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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nrsing Home

Address: 500 S Art Bartell Dr (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 12/01/2013 to 12/31/14 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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	243	Skilled (SNF)	243	96,228	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	243	TOTALS	243	96,228	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	756	662	5,900	7,318	8
9	SNF/PED					9
10	ICF	42,027	26,183	3,939	72,149	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,783	26,845	9,839	79,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.58%

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 2007

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 3,854

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Champaign County Nrsing Home # 0046664 **Report Period Beginning:** 12/01/2013 **Ending:** 12/31/14

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	484,351	499,876	84,155	1,068,382		1,068,382	(16,252)	1,052,130			1
2	Food Purchase		293,826		293,826		293,826	(12,285)	281,541			2
3	Housekeeping	403,027	59,321		462,348		462,348	(255)	462,093			3
4	Laundry	128,411	29,460		157,871		157,871		157,871			4
5	Heat and Other Utilities			520,122	520,122		520,122	(2,236)	517,886			5
6	Maintenance	78,426	29,569	243,941	351,936		351,936	(1,176)	350,760			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,094,215	912,052	848,218	2,854,485		2,854,485	(32,204)	2,822,281			8
	B. Health Care and Programs											
9	Medical Director			50,600	50,600		50,600		50,600			9
10	Nursing and Medical Records	4,553,044	434,478	1,339,443	6,326,965		6,326,965		6,326,965			10
10a	Therapy	87,672			87,672		87,672		87,672			10a
11	Activities	174,267	7,945	1,646	183,858		183,858		183,858			11
12	Social Services	140,889		42,929	183,818		183,818		183,818			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Adult Day Care**	161,914	20,016	74,188	256,118		256,118	(256,118)				15
16	**TOTAL Health Care and Programs**	5,117,786	462,439	1,508,806	7,089,031		7,089,031	(256,118)	6,832,913			16
	C. General Administration											
17	Administrative	192,568		395,865	588,433		588,433		588,433			17
18	Directors Fees											18
19	Professional Services			207,027	207,027		207,027	(11,591)	195,436			19
20	Dues, Fees, Subscriptions & Promotions			79,098	79,098		79,098	(27,362)	51,736			20
21	Clerical & General Office Expenses	303,820	18,730	42,160	364,710		364,710	(678)	364,032			21
22	Employee Benefits & Payroll Taxes			2,202,875	2,202,875		2,202,875	(816)	2,202,059			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,758	11,758		11,758		11,758			24
25	Other Admin. Staff Transportation			2,580	2,580		2,580	(19)	2,561			25
26	Insurance-Prop.Liab.Malpractice			312,155	312,155		312,155	(7,134)	305,021			26
27	Other (specify):*											27
28	**TOTAL General Administration**	496,388	18,730	3,253,518	3,768,636		3,768,636	(47,600)	3,721,036			28
29	**TOTAL Operating Expense (sum of lines 8, 19 & 28)**	6,708,389	1,393,221	5,610,542	13,712,152		13,712,152	(335,922)	13,376,230			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 Nrsing Home #0046664 **Report Period Beginning:** 12/01/2013 **Ending:** 12/31/14

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			807,945	807,945		807,945	(2,338)	805,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			126,456	126,456		126,456	(443)	126,013			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,657	49,657		49,657		49,657			35
36	Other (specify):*											36
37	**TOTAL Ownership**			984,058	984,058		984,058	(2,781)	981,277			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	44,600	235,420	1,097,398	1,377,418		1,377,418		1,377,418			39
40	Barber and Beauty Shops	58,719	2,083		60,802		60,802		60,802			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			602,932	602,932		602,932		602,932			42
43	Other (specify):* Non-Allowable Cos			444,747	444,747		444,747	(444,747)				43
44	**TOTAL Special Cost Centers**	103,319	237,503	2,145,077	2,485,899		2,485,899	(444,747)	2,041,152			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,811,708	1,630,724	8,739,677	17,182,109		17,182,109	(783,450)	16,398,659			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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	$ (256,118)	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	(29,651)	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	1,135	30		9
10	Interest and Other Investment Income	(443)	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	(40,025)	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	(1,373)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(27,362)	43		28
29	Other-Attach Schedule See Page 5A	(429,613)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (783,450)		$	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))**	$ (783,450)		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

