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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nursing Home

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

County: Champaign

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2011 to 11/30/2012 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) McGladrey 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: 12/01/2011 Ending: 11/30/2012

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 02/23/2013

	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)	204	73,763	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	39	15,175	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,938	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	4,124	3,629	5,606	13,359	8
9	SNF/PED					9
10	ICF	39,666	19,666	857	60,189	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,790	23,295	6,463	73,548	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.70%

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 204 and days of care provided 4,683

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: 11/30/2012 Fiscal Year: 11/30/2012

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

Champaign County Nursing Home **Schedule 2A**
Provider #: 0001636
FYE: November 30, 2012

Census Calculation

Dates	Days
1/1-2/22	53
2/23-12/31	313
	366

	Beds From 1/1-2/22	Bed Days Avail 1/1-2/22	Beds From 2/23-12/31	Bed Days Avail 2/23-12/31	Total Beds Available
Skilled	187	9,911	204	63,852	73,763
Intermediate	56	2,968	39	12,207	15,175
					88,938

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	512,181	87,941	46,747	646,869		646,869	(3,799)	643,070			1
2	Food Purchase		456,748		456,748		456,748	(19,520)	437,228			2
3	Housekeeping	385,170	56,438		441,608		441,608	(243)	441,365			3
4	Laundry	114,425	33,554		147,979		147,979		147,979			4
5	Heat and Other Utilities			523,455	523,455		523,455	(2,250)	521,205			5
6	Maintenance	53,844	49,727	138,706	242,277		242,277	(810)	241,467			6
7	Other (specify):*											7
8	TOTAL General Services	1,065,620	684,408	708,908	2,458,936		2,458,936	(26,622)	2,432,314			8
	B. Health Care and Programs											
9	Medical Director			53,400	53,400		53,400		53,400			9
10	Nursing and Medical Records	4,465,343	407,168	981,841	5,854,352		5,854,352		5,854,352			10
10a	Therapy	80,560			80,560		80,560		80,560			10a
11	Activities	157,363	3,832	1,496	162,691		162,691		162,691			11
12	Social Services	149,908	153	6,814	156,875		156,875		156,875			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Adult Day Care	158,212	13,993	70,762	242,967		242,967	(242,967)				15
16	TOTAL Health Care and Programs	5,011,386	425,146	1,114,313	6,550,845		6,550,845	(242,967)	6,307,878			16
	C. General Administration											
17	Administrative	180,248		298,795	479,043		479,043		479,043			17
18	Directors Fees											18
19	Professional Services			221,681	221,681		221,681	(18,743)	202,938			19
20	Dues, Fees, Subscriptions & Promotions			71,488	71,488		71,488	(15,653)	55,835			20
21	Clerical & General Office Expenses	274,318	32,128	37,139	343,585		343,585	(190)	343,395			21
22	Employee Benefits & Payroll Taxes			2,188,913	2,188,913		2,188,913		2,188,913			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,913	14,913		14,913		14,913			24
25	Other Admin. Staff Transportation			3,869	3,869		3,869	(23)	3,846			25
26	Insurance-Prop.Liab.Malpractice			302,332	302,332		302,332	(11,105)	291,227			26
27	Other (specify):*											27
28	TOTAL General Administration	454,566	32,128	3,139,130	3,625,824		3,625,824	(45,714)	3,580,110			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,531,572	1,141,682	4,962,351	12,635,605		12,635,605	(315,303)	12,320,302			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 County Nursing Home #0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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			734,719	734,719		734,719	10,842	745,561			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			142,740	142,740		142,740	(1,274)	141,466			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			57,654	57,654		57,654		57,654			35
36	Other (specify):*											36
37	**TOTAL Ownership**			935,113	935,113		935,113	9,568	944,681			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		198,304	902,212	1,100,516		1,100,516		1,100,516			39
40	Barber and Beauty Shops	52,822	1,472		54,294		54,294		54,294			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			808,479	808,479		808,479		808,479			42
43	Other (specify):* **Non-Allowable Cos**			158,727	158,727		158,727	(158,727)				43
44	**TOTAL Special Cost Centers**	52,822	199,776	1,869,418	2,122,016		2,122,016	(158,727)	1,963,289			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,584,394	1,341,458	7,766,882	15,692,734		15,692,734	(464,462)	15,228,272			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 County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	$ (242,967)	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	(29,490)	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	14,000	30		9
10	Interest and Other Investment Income	(1,274)	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	(7,370)	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	(1,220)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(15,653)	20		28
29	Other-Attach Schedule See Pg 5A	(180,488)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (464,462)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (464,462)		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: 12/01/2011

