		FOR BHF USE					

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

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: 0050062

Facility Name: Champaign Regional Rehab Center

Address: 302 Burwash Avenue (Number) Savoy (City) 61874 (Zip Code)

County: Champaign

Telephone Number: (217)402-9700 **Fax #** (727)723-3076

HFS ID Number:

Date of Initial License for Current Owners: 11/4/2009

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Melissa Miller **Telephone Number:** (727)724-2403
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 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) (Date) (Print Name and Title) (Firm Name & Address) (Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	213	Skilled (SNF)	213	77,745	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	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	33,194	18,404	14,604	66,202	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,194	18,404	14,604	66,202	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.15%

D. How many bed-hold days during this year were paid by the Department?
454 (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)
0

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 [ ]

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

I. On what date did you start providing long term care at this location?
Date started 11/04/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/04/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 213 and days of care provided 9,461

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	6,272	75,909	1,065,926	1,148,107		1,148,107		1,148,107			1
2	Food Purchase		(1,795)		(1,795)		(1,795)		(1,795)			2
3	Housekeeping		46,998	281,290	328,288		328,288		328,288			3
4	Laundry		12,075	189,777	201,852		201,852		201,852			4
5	Heat and Other Utilities			276,888	276,888		276,888		276,888			5
6	Maintenance	85,221	1,546	166,060	252,827		252,827		252,827			6
7	Other (specify):*											7
8	TOTAL General Services	91,493	134,733	1,979,941	2,206,167		2,206,167		2,206,167			8
	B. Health Care and Programs											
9	Medical Director			36,200	36,200		36,200		36,200			9
10	Nursing and Medical Records	4,872,319	524,198	76,123	5,472,640		5,472,640		5,472,640			10
10a	Therapy		3,152	1,272,249	1,275,401		1,275,401		1,275,401			10a
11	Activities	176,652	2,983	17,846	197,481		197,481		197,481			11
12	Social Services	116,652		5,486	122,138		122,138		122,138			12
13	CNA Training											13
14	Program Transportation	36,865	421	9,451	46,737		46,737		46,737			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,202,488	530,754	1,417,355	7,150,597		7,150,597		7,150,597			16
	C. General Administration											
17	Administrative	147,348		700,229	847,577		847,577	(700,229)	147,348			17
18	Directors Fees											18
19	Professional Services			65,268	65,268		65,268	(11,187)	54,081			19
20	Dues, Fees, Subscriptions & Promotions			37,075	37,075		37,075		37,075			20
21	Clerical & General Office Expenses	238,492	55,994	39,290	333,776		333,776	(5,713)	328,063			21
22	Employee Benefits & Payroll Taxes			881,373	881,373		881,373		881,373			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,667	7,667		7,667		7,667			24
25	Other Admin. Staff Transportation			7,376	7,376		7,376		7,376			25
26	Insurance-Prop.Liab.Malpractice			219,866	219,866		219,866		219,866			26
27	Other (specify):* Home Office A&G							502,653	502,653			27
28	TOTAL General Administration	385,840	55,994	1,958,144	2,399,978		2,399,978	(214,476)	2,185,502			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,679,821	721,481	5,355,440	11,756,742		11,756,742	(214,476)	11,542,266			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Champaign Regional Rehab Center #0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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			24,903	24,903		24,903	128	25,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			163,718	163,718		163,718	(6,062)	157,656			32
33	Real Estate Taxes			73,274	73,274		73,274		73,274			33
34	Rent-Facility & Grounds			858,341	858,341		858,341	(20,400)	837,941			34
35	Rent-Equipment & Vehicles			88,803	88,803		88,803		88,803			35
36	Other (specify):* Home Office Cap							15,362	15,362			36
37	TOTAL Ownership			1,209,039	1,209,039		1,209,039	(10,972)	1,198,067			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		518,359	29,702	548,061		548,061		548,061			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,299	116,299		116,299		116,299			42
43	Other (specify):* Nonallowable Exp			437,512	437,512		437,512	(437,512)				43
44	TOTAL Special Cost Centers		518,359	583,513	1,101,872		1,101,872	(437,512)	664,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,679,821	1,239,840	7,147,992	14,067,653		14,067,653	(662,960)	13,404,693			45

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

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 Refer-ence	3 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	128	30		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	(4,003)	43		19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(228,000)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pg 5A	(248,771)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (480,746)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(260,249)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (260,249)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (740,995)		37

