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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nrsg 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 01/01/2016 to 12/31/2016 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) RSM US 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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	88,938	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	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	1,199	108	4,717	6,024	8
9	SNF/PED					9
10	ICF	40,135	12,807	5,962	58,904	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,334	12,915	10,679	64,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.00%

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 2,234

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	480,515	754,012		1,234,527		1,234,527	(13,854)	1,220,673			1
2	Food Purchase											2
3	Housekeeping	368,701	52,451	307	421,459		421,459	(220)	421,239			3
4	Laundry	99,488	42,265		141,753		141,753		141,753			4
5	Heat and Other Utilities			611,072	611,072		611,072	(2,627)	608,445			5
6	Maintenance	42,501	20,792	212,690	275,983		275,983	(1,004)	274,979			6
7	Other (specify):*											7
8	TOTAL General Services	991,205	869,520	824,069	2,684,794		2,684,794	(17,705)	2,667,089			8
	B. Health Care and Programs											
9	Medical Director			67,228	67,228		67,228		67,228			9
10	Nursing and Medical Records	4,574,243	363,642	609,150	5,547,035		5,547,035	57,029	5,604,064			10
10a	Therapy	72,206			72,206		72,206		72,206			10a
11	Activities	217,061	5,807	1,427	224,295		224,295		224,295			11
12	Social Services	193,167	514	1,427	195,108		195,108		195,108			12
13	CNA Training											13
14	Program Transportation							3,216	3,216			14
15	Other (specify):* Adult Day Care	139,451	11,570	53,645	204,666		204,666	(204,666)				15
16	TOTAL Health Care and Programs	5,196,128	381,533	732,877	6,310,538		6,310,538	(144,421)	6,166,117			16
	C. General Administration											
17	Administrative	182,462		332,508	514,970		514,970		514,970			17
18	Directors Fees											18
19	Professional Services			435,766	435,766		435,766	(104,856)	330,910			19
20	Dues, Fees, Subscriptions & Promotions			51,463	51,463		51,463	(24,746)	26,717			20
21	Clerical & General Office Expenses	270,382	18,009	36,292	324,683		324,683	(631)	324,052			21
22	Employee Benefits & Payroll Taxes			1,962,414	1,962,414		1,962,414		1,962,414			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,697	21,697		21,697		21,697			24
25	Other Admin. Staff Transportation			1,878	1,878		1,878	(22)	1,856			25
26	Insurance-Prop.Liab.Malpractice			276,670	276,670		276,670	(7,375)	269,295			26
27	Other (specify):*											27
28	TOTAL General Administration	452,844	18,009	3,118,688	3,589,541		3,589,541	(137,630)	3,451,911			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,640,177	1,269,062	4,675,634	12,584,873		12,584,873	(299,756)	12,285,117			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 Nrsg Home #0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			750,239	750,239		750,239	4,857	755,096			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,581	53,581		53,581	405,745	459,326			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			80,421	80,421		80,421		80,421			35
36	Other (specify):*											36
37	**TOTAL Ownership**			884,241	884,241		884,241	410,602	1,294,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	40,129	260,112	722,548	1,022,789		1,022,789		1,022,789			39
40	Barber and Beauty Shops	56,698	1,294		57,992		57,992		57,992			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			505,971	505,971		505,971		505,971			42
43	Other (specify):* Non-Allowable Cos	57,515		619,236	676,751		676,751	(676,751)				43
44	**TOTAL Special Cost Centers**	154,342	261,406	1,847,755	2,263,503		2,263,503	(676,751)	1,586,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,794,519	1,530,468	7,407,630	15,732,617		15,732,617	(565,905)	15,166,712			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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ (204,666)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(28,145)	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	8,082	30		9
10	Interest and Other Investment Income	(1,477)	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	407,222	32		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	(56,745)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(32,877)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(464,282)	43		24
25	Fund Raising, Advertising and Promotional	(2,127)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(21,810)	20		28
29	Other-Attach Schedule See Page 5A	(169,080)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (565,905)		$	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))**	$ (565,905)		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 Nrsg Home