STATE OF ILLINOIS **Page 5A**

Champaign County Nrsing Home

ID# **0046664**

Report Period Beginning: **12/01/2013**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset meal revenue against food cost	$ (4,109)	2	1
2	Laboratory fees	(29,279)	43	2
3	Medicare ancillary expense	(32,434)	43	3
4	Public relations expense	(8,667)	19	4
5	Dietary	(16,252)	1	5
6	Food	(8,176)	2	6
7	Housekeeping	(255)	3	7
8	Utilities	(2,236)	5	8
9	Maintenance	(1,176)	6	9
10	Professional Fees	(1,552)	19	10
11	Office	(140)	21	11
12	Staff Transportation	(19)	25	12
13	Insurance - Auto	(4,795)	26	13
14	Insurance - Other	(2,339)	26	14
15	Depreciation - Other	(3,473)	30	15
16	Financial Charges	(1)	43	16
17	Out-of-Period Legal Exp	(1,372)	19	17
18	Bad Debt Expense	(311,984)	43	18
19	Offset Miscellaneous Income	(538)	21	19
20	Worker's Comp	(816)	22	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**	(429,613)		49

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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			$			$	$	1
2	V								2
3	V		N/A						3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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					$	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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	244,330		$ 584,031	$	6,799	$ 16,252	1
2	2	Food	Meals	244,330		293,826		6,799	8,176	2
3	3	Housekeeping	Square Feet	67,925		59,321		292	255	3
4	5	Utilities	Square Feet	67,925		520,122		292	2,236	4
5	6	Maintenance	Square Feet	67,925		273,510		292	1,176	5
6	19	Professional Fees	Revenue	17,308,341		242,264		129,717	1,816	6
7	21	Office Expense	Revenue	17,308,341		18,622		129,717	140	7
8	25	Staff Transportation	Revenue	17,308,341		2,580		129,717	19	8
9	26	Insurance - Auto	Direct	1		4,795		1	4,795	9
10	26	Insurance - Other	Revenue	17,308,341		312,155		129,717	2,339	10
11	30	Depreciation - Other	Square Feet	67,925		807,945		292	3,473	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					$ 3,119,171	$		$ 40,677	25

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Interest - Bonds Payable		X	Construction	Varies	06/30/06	$ 4,000,000	$ 2,700,000	6/30/2026	Varies	$ 122,665	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Champaign County	X		Interfund Loan - working capital		6/30/2014	438,053	438,053	6/30/2015			6
7	Midland States Bank		X	Tax Anticipation	Varies	12/1/2014	971,120	971,120	9/30/2015	0.0055	3,791	7
8												8
9	TOTAL Facility Related						$ 5,409,173	$ 4,109,173			$ 126,456	9
	B. Non-Facility Related*											
10												10
11									Offset interest income		(443)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (443)	14
15	TOTALS (line 9+line14)						$ 5,409,173	$ 4,109,173			$ 126,013	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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)	**2013**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 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.)**	**Allocated from Managment Co.**	$	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:			
	2009		**8**
	2010		**9**
	2011		**10**
	2012	**N/A**	**11**
	2013		**12**

County nursing home. Exempt from real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	**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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nrsing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0046664

CONTACT PERSON REGARDING THIS REPORT Karen Noffke, 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	County Nursing Home. Exempt from real estate tax.		$	$
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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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 [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	Facility	670,000	2007	$ 253,543	1
2					2
3	TOTALS	670,000		$ 253,543	3