Ending: 11/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset meal revenue against food cost	$ (6,638)	2	1
2	Laboratory fees	(17,998)	43	2
3	Medicare ancillary expense	(65,503)	43	3
4	Non-allowable transfers to General Corporate F	(3,960)	43	4
5	Public relations expense	(7,667)	19	5
6	Dietary	(3,799)	1	6
7	Food	(12,882)	2	7
8	Housekeeping	(243)	3	8
9	Utilities	(2,250)	5	9
10	Maintenance	(810)	6	10
11	Professional Fees	(1,308)	19	11
12	Office	(190)	21	12
13	Staff Transportation	(23)	25	13
14	Insurance - Auto	(9,321)	26	14
15	Insurance - Other	(1,784)	26	15
16	Depreciation - Other	(3,158)	30	16
17	Financial Charges	(33,186)	43	17
18	Out-of-Period Legal Exp	(9,768)	19	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**	(180,488)		49

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	See Attached List	Board of Directors	Administrative	0.00	None	<1	<1%		$ None	N/A	1
2											2
3	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										3
4	transactions with the nursing home during the reporting period.										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 County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 1/30/2012

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	222,595		$ 134,688	$	6,278	$ 3,799	1
2	2	Food	Meals	222,595		456,748		6,278	12,882	2
3	3	Housekeeping	Square Feet	67,925		56,438		292	243	3
4	5	Utilities	Square Feet	67,925		523,455		292	2,250	4
5	6	Maintenance	Square Feet	67,925		188,433		292	810	5
6	19	Professional Fees	Revenue	14,792,770		221,681		87,305	1,308	6
7	21	Office Expense	Revenue	14,792,770		32,128		87,305	190	7
8	25	Staff Transportation	Revenue	14,792,770		3,869		87,305	23	8
9	26	Insurance - Auto	Direct	1		9,321		1	9,321	9
10	26	Insurance - Other	Revenue	14,792,770		302,332		87,305	1,784	10
11	30	Depreciation - Other	Square Feet	67,925		734,719		292	3,158	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					$ 2,663,812	$		$ 35,768	25

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	Interest - Bonds Payable		X	Construction	Varies	06/30/06	$ 4,000,000	$ 3,065,000	6/30/2026	Varies	$ 137,103	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Champaign County		X	Interfund Loan - working capital							5,637	6
7												7
8												8
9	TOTAL Facility Related						$ 4,000,000	$ 3,065,000			$ 142,740	9
	B. Non-Facility Related*											
10												10
11									Offset interest income		(1,274)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,274)	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 3,065,000			$ 141,466	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.)**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)	2011	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	N/A	12

County nursing home. Exempt from real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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 N/A 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 12/01/2011 Ending: 11/30/2012

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	$ 3,387,392	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New NH parking lot			2007	189,924	36,355	20	22,173	(14,182)	141,261	9
10	Masonry sign			2008	16,741	685	25	670	(15)	3,015	10
11	Smoke Barriers			2010	89,879	2,429	37	2,429		6,073	11
12	Smoke Barriers			2011	3,900	110	35.5	110		146	12
13	Boiler Repair			2011	4,990	2,495	2	2,495	(0)	3,743	13
14											14
15	Boiler Upgrades-Basement			2012	21,339	533	20	533	(0)	533	15
16	Fulton Boiler Controller-Basement			2012	7,309	487	5	487		487	16
17	External Storage Unit			2012	6,217	415	5	415		415	17
18	Basement Water Leak Repair			2012	4,441		10	222	222	222	18
19	Basement Heat Trace Repair			2012	2,992		10	150	150	150	19
20	Emergency Generator Repair			2012	3,040		10	152	152	152	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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)		$ 23,577,965	$ 621,237		$ 610,516	$ (10,721)	$ 3,543,589	70

**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: 12/01/2011 Ending: 11/30/2012

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	$ 1,062,359	$ 87,469	$ 112,156	$ 24,687	5-10	$ 780,332	71
72	Current Year Purchases	26,003	3,861	3,861		3-10	3,861	72
73	Fully Depreciated Assets							73
74	Disallowed Day Care Depreciation			(3,158)	(3,158)			74
75	TOTALS	$ 1,088,362	$ 91,330	$ 112,859	$ 21,529		$ 784,193	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	See Sch 13A	See Sch 13A	See Sch 13A	$ 209,013	$ 22,152	$ 22,186	$ 34	5-10	$ 133,905	76
77										77
78										78
79										79
80	TOTALS			$ 209,013	$ 22,152	$ 22,186	$ 34		$ 133,905	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)	$ 25,128,883	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 734,719	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 745,561	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,842	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,461,687	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