ID# 0046664

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Expense	$ (2,936)	21	1
2	Laboratory fees	(12,587)	43	2
3	Medicare ancillary expense	(18,022)	43	3
4	Public relations expense	(6,667)	19	4
5	Dietary	(12,326)	1	5
6	Housekeeping	(220)	3	6
7	Utilities	(2,627)	5	7
8	Maintenance	(1,004)	6	8
9	Professional Fees	(5,067)	19	9
10	Office	(631)	21	10
11	Staff Transportation	(22)	25	11
12	Insurance - Auto	(4,158)	26	12
13	Insurance - Other	(3,217)	26	13
14	Depreciation - Other	(3,225)	30	14
15	Financial Charges	(37,328)	43	15
16	Offset Meal Income	(1,528)	8	16
17	Marketing wages	(57,515)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(169,080)		49

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Catherine Emanuel	Board of Directors	Administrative	0.00	N/A	0			$ 0	N/A	1
2	Deb Busey	Board of Directors	Administrative	0.00	N/A	0			0	N/A	2
3	Mary Hodson	Board of Directors	Administrative	0.00	N/A	0			0	N/A	3
4	Samuel P. Banks	Board of Directors	Administrative	0.00	N/A	0			0	N/A	4
5	Edmund C. Sutton	Board of Directors	Administrative	0.00	N/A	0			0	N/A	5
6	Josh Hartke	Board of Directors	Administrative	0.00	N/A	0			0	N/A	6
7	Jack Anderson	Board of Directors	Administrative	0.00	N/A	0			0	N/A	7
8											8
9											9
10	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										10
11	transactions with the nursing home during the reporting period.										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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	197,521	197,521	$ 754,012	$	3,229	$ 12,326	1
2	2	Food	Meals	197,521	197,521	0		3,229	0	2
3	3	Housekeeping	Square Feet	67,925	67,925	51,173		292	220	3
4	5	Utilities	Square Feet	67,925	67,925	611,072		292	2,627	4
5	6	Maintenance	Square Feet	67,925	67,925	233,482		292	1,004	5
6	19	Professional Fees	Revenue	14,505,248	14,505,248	435,766		168,673	5,067	6
7	21	Office Expense	Revenue	14,505,248	14,505,248	54,301		168,673	631	7
8	25	Staff Transportation	Revenue	14,505,248	14,505,248	1,878		168,673	22	8
9	26	Insurance - Auto	Direct	1	1	4,158		1	4,158	9
10	26	Insurance - Other	Revenue	14,505,248	14505248	276,670		168,673	3,217	10
11	30	Depreciation - Other	Square Feet	67,925	67925	750,239		292	3,225	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					$ 3,172,751	$		$ 32,497	25

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 2,505,000	6/30/2026	Varies	$ 46,626	1
2												2
3								County Interest Allocation			407,222	3
4												4
5												5
	Working Capital											
6	Champaign County	X		Interfund Loan - working capital		6/30/2014	438,053	280	6/30/2017			6
7	Champaign County	X		Interfund Loan - Working Capi	Varies	9/27/2016	282,802	282,802	9/27/2017			7
8	Commerce Bank		X	Tax Anticipation Warrants		12/1/2016	1,021,757	1,021,757	9/29/2017	0.0157	6,955	8
9	TOTAL Facility Related						$ 5,742,612	$ 3,809,839			$ 460,803	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(1,477)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,477)	14
15	TOTALS (line 9+line14)						$ 5,742,612	$ 3,809,839			$ 459,326	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 Nrsg Home # 0046664 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	**2015**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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.)**	**Alloc. Fr. Mgmt 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:			
	2011		8
	2012	N/A	9
	2013		10
	2014		11
	2015		12

County nursing home. Exempt from real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0001636