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	$ 639,843	40	$ 639,843	$	$ 4,674,210	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New NH parking lot			2007	189,924	25,391	8	25,391		186,279	9
10	Masonry sign			2008	16,741	725	25	725		4,408	10
11	Smoke Barriers			2010	89,879	2,632	37	2,632		11,943	11
12	Smoke Barriers			2011	3,900	119	35.5	119		375	12
13	Boiler Repair			2011	4,990		2			4,990	13
14											14
15	Boiler Upgrades-Basement			2012	21,339	1,156	20	1,156		2,756	15
16	Fulton Boiler Controller-Basement			2012	7,309	1,584	5	1,584		3,533	16
17	External Storage Unit			2012	6,217	1,347	5	1,347		3,005	17
18	Basement Water Leak Repair			2012	4,441		10	481	481	1,147	18
19	Basement Heat Trace Repair			2012	2,992		10	324	324	774	19
20	Emergency Generator Repair			2012	3,040		10	329	329	785	20
21											21
22	Additional Fulton Boiler Work			2013	10,700	2,318	5	2,318		4,102	22
23	Water Heater Replacement			2013	28,445	3,082	10	3,082		4,978	23
24	Chiller Phase Sequencers and installation			2013	9,968	1,080	10	1,080		1,537	24
25	Water Mixing Valves			2013	8,761	949	10	949		1,022	25
26											26
27	Fulton Pulse Boiler Repair - Mechanical Room			2014	7,220	1,324	5	1,324		1,324	27
28	Heat Exchanger - Roof			2014	2,547	467	5	467		467	28
29	Air Handler Coil - Mechanical Room			2014	7,938	926	5	926		926	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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	N/A								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)		$ 23,653,544	$ 682,942		$ 684,077	$ 1,134	$ 4,908,561	70

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

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	$ 899,379	$ 96,611	$ 96,611	$		$ 579,966	71
72	Current Year Purchases	99,337	11,079	11,079			11,079	72
73	Fully Depreciated Assets	195,841					195,841	73
74	Disallowed Day Care Depreciation			(3,473)	(3,473)			74
75	TOTALS	$ 1,194,557	$ 107,690	$ 104,217	$ (3,473)		$ 786,886	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	$ 17,313	$ 17,313	$	5-10	$ 173,370	76
77										77
78										78
79										79
80	TOTALS			$ 209,013	$ 17,313	$ 17,313	$		$ 173,370	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)	$ 25,310,657	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 807,945	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 805,607	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,339)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,868,817	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		N/A			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.

Facility Name: **Champaign County Nrsing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/14**

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Resident Use	96 Ford Bus	1996	36,532			-	10	36,532
Resident Use	98 Dodge Van	1998	33,746			-	10	33,746
Resident Use	Lift for Van	2001	537			-	5	537
Resident Use	97 Ford	2002	1,358			-	10	1,358
Resident Use	Mini Van Paratransit w/ ramp	2009	33,104	2,207	2,207	-	5	33,104
Resident Use	09 Ford Eldorado Van	2009	51,576	9,456	9,456	-	5	51,576
Resident Use	2011 Ford Van	2011	52,160	5,650	5,650	-	10	16,517
						-		
						-		
TOTAL			**209,013**	**17,313**	**17,313**	**-**		**173,370**

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 49,657 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.

Facility Name: **Champaign County Nrsing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/14**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Trash Compactor	3,363
Construction vehicles	71
Dishwasher	5,292
Office Equipment	166
Mattresses	4,315
Mattresses & Bed Rentals	5,468
Medical Supply	234
Respiratory Equipment	6,281
Therapy Equipment	16,900
Wound Vac	7,566
Total - Line 16	**49,657**

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	$	4,748	$ 356,130	$	4,748	$ 356,130	1
2	Licensed Speech and Language Development Therapist	L39, C3		hrs		2,019	151,445	168	2,019	151,613	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L39, C3		hrs		6,323	474,205		6,323	474,205	4
5	Physician Care			visits							5
6	Dental Care	L39, C1	1755	visits	44,600				1,755	44,600	6
7	Work Related Program			hrs							7
8	Habilitation	L39, C3		hrs		1,542	115,618		1,542	115,618	8
9	Pharmacy	L39, C2		# of prescrpts				235,252		235,252	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				$ 44,600	14,632	$ 1,097,398	$ 235,420	16,387	$ 1,377,418	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.