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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		34	34	10	1,358
Resident Use	Mini Van Paratransit w/ ramp	2009	33,104	6,621	6,621	0	5	24,276
Resident Use	09 Ford Eldorado Van	2009	51,576	10,315	10,315	0	5	31,805
Resident Use	2011 Ford Van	2011	52,160	5,216	5,216	0	10	5,651
			209,013	**22,152**	**22,186**	**34**		**133,905**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 57,654 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
FYE: November 30, 2012

XII. RENTAL COSTS
B(16). Rental Amount & Descriptions

Description	Amount
Trash Compactor	2,856
Construction vehicles	73
Dishwasher	4,771
Wound Vac	9,608
Therapy Equipment	10,865
Mattresses & Bed Rentals	17,053
Mattresses	5,886
Medical Supply	2,303
Oxygen Concentrators	1,430
Oxygen Cylinders	132
Medical Oxygen Equip	2,677
Total Line B (16)	57,654

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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: 12/01/2011 Ending: 11/30/2012

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	L39, C3	hrs	$	4,964	$ 372,310	$	4,964	$ 372,310	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,747	131,020		1,747	131,020	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,318	398,882		5,318	398,882	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				198,304		198,304	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			$	12,029	$ 902,212	$ 198,304	12,029	$ 1,100,516	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 County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2012 (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	$ 798,749	$ 798,749	1
2	Cash-Patient Deposits	7,805	7,805	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 143,960)	1,235,964	1,235,964	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,217	20,217	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Other Funds	1,864,032	1,864,032	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,926,767	$ 3,926,767	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	23,223,630	23,227,194	14
15	Leasehold Improvements, at Historical Cost	469,744	350,771	15
16	Equipment, at Historical Cost	1,313,192	1,297,375	16
17	Accumulated Depreciation (book methods)	(4,361,370)	(4,461,687)	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)**	$ 20,645,196	$ 20,667,196	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,571,963	$ 24,593,963	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,018,480	$ 2,018,480	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,805	7,805	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	485,521	485,521	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			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)**	$ 2,844,948	$ 2,844,948	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,065,000	3,065,000	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)**	$ 3,065,000	$ 3,065,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,909,948	$ 5,909,948	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,662,015	$ 18,684,015	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,571,963	$ 24,593,963	48

*(See instructions.)

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 19,571,951	1	
2	Restatements (describe):		2	
3	**Prior period adjustment**	(9,972)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 19,561,979	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(899,964)	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)**	$ (899,964)	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)**	$ 18,662,015	24	*

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,707,857	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,707,857	3
	B. Ancillary Revenue		
4	Day Care	87,305	4
5	Other Care for Outpatients	190,486	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 277,791	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	161,908	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	44,074	13
14	Non-Patient Meals	6,638	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	63,001	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 275,621	23
	D. Non-Operating Revenue		
24	Contributions	5,287	24
25	Interest and Other Investment Income***	1,274	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,561	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	524,940	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 524,940	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,792,770	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,458,936	31
32	Health Care	6,550,845	32
33	General Administration	3,625,824	33
	B. Capital Expense		
34	Ownership	935,113	34
	C. Ancillary Expense		
35	Special Cost Centers	1,313,537	35
36	Provider Participation Fee	808,479	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,692,734	40
41	**Income before Income Taxes (line 30 minus line 40)****	(899,964)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (899,964)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,278,695	44
45	Private Pay - Net Inpatient Revenue	4,022,209	45
46	Medicare - Net Inpatient Revenue	2,595,975	46
47	Other-(specify) VA - Veterans Care	172,077	47
48	Other-(specify) Hospice and HMO	638,901	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,707,857	49

* **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.**

*** **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.**

^ - Government Entity (Part of County)

Champaign County Nursing Home **Schedule 19A**
Provider #: 0001636
FYE: November 30, 2012

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

Description	Amount
Taxes - Current Operating	1,022,365
Other Operating Taxes	1,589
Mobile Home Tax	1,127
Payment in Lieu of Taxes	167
Resident Transportation	13,764
Late charges	18,879
Misc Income	4,123
Prior Period Adjustment	(537,074)
Total - Line 28	524,940