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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 577,728	$	$ 5,829,666	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New NH parking lot			2007	189,924		8			189,924	9
10	Masonry sign			2008	16,741	670	25	670		5,748	10
11	Smoke Barriers			2010	89,879	2,429	37	2,429		16,801	11
12	Smoke Barriers			2011	3,900	110	35.5	110		595	12
13	Boiler Repair			2011	4,990		2			4,990	13
14											14
15	Boiler Upgrades-Basement			2012	21,339	1,067	20	1,067		4,890	15
16	Fulton Boiler Controller-Basement			2012	7,309	1,462	5	1,462		6,457	16
17	External Storage Unit			2012	6,217	1,244	5	1,244		5,493	17
18	Basement Water Leak Repair			2012	4,441		10	444	444	2,035	18
19	Basement Heat Trace Repair			2012	2,992		10	300	300	1,374	19
20	Emergency Generator Repair			2012	3,040		10	304	304	1,393	20
21											21
22	Additional Fulton Boiler Work			2013	10,700	1,783	5	1,783		7,668	22
23	Water Heater Replacement			2013	28,445	2,845	10	2,845		10,668	23
24	Chiller Phase Sequencers and installation			2013	9,968	997	10	997		3,531	24
25	Water Mixing Valves			2013	8,761	876	10	876		2,774	25
26											26
27	Fulton Pulse Boiler Repair - Mechanical Room			2014	7,220	1,444	5	1,444		4,212	27
28	Heat Exchanger - Roof			2014	2,547	509	5	509		1,485	28
29	Air Handler Coil - Mechanical Room			2014	7,938	1,588	5	1,588		4,102	29
30											30
31	Bathroom Remodel - Unit 3 - ADA Compliant, Flooring, Fixtures			2015	2,948	295	10	295		442	31
32	ADC Flooring - Replaced tile flooring with hardwood			2015	7,485	1,497	5	1,497		2,745	32
33	EMAR Installation - Facility wide			2015	27,614	5,523	5	5,523		6,903	33
34	Emar Wiring - Facility Wide			2015	10,669	2,134	5	2,134		3,023	34
35	4 new Hot Water Heaters - Basement Mechanical Room			2015	102,692	10,269	10	10,269		16,260	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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Kitchen Drain Repairs - Replaced plumbing, Added clean-outs	2015	$ 16,873	$ 3,375	5	$ 3,375	$	$ 4,218	37
38	Water Heater Repairs - Basement Mechanical Room	2015	4,119	412	10	412		892	38
39									39
40	Fire Dampers - Basement Mechanical Room	2016	98,080	4,904	20	4,904		4,904	40
41	Lint Filtration System - Courtyard	2016	172,263	6,699	15	6,699		6,699	41
42	Install/Repair Doors - Throughout Building	2016	4,080	85	20	85		85	42
43	Door Closers - Throughout Builidng	2016	4,950	206	10	206		206	43
44	RTU Unit - Kitchen Area	2016	15,930	354	15	354		354	44
45	Nurse Call System Repair - Throughout Building	2016	4,945	206	10	206		206	45
46	Boiler Project - Basement Mechanical Room	2016	292,156	3,652	20	3,652		3,652	46
47	Water Heater Repair - Basement Mechanical Room	2016	3,300	28	10	28		28	47
48	Egress Exit Door - Employee Entrance	2016	2,900	24	20	24		24	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	To Adjust to Book Depreciation			(7,034)			7,034		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 24,424,548	$ 627,379		$ 635,461	$ 8,082	$ 6,154,446	70

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

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 1,096,935	$ 113,237	$ 113,237	$ -		$ 760,658	71
72	Current Year Purchases	28,734	4,407	4,407	-	5	4,407	72
73	Fully Depreciated Assets	262,165			-		262,165	73
74	Disallowed Day Care Depreciation			(3,225)	(3,225)			74
75	TOTALS	$ 1,387,834	$ 117,644	$ 114,419	$ (3,225)		$ 1,027,230	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	$ 5,216	$ 5,216	$ -	5-10	$ 183,802	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ 209,013	$ 5,216	$ 5,216	$ -		$ 183,802	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)	$ 26,274,938	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 750,239	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 755,096	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,857	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,365,478	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 Nrsg Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/2016**

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			-	5	33,104
Resident Use	09 Ford Eldorado Van	2009	51,576			-	5	51,576
Resident Use	2011 Ford Van	2011	52,160	5,216	5,216	-	10	26,949
						-		
TOTAL			**209,013**	**5,216**	**5,216**	**-**		**183,802**

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 80,421 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 Nrsg Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/2016**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Trash Compactor	3,096
Dishwasher	4,859
Mattresses	18,646
Bed rentals	2,100
Medical equipment	2,592
Respiratory equipment	20,740
Therapy Equipment	15,600
Wound vac	7,908
Gerichairs	4,880
Total - Line 16	**80,421**