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 704,383	$ 704,383	1
2	Cash-Patient Deposits	20,720	20,720	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 281,140)	2,393,660	2,393,660	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,031	16,031	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Other Funds	2,294,955	2,294,955	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,429,749	$ 5,429,749	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	23,291,271	23,227,194	14
15	Leasehold Improvements, at Historical Cost	477,682	426,350	15
16	Equipment, at Historical Cost	1,455,698	1,403,570	16
17	Accumulated Depreciation (book methods)	(5,913,253)	(5,868,817)	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)**	$ 19,311,398	$ 19,441,840	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,741,147	$ 24,871,589	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,719,123	$ 1,719,123	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,720	20,720	28
29	Short-Term Notes Payable	971,120	971,120	29
30	Accrued Salaries Payable	547,743	547,743	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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 29 thru 37)**	$ 3,258,706	$ 3,258,706	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	438,053	438,053	39
40	Mortgage Payable			40
41	Bonds Payable	2,700,000	2,700,000	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)**	$ 3,138,053	$ 3,138,053	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,396,759	$ 6,396,759	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,344,388	$ 18,474,830	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 49 and 47)**	$ 24,741,147	$ 24,871,589	48

***(See instructions.)**

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,218,154	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,218,154	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	126,232	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) **Rounding**	2	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 126,234	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)**	$ 18,344,388	24	*

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

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	$ 15,435,153	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,435,153	3
	B. Ancillary Revenue		
4	Day Care	129,717	4
5	Other Care for Outpatients	308,549	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 438,266	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	148,462	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	41,575	13
14	Non-Patient Meals	4,109	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	73,510	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 267,656	23
	D. Non-Operating Revenue		
24	Contributions	8,785	24
25	Interest and Other Investment Income***	443	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,228	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	1,158,038	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,158,038	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 29 and 29)**	$ 17,308,341	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,854,485	31
32	Health Care	7,089,031	32
33	General Administration	3,768,636	33
	B. Capital Expense		
34	Ownership	984,058	34
	C. Ancillary Expense		
35	Special Cost Centers	1,882,967	35
36	Provider Participation Fee	602,932	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,182,109	40
41	**Income before Income Taxes (line 30 minus line 40)****	126,232	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 126,232	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,612,764	44
45	Private Pay - Net Inpatient Revenue	5,122,182	45
46	Medicare - Net Inpatient Revenue	2,106,789	46
47	Other-(specify) VA - Veterans Care	269,774	47
48	Other-(specify) Hospice and HMO	1,323,644	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,435,153	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.**

^ - County Home does not file income tax return

Facility Name: **Champaign County Nrsing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/14**

Schedule 19A

XVII. Income Statement
Line 27 Other Revenue (specify):

Description	Amount
Taxes - Current Operating	1,094,709
Other Operating Taxes	441
Mobile Home Tax	1,057
Payment in Lieu of Taxes	783
Resident Transportation	17,989
Late charges	34,735
Misc Income	6,397
Vending Machine	1,111
Worker's Comp Reimbursement	816
Total - Line 27	**1,158,038**

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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	1,611	1,728	$ 67,162	$ 38.87	1
2	Assistant Director of Nursing	2,297	2,542	80,529	31.68	2
3	Registered Nurses	35,000	37,866	1,080,675	28.54	3
4	Licensed Practical Nurses	42,464	45,072	1,085,335	24.08	4
5	CNAs & Orderlies	151,170	154,184	2,095,747	13.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,810	6,923	87,672	12.66	8
9	Activity Director					9
10	Activity Assistants	12,962	14,180	174,267	12.29	10
11	Social Service Workers	8,245	9,103	140,889	15.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,024	43,434	484,351	11.15	15
16	Dishwashers					16
17	Maintenance Workers	6,189	6,776	78,426	11.57	17
18	Housekeepers	32,145	35,061	403,027	11.50	18
19	Laundry	9,587	11,124	128,411	11.54	19
20	Administrator	4,195	4,371	192,568	44.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,320	25,342	303,820	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	627	627	13,528	21.58	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,109	2,352	23,305	9.91	31
32	Other Health C: Adult Day Care	9,449	11,357	161,914	14.26	32
33	Other(specify) See Sch 20A	11,535	13,002	210,082	16.16	33
34	TOTAL (lines 1 - 33)	398,739	425,044	$ 6,811,708 *	$ 16.03	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	$ 81,789	1(3)	35
36	Medical Director	Monthly	50,600	9(3)	36
37	Medical Records Consultant	Monthly	4,065	10(3)	37
38	Nurse Consultant	Monthly	83,255	10(3)	38
39	Pharmacist Consultant	Monthly	7,863	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	1,646	11(3)	44
45	Social Service Consultant	Monthly	42,929	12(3)	45
46	Other(specify) MDS Consultant	Monthly	93,527	10(3)	46
47	Care Plan Coordinator	Monthly	215,411	10(3)	47
48	Transport Services	Monthly	5,004	10(3)	48
49	TOTAL (lines 35 - 48)		$ 586,089		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	520	$ 25,783	10(3)	50
51	Licensed Practical Nurses	2,646	86,260	10(3)	51
52	Certified Nurse Assistants/Aides	33,333	787,047	10(3)	52
53	TOTAL (lines 50 - 52)	36,499	$ 899,090		53