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

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

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

Champaign Regional Rehab Center

ID# 0050062

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable Marketing Expenses	$ (72,999)	43	1
2	Lab Fees - Part A	(67,531)	43	2
3	X-Rays - Part A	(44,682)	43	3
4	Collection/Late Fees	(16,577)	43	4
5	State Income Taxes	(3,620)	43	5
6	Offset Vending Machine Revenue	(5,713)	21	6
7	Offset Interest Income	(6,062)	32	7
8	Non-Care Related Rent Expense	(20,400)	34	8
9	Non-Allowable Consultant	(577)	19	9
10	Non-Allowable Legal Fees	(10,610)	19	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**	(248,771)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(700,229)	0	0	0	0	0	0	0	0	0	(700,229)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,187)	0	0	0	0	0	0	0	0	0	0	(11,187)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(5,713)	0	0	0	0	0	0	0	0	0	0	(5,713)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	502,653	0	0	0	0	0	0	0	0	0	502,653	27
28	**TOTAL General Administration**	(16,900)	(197,576)	0	0	0	0	0	0	0	0	0	(214,476)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,900)	(197,576)	0	0	0	0	0	0	0	0	0	(214,476)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	128	0	0	0	0	0	0	0	0	0	0	128	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,062)	0	0	0	0	0	0	0	0	0	0	(6,062)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(20,400)	0	0	0	0	0	0	0	0	0	0	(20,400)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	15,362	0	0	0	0	0	0	0	0	0	15,362	36
37	**TOTAL Ownership**	(26,334)	15,362	0	0	0	0	0	0	0	0	0	(10,972)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(437,512)	0	0	0	0	0	0	0	0	0	0	(437,512)	43
44	**TOTAL Special Cost Centers**	(437,512)	0	0	0	0	0	0	0	0	0	0	(437,512)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(480,746)	(182,214)	0	0	0	0	0	0	0	0	0	(662,960)	45

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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
Ben Atkins	33.33	N/A		Traditions Sr Mgmt	Clearwater, FL	Mgmt Company
Morrison Family LTD Partnership, LLP	20					
Careen, LLC	13.33					
Adam Garff	33.33					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 700,229	Traditions Management		$	$ (700,229)	1
2	V	27	Home Office A&G		Traditions Management		502,653	502,653	2
3	V	36	Home Office Capital		Traditions Management		15,362	15,362	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			$ 700,229			$ 518,015	$ * (182,214)	14

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

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	No compensation paid to owners								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											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**

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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: Traditions Management
Street Address: 24641 US Hwy 19 N
City / State / Zip Code: Clearwater/FL/33763
Phone Number: (727)724-2403
Fax Number: (727)723-3076

	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	27	Home Office A&G	Census Days		21	$	$	66,202	$ 426,780	1
2	36	Home Office Capital	Census Days		21			66,202	13,200	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	TOTALS					$	$		$ 439,980	25

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank and Trust		X	Van	$911.84	4/22/10	$ 38,000	$ 23,398	4/22/14	7.0000	$ 1,867	1
2												2
3												3
4												4
5												5
	Working Capital											
6	See Sch 9A						2,317,990	2,123,689			161,851	6
7												7
8												8
9	TOTAL Facility Related				$911.84		$ 2,355,990	$ 2,147,087			$ 163,718	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,355,990	$ 2,147,087			$ 163,718	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.)**

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

Champaign Regional Rehab Center
FYE 12/31/11
Schedule 9A

	Name of Lender Working Capital	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
1	TM - Fifth Third bank		X	LOC	Interest Only	11/1/2009	150,000	150,000	LOC	5.700	5,466	
2	Mrs. Christiansen	X		LOC	Interest Only	11/2/2009	1,219,403	1,032,113	LOC	9.000	112,367	
3	Owner	X		Working Capital	Interest Only	7/1/2011	648,587	641,576	6/30/2012	10.000	31,268	
4	Ben Atkins	X		LOC	Interest Only	7/5/2011	300,000	300,000	LOC	9.000	12,750	
9	TOTAL Facility Related						2,317,990	2,123,689			161,851	

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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.)		$ 74,357	2
3. Under or (over) accrual (line 2 minus line 1).		$ 74,357	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 74,357	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign Regional Rehab Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0050062

CONTACT PERSON REGARDING THIS REPORT Melissa Miller

TELEPHONE (727)724-2403 FAX #: (727)723-3076

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.	03-20-25-300-004	302 Burwash Ave	$ 74,357.00	$ 74,357.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,357.00	$ 74,357.00

