker & Allen	Legal	55,890
Hill, Marvin F. Jr.	Arbitration	750
Malin, Martin H.	Arbitration	1,456
Mcallister, Robert W.	Legal	600
Torricelli & Limentato, P.C.	Legal	1,322
Isaksen, Glerum, Wachter, LLC	Architect Fees	570
	Total agreeing to Schedule V, Line 19, Col 3	242,282 To PG21
	Allocated to Day Care and eliminated	(1,327)
	To Disallow OOP Legal Expenses	(1,194)
	To Disallow Photography and PR	(3,933)
	Total (agree to Schedule V, line 20, column 8)	235,828

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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		$		$	$	$	$	$	$	$	$	$

#REF!

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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-$ 13982**

(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. $ **95,471** 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.

#REF!

(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. $ **4,896**

(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.