Facility Name: **Champaign County Nrsing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/14**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Barber & Beauty	3,965	4,634	58,718	$ 12.67
Unit Secretary	3,846	4,274	43,850	$ 10.26
Dental Hygienist	1,511	1,755	44,600	$ 25.41
Care Plan Coordinator	2,214	2,339	62,914	$ 26.90
Total - Line 33 Other (specify):	**11,536**	**13,002**	**210,082**	**$ 16.16**

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Noffke	Administrator	0	$ 110,500
Traci Harris	Assistant Administrator	0	82,068
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 192,568

B. Administrative - Other

Description	Amount
Management Performance (Management Fees)	$ 395,865
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 395,865

C. Professional Services

Vendor/Payee	Type	Amount
See SCH 21A	See SCH 21A	$ 207,027
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 207,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 170,516
Unemployment Compensation Insurance	128,078
FICA Taxes	489,333
Employee Health Insurance	771,845
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	609,648
Employee Morale	608
Employee Labs & Physicals	32,031
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,202,059

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	$
Advertising: Employee Recruitment	24,644
Health Care Worker Background Check (Indicate # of checks performed 66)	2,060
Patient Background Checks 432	4,320
Life Services Network	17,045
Yellow Page Advertising	27,362
Miscellaneous Dues	2,489
Miscellaneous Publications	1,179
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(27,362)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,736

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,758
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,758

**See instructions.

Facility Name: **Champaign County Nrsing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/14**

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Elvidge Kelley	Legal	1,975
Evans, Froehlich, Beth & Chamley	Legal	5,500
Heyl, Royster, Voelker & Allen	Legal	22,460
Meyer Capel	Legal	12,348
Polsinelli Shughart PC	Legal	5,591
Champaign County Treasurer	Accounting	11,834
Mcgladrey & Pullen, LLP	Accounting	14,825
Harmony Healthcare International Inc	Compliance Consulting	9,874
Greenberg & Associates, Inc.	Health Information Management	814
Illinois Health Information Exchange	Health Information Management	220
Providertrust, Inc.	Healthcare Compliance	4,959
Pinnacle Consulting	IT Consulting	4,725
Aspex Solutions	IT Staffing & Recruiting Services	1,291
Healthport	Medical Records	318
Triad Shredding Corp	Paper Shredding Services	1,740
The Oliver Group	Predicitive Index	8,558
Cris Senior Services	Resident Transportation	277
Quality Limo & Taxi Inc.	Resident Transportation	1,298
Trillium	Software	6,989
Labor Ready Midwest, Inc.	Temp Service	346
Stricklin & Associates	Public Relations	8,667
E-health Data Solutions	Computer Services	4,485
A T & T	Computer Services	783
Ability Network Inc	Computer Services	315
Ability Network, Inc., Dept. #33	Computer Services	3,938
Matrixcare	Computer Services	24,280

Mdi Achieve Inc	Computer Services	15,175
County IT Services	Computer Services	33,441
	Total (agree to Schedule V, line 19, column 3)	207,027
	Less: Indirect ADC Costs	(1,816)
	Less: Non-Allowable Public Relations	(8,667)
	Less: Non-Allowable Legal Fees	(1,372)
	Total (agree to Schedule V, line 19, column 8)	195,172

Facility Name & ID Number Champaign County Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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 Nrsing Home # 0046664 Report Period Beginning: 12/01/2013 Ending: 12/31/14

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 - $17,045**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **128,322** 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. $ **602,932**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,109**

(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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.