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 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 Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,118 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Second Floor Utility Room Repair			2010	3,845		15	128	128	256	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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)		$ 3,845	$		$ 128	$ 128	$ 256	70

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

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 26,533	$ 6,602	$ 6,602	$	3-5	$ 8,049	71
72	Current Year Purchases	62,262	8,831	8,831		3-5	8,831	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 88,795	$ 15,433	$ 15,433	$		$ 16,880	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	Resident Care	Champion Bus 2010	2010	$ 47,350	$ 9,470	$ 9,470	$	5	$ 15,783	76
77										77
78										78
79										79
80	TOTALS			$ 47,350	$ 9,470	$ 9,470	$		$ 15,783	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)	$ 139,990	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,903	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,031	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 128	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 32,919	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.

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Savoy HCP

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. [X] 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:	1975	231	11/4/09	$ 837,941			3
4	Additions							4
5								5
6								6
7	TOTAL		231		$ 837,941 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 88,771 Description: See Sch 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					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.

Schedule 14A

#16	**Description**	**Amount**
	Maintenance Equipment (Acct 410765)	66,949
	Dish Machine (Acct 440960)	3,653
	Copier Lease (Acct 560906)	16,434
	Shredder (Acct 560960)	1,735
	Total Rental Exp	88,771

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

   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 Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,752	$ 486,165	$	6,752	$ 486,165	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,147	226,612		3,147	226,612	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)(3)	hrs		7,770	559,443	3,152	7,770	562,595	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				518,359		518,359	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			$	17,670	$ 1,272,220	$ 521,511	17,670	$ 1,793,731	14

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

STATE OF ILLINOIS

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 406,002	$ 406,002	1
2	Cash-Patient Deposits	16,371	16,371	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 223,303)	2,480,648	2,480,648	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,084	45,084	6
7	Other Prepaid Expenses	45,038	45,038	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17	868,524	868,524	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,861,667	$ 3,861,667	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		3,845	15
16	Equipment, at Historical Cost	136,146	136,146	16
17	Accumulated Depreciation (book methods)	(32,664)	(32,792)	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)**	$ 103,482	$ 107,199	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,965,149	$ 3,968,866	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,066,629	$ 3,066,629	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,371	16,371	28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	166,561	166,561	30
31	Accrued Taxes Payable (excluding real estate taxes)	63,655	63,655	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,337	15,337	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17	16,280	16,280	36
37	See Sch 17	1,973,688	1,973,688	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,468,522	$ 5,468,522	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	23,398	23,398	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)**	$ 23,398	$ 23,398	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,491,920	$ 5,491,920	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (374,028)	$ (370,281)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,117,892	$ 5,121,639	48

*(See instructions.)

Champaign Regional Rehab Center
FYE 12/31/11
Schedule 17A

Ln 9		Operating	After Consolidation
1	Deposits on Utilities	6,458	6,458
2	Cash - Replacement Reserve	171,140	171,140
3	Cash - Insurance Escrow	465,160	465,160
4	Cash - AR Escrow	225,000	225,000
5	Due from Wytheville	766	766
	Total	868,524	868,524

Ln 36			
1	Medicare Remittance Adjustment	358	358
2	Employee Deductions - 401K	2,362	2,362
3	Accrued Accounting/Audit Fees	13,560	13,560
	Total	16,280	16,280

Ln 37			
1	Due to Christiansen	1,032,113	1,032,113
2	Due to Trad Mgmt of USA	941,575	641,575
	Total	1,973,688	1,673,688

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(57,010)	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	(317,018)	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)**	$ (374,028)	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)**	$ (374,028)	24 *

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

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 12,811,045	1
2	Discounts and Allowances for all Levels	(4,808,479)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,002,566	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,068,664	6
7	Oxygen	3,141	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,071,805	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	1,200	13
14	Non-Patient Meals	3,379	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	411,315	16
17	Sale of Drugs	1,466,817	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	200,938	19
20	Radiology and X-Ray		20
21	Other Medical Services	755,870	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,839,519	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,062	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,062	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19	90,691	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 90,691	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,010,643	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,206,167	31
32	Health Care	7,150,597	32
33	General Administration	2,399,978	33
	B. Capital Expense		
34	Ownership	1,209,039	34
	C. Ancillary Expense		
35	Special Cost Centers	985,573	35
36	Provider Participation Fee	116,299	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,067,653	40
41	**Income before Income Taxes (line 30 minus line 40)****	(57,010)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (57,010)	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.**