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$	4,028	$ 302,095	$	4,028	$ 302,095	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,295	97,123		1,295	97,123	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		3,744	280,813		3,744	280,813	4
5	Physician Care		visits							5
6	Dental Care	L39, C1	1565 visits	40,129				1,565	40,129	6
7	Work Related Program		hrs							7
8	Habilitation	L39, C3	hrs		567	42,517		567	42,517	8
9	Pharmacy	L39, C2	# of prescrpts				245,783		245,783	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					14,329		14,329	12
13	Other (specify):									13
14	TOTAL			$ 40,129	9,634	$ 722,548	$ 260,112	11,199	$ 1,022,789	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 Nrsg Home **#** 0046664 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 313,005	$ 313,005	1
2	Cash-Patient Deposits	21,507	21,507	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 927,736)	2,122,551	2,122,551	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,197	21,197	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Other Funds	2,830,692	2,830,692	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,308,952	$ 5,308,952	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	23,473,120	23,227,194	14
15	Leasehold Improvements, at Historical Cost	1,094,860	1,197,354	15
16	Equipment, at Historical Cost	1,641,908	1,596,847	16
17	Accumulated Depreciation (book methods)	(7,395,122)	(7,365,478)	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 (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,814,766	$ 18,909,460	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,123,718	$ 24,218,412	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,187,829	$ 3,187,829	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,507	21,507	28
29	Short-Term Notes Payable	1,304,839	1,304,839	29
30	Accrued Salaries Payable	564,476	564,476	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,914	22,914	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,101,565	$ 5,101,565	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,505,000	2,505,000	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)**	$ 2,505,000	$ 2,505,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,606,565	$ 7,606,565	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,517,153	$ 16,611,847	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,123,718	$ 24,218,412	48

***(See instructions.)**

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,746,298	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(1,776)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,744,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,227,369)	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**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,227,369)	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)**	$ 16,517,153	24 *

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

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 12,942,408	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,942,408	3
	B. Ancillary Revenue		
4	Day Care	168,673	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 168,673	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	109,915	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,689	13
14	Non-Patient Meals	1,528	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	51,801	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 193,933	23
	D. Non-Operating Revenue		
24	Contributions	4,542	24
25	Interest and Other Investment Income***	365	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,907	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	1,195,327	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,195,327	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,505,248	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,684,794	31
32	Health Care	6,310,538	32
33	General Administration	3,589,541	33
	B. Capital Expense		
34	Ownership	884,241	34
	C. Ancillary Expense		
35	Special Cost Centers	1,757,532	35
36	Provider Participation Fee	505,971	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,732,617	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,227,369)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,227,369)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,148,396	44
45	Private Pay - Net Inpatient Revenue	3,079,480	45
46	Medicare - Net Inpatient Revenue	1,311,274	46
47	Other-(specify) VA - Veterans Care	552,474	47
48	Other-(specify) Hospice and HMO	1,850,784	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,942,408	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 Nrsg Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/2016**

Schedule 19A

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

Description	Amount
Current- Nursing Home Operating	1,173,918
Back Tax- Nursing Home Operating	683
Mobile Home Tax	1,073
Payment in Lieu of Taxes	816
Patient Transporation Charges	17,595
Vending Machine Revenue	3,530
Late Charge, NSF Check Charge	(3,400)
Misc Revenue - Work Comp	501
Other Miscellaneous Revenue	611
Total - Line 28	**1,195,327**

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	400	513	$ 24,483	$ 47.73	1
2	Assistant Director of Nursing	2,280	2,800	92,398	33.00	2
3	Registered Nurses	22,389	24,047	673,084	27.99	3
4	Licensed Practical Nurses	50,623	54,879	1,351,091	24.62	4
5	CNAs & Orderlies	146,824	149,911	2,242,527	14.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,765	5,179	72,206	13.94	8
9	Activity Director	1,957	2,080	45,386	21.82	9
10	Activity Assistants	14,397	15,685	171,675	10.95	10
11	Social Service Workers	10,982	11,978	193,167	16.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,439	43,625	480,515	11.01	15
16	Dishwashers					16
17	Maintenance Workers	3,174	3,470	42,501	12.25	17
18	Housekeepers	26,976	30,580	368,701	12.06	18
19	Laundry	8,147	9,063	99,488	10.98	19
20	Administrator	2,080	2,080	102,000	49.04	20
21	Assistant Administrator	925	1,817	80,462	44.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,700	16,963	270,382	15.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,928	2,098	47,148	22.47	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,542	1,924	22,638	11.77	31
32	Other Health C: Adult Day Care	7,768	9,102	139,451	15.32	32
33	Other(specify) See Sch 20A	12,929	14,721	275,216	18.70	33
34	TOTAL (lines 1 - 33)	374,225	402,515	$ 6,794,519 *	$ 16.88	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		$		35
36	Medical Director	Monthly	67,228	9(3)	36
37	Medical Records Consultant	Monthly	3,449	10(3)	37
38	Nurse Consultant	Monthly	118,261	10(3)	38
39	Pharmacist Consultant	Monthly	7,120	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	1,427	11(3)	44
45	Social Service Consultant	Monthly	1,427	12(3)	45
46	Other(specify) MDS Consultant	Monthly	93,754	10(3)	46
47	Care Plan Coordinator	Monthly	186,125	10(3)	47
48	Transport Services	Monthly	12,020	10(3)	48
49	TOTAL (lines 35 - 48)		$ 490,811		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	865	$ 51,156	10(3)	50
51	Licensed Practical Nurses	210	10,682	10(3)	51
52	Certified Nurse Assistants/Aides	5,428	116,038	10(3)	52
53	TOTAL (lines 50 - 52)	6,503	$ 177,876		53