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	1,987	2,260	$ 81,358	$ 36.00	1
2	Assistant Director of Nursing	1,606	1,800	56,784	31.55	2
3	Registered Nurses	25,483	27,556	800,409	29.05	3
4	Licensed Practical Nurses	45,341	47,465	1,151,481	24.26	4
5	CNAs & Orderlies	169,602	173,990	2,375,311	13.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,504	6,414	80,560	12.56	8
9	Activity Director					9
10	Activity Assistants			157,363		10
11	Social Service Workers	8,210	8,955	149,908	16.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,895	43,574	512,181	11.75	15
16	Dishwashers					16
17	Maintenance Workers	4,958	5,397	53,844	9.98	17
18	Housekeepers	28,898	32,652	385,170	11.80	18
19	Laundry	8,734	9,981	114,425	11.46	19
20	Administrator	3,544	4,467	180,248	40.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,273	18,656	274,318	14.70	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	8,465	10,253	158,212	15.43	32
33	Other(specify) Barber & Beauty	3,572	4,188	52,822	12.61	33
34	TOTAL (lines 1 - 33)	371,072	397,608	$ 6,584,394 *	$ 16.56	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	$ 45,485	1(7)	35
36	Medical Director	Monthly	53,400	9(3)	36
37	Medical Records Consultant	Monthly	4,026	10(3)	37
38	Nurse Consultant	Monthly	10,130	10(3)	38
39	Pharmacist Consultant	Monthly	8,718	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	1,496	11(3)	44
45	Social Service Consultant	Monthly	6,814	12(3)	45
46	Other(specify) MDS Consultant	Monthly	73,907	10(3)	46
47	Care Plan Coordinator	Monthly	119,425	10(3)	47
48	Transport Services	Monthly	20,839	10(3)	48
49	TOTAL (lines 35 - 48)		$ 344,240		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	787	$ 38,267	10(3)	50
51	Licensed Practical Nurses	3,903	122,599	10(3)	51
52	Certified Nurse Assistants/Aides	25,116	577,885	10(3)	52
53	TOTAL (lines 50 - 52)	29,806	$ 738,751		53

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles S. Schuette (1/1/12-7/20/12)	Administrator	0	$ 55,511
Karen Noffke (7/21/12-12/31/12)	Administrator	0	50,191
Traci Harris	Assistant Administrator	0	74,546
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 180,248

B. Administrative - Other

Description	Amount
Management Performance (Management Fees)	$ 298,795
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 298,795

C. Professional Services

Vendor/Payee	Type	Amount
See Sch21A	See Sch21A	$ 221,681
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 221,681

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 318,183
Unemployment Compensation Insurance	173,693
FICA Taxes	478,833
Employee Health Insurance	551,586
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	636,719
Employee Morale	1,259
Employee Labs & Physicals	28,640
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,188,913

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	26,272
Health Care Worker Background Check (Indicate # of checks performed 161)	1,605
Patient Background Checks 404	4,043
Life Services Network	19,501
Yellow Page Advertising	15,653
Miscellaneous Dues	410
Miscellaneous Publications	2,014
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(15,653)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,835

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14,913
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,913

**See instructions.

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor	Type	Amount
Champaign County Treasurer	Accounting	50,882
Stricklin & Associates	Public Relations - Disallow	7,667
Accountemps	Accounting Services	6,354
Healthport	Health Audit Technology	1,146
Pinnacle Consulting	IT Consulting	4,200
Lifecycle Systems	Aviary Delivery	857
Oliver Group, The	Predictive Index	658
Spherion	Recruiting Services	1,054
Record Copy Services	Procurement and Litigation Support	1,179
Mcgladrey & Pullen, Llp	Accounting	20,395
Kelley, Elvidge	LTC Issues - Legal	350
Trillium	Software	6,506
Champaign County Treasurer- Gen	Accounting	3,086
Heyl, Royster, Voelker & Allen	Legal Fees	49,096
Polsinelli Shughart Pc	Legal Fees	4,707
Evans, Froehlich, Beth & Chamley	Legal Fees	2,750
Malin, Martin H.	Legal Fees	325
Meyer Capel	Legal Fees	8,594
Champaign County Treasurer- Gen	Legal Fees	2,125
Torricelli & Limentato, P.c.	Legal Fees	2,395
E-health Data Solutions	Computer Services	4,140
Allscripts Healthcare, Llc	Computer Services	3,566
MDI Achieve Inc	Computer Services	35,340
Comcast Cable	Computer Services	847
Ivans, Inc	Computer Services	2,418
AT&T	Computer Services	865
Champaign County Treasurer- Gen	Computer Services	36
Activity Connection.com	Computer Services	143
	Total agreeing to Schedule V, Line 19, Col 3	221,681

To Disallow Adult Day Care Expenses	(1,308)
To Disallow OOP Legal Expenses	(9,768)
To Disallow Public Relations	(7,667)
Total (agree to Schedule V, line 20, column 8)	202,938

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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-$ 19,501**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **113,827** 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. $ **808,479**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes-See Pg 8** 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. $ **6,638**

(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.