****LLC Members are cash basis tax payers.**

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

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

Champaign Regional Rehab Center
FYE 12/31/11
Schedule 19A

Line 28

1 Transportation - PVT	28,665
2 Transportation - MRA	6,655
3 Transportation - MCD	13,785
4 Transportation - INS	8
5 Vending Machine Revenue	5,713
6 Miscellaneous Operating Income - Adm	35,865
	90,691

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	1,978	2,118	$ 79,950	$ 37.75	1
2	Assistant Director of Nursing	10,105	10,781	355,415	32.97	2
3	Registered Nurses	28,164	28,701	860,035	29.97	3
4	Licensed Practical Nurses	42,492	43,593	1,007,872	23.12	4
5	CNAs & Orderlies	162,405	164,798	2,254,442	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,893	4,131	88,332	21.38	9
10	Activity Assistants	7,768	8,193	88,320	10.78	10
11	Social Service Workers	5,467	5,843	116,652	19.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants			6,272		15
16	Dishwashers					16
17	Maintenance Workers	5,201	5,474	85,221	15.57	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,112	2,248	147,348	65.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,139	11,859	238,492	20.11	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	2,832	3,016	48,888	16.21	31
32	Other Health Ca See Sch 20	11,567	12,639	265,717	21.02	32
33	Other(specify) Transportation	3,044	3,233	36,865	11.40	33
34	TOTAL (lines 1 - 33)	298,167	306,627	$ 5,679,821 *	$ 18.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,065,511	1(3)	35
36	Medical Director	Monthly	36,200	9(3)	36
37	Medical Records Consultant	Monthly	3,238	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,397	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	Monthly	4,610	11(3)	44
45	Social Service Consultant	Monthly	5,486	12(3)	45
46	Other(specify)				46
47	Managed Care Consultant	5 visits	942	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 1,130,384		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	632	$ 15,529	10(3)	50
51	Licensed Practical Nurses	1,028	35,297	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,660	$ 50,826		53

Champaign Regional Rehab Center
FYE 12/31/11
Schedule 20A

		Hours Worked	Hours Paid	Salaries
1	MDS Coordinator	6,213	6,781	$166,641
2	Ward Clerk	5,354	5,858	$99,076
		11,567	12,639	$265,717

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Twardowski	Administrator	0	$ 57,349
Lorraine Bellinger	Administrator	0	60,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 117,349

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in Col. 7"	$ 700,229
TOTAL (agree to Schedule V, line 17, col. 3)	$ 700,229
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21A		$ 65,268
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 65,268

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 179,245
Unemployment Compensation Insurance	
FICA Taxes	529,921
Employee Health Insurance	132,276
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits/Expenses	33,304
Employee Life Insurance	5,572
Employee Dental Insurance	282
Employee Vision Insurance	773
TOTAL (agree to Schedule V, line 22, col.8)	$ 881,373

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,254
Health Care Worker Background Check	
(Indicate # of checks performed 406)	6,507
Patient Background Checks	
Miscellaneous License & Fees	10,812
Miscellaneous Dues & Subscriptions	4,858
Pre-Employment Physicals	7,139
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,570

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,667
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,667

**See instructions.

C.

Vendor/Payee	Type	Amount
CT Corporation	Legal	208
McCumber, Daniels Buntz	Legal	320
Helperbroom	Legal	6,535
Wilkinson & Sadorf	Legal	2,735
Livingston, Barger, Brandt	Legal	633
Champaign County Clerk	Legal	40
Broad and Cassel	Legal	812
Spherion	HR Temp	13,781
Barbara Clark & Company	401K & Financial Audit	11,500
Chris Pape CPA	Taxes	2,250
My Innerview	Patient Surveys	3,262
Paychex	Payroll Processing Fees	18,110
RSM McGladrey	Consulting/Cost Rep Prep	4,375
Mystery Shoppers, Inc	Marketing Consultant	577
Paychex	Cobra Mgmt Fee	130
Total (agrees to Sch V, line 19, column 3)		65,268
	Non-Allowable Legal Fees	(10,610)
	Non-Allowable Consultant	(577)
Total (agrees to Sch V, line 19, column 8)		54,081

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Champaign Regional Rehab Center # 0050062 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **95,629** 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 fo
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 Departmen
during this cost report period. $ **116,299**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **0** 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 fo
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? **100**
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 othe
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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