Facility Name: **Champaign County Nrsg Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/2016**

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	3,237	4,176	56,698	$ 13.58
Unit Secretary	3,841	4,172	43,934	$ 10.53
Dental Hygentist	1,345	1,565	40,129	$ 25.64
Care Plan Coordinator	2,547	2,720	76,940	$ 28.29
Marketing/ Admissions	1,959	2,088	57,515	$ 27.55
Total - Line 33 Other (specify):	**12,929**	**14,721**	**275,216**	**$ 18.70**

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Noffke	Administrator	0	$ 102,000
Traci Harris	Assistant Administrator	0	80,462
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 182,462

B. Administrative - Other

Description	Amount
Management Performance (Management Fees)	$ 332,508
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 332,508

C. Professional Services

Vendor/Payee	Type	Amount
See SCH 21C	See SCH 21C	$ 435,766
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 435,766

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 174,176
Unemployment Compensation Insurance	104,446
FICA Taxes	492,974
Employee Health Insurance	632,899
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	536,358
Employee Morale	824
Employee Labs & Physicals	41,703
TOPS	(20,966)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,962,414

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,501
Health Care Worker Background Check	
(Indicate # of checks performed 123)	3,827
Patient Background Checks 297	2,972
LeadingAge	14,679
Yellow Page Advertising	21,810
Miscellaneous Dues	4,011
Miscellaneous Publications	673
Less: Public Relations Expense	(2,936)
Non-allowable advertising	(21,810)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,717

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	21,697
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,697

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Champaign County Nrsg Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Hennelly, Jacob, Quinlan & Associates	Legal	9,500
Chapman and Cutler LLP	Legal	6,650
Meyer Capel	Legal	2,481
Heyl, Royster, Voelker, & Allen	Legal	30,379
Meade, Roach, Annulis, LLP	Legal	26,038
Polsinelli PC	Legal	32,814
Taylor, Pigue, Marchetti & Blair, PLLC	Legal	7,241
Champaign County Treasurer	Accounting	48,658
RSM US LLP	Accounting	101,579
Providertrust, Inc.	Healthcare Compliance	4,122
Pinnacle Consulting	IT Consulting	3,350
Champaign County Treasurer - General Corp	County Services	1,342
Triad Shredding Corp	Paper Shredding Services	3,550
The Oliver Group	Predicitive Index	16,520
Quality Limo & Taxi, Inc.	Resident Transportation	2,180
Tri-Color Locksmiths	Software	835
Target Research, Inc.	Consulting	100
Spherion	Temp Service	18,759
Stricklin & Assoicates	Public Relations	6,667
Ariel Avgar	Consulting	2,750
Frontline Technologies Group, LLC	Consulting	694
A T & T	Computer Services	768
Ability Network, Inc.	Computer Services	5,486
Matrixcare	Computer Services	58,065
County IT Services	Computer Services	40,522
Provinet Solutions	Billing Consultant	4,145
Uvanta Pharmacy of Central Illinois	Consulting	571
	Total (agree to Schedule V, line 19, column 3)	435,766
Less: Indirect ADC Costs		(5,067)
Less: Non-Allowable Public Relations		(6,667)
Less: Non-Allowable Legal Fees	Legal Fees	(32,877)
Less: Non-Allowable MDS & Medical Records Expense	Computer Services	(58,065)
Less: Resident Transportation		(2,180)
	Total (agree to Schedule V, line 19, column 8)	330,910

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. **LeadingAge $14,679**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **119,929** 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. $ **505,971**
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. $ **1528**

(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: **Baker Tilly**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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