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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nursing Hom

Address: 500 S Art Bartell Dr (Number) | Urbana (City) | ###### (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: Chris Joos **Telephone Number:** 614.222.9040
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 01/01/2017 to 12/31/2017 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) Chris Joos, Partner
(Firm Name & Address) Plante Moran, PLLC, 250 South High Street, Suite 100
(Telephone) 614.222.9040 Fax # 248.233.8811

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 _____

	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	243.00	Skilled (SNF)	243	88,695	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	88,695	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	760	81	3,674	4,515	8
9	SNF/PED					9
10	ICF	28,808	11,262	7,113	47,183	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,568	11,343	10,787	51,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.29%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 [ ]

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 243 and days of care provided 2,367

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	476,113	34,541	6,922	517,576		517,576	(63)	517,513			1
2	Food Purchase		497,135		497,135		497,135	(753)	496,382			2
3	Housekeeping	287,447	40,571		328,018		328,018	(174)	327,844			3
4	Laundry	102,016	13,318	1,511	116,845		116,845		116,845			4
5	Heat and Other Utilities			595,034	595,034		595,034	(34,712)	560,322			5
6	Maintenance	125,651	243,013	8,348	377,012		377,012	(1,081)	375,931			6
7	Other (specify):* Trash/Waste			33,393	33,393		33,393		33,393			7
8	**TOTAL General Services**	991,227	828,578	645,208	2,465,013		2,465,013	(36,783)	2,428,230			8
	B. Health Care and Programs											
9	Medical Director			42,740	42,740		42,740		42,740			9
10	Nursing and Medical Records	4,298,925	242,324	156,949	4,698,198		4,698,198		4,698,198			10
10a	Therapy		81	497,923	498,004		498,004		498,004			10a
11	Activities	167,193	4,050	1,505	172,748		172,748		172,748			11
12	Social Services	124,137		6,168	130,305		130,305		130,305			12
13	CNA Training											13
14	Program Transportation	42,394			42,394		42,394		42,394			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,632,649	246,455	705,285	5,584,389		5,584,389		5,584,389			16
	C. General Administration											
17	Administrative	55,000		493,946	548,946		548,946		548,946			17
18	Directors Fees											18
19	Professional Services			419,616	419,616		419,616	(84,715)	334,901			19
20	Dues, Fees, Subscriptions & Promotions			27,003	27,003		27,003		27,003			20
21	Clerical & General Office Expenses	242,552	61,211	285,647	589,410		589,410	(275,012)	314,398			21
22	Employee Benefits & Payroll Taxes			1,758,857	1,758,857		1,758,857	(61,687)	1,697,170			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,303	3,303		3,303		3,303			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			274,097	274,097		274,097	(14,832)	259,265			26
27	Other (specify):* Marketing	64,917		19,817	84,734		84,734	(84,734)				27
28	**TOTAL General Administration**	362,469	61,211	3,282,286	3,705,966		3,705,966	(520,980)	3,184,986			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,986,345	1,136,244	4,632,779	11,755,368		11,755,368	(557,763)	11,197,605			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.

Champaign County Nursing Hom
0046664
12/31/2017

SUMMARY OF ALLOWABLE LEGAL FEES INCLUDED IN LINE 19

MCDACCT	AccountNumber	Description	Reference	InterfaceName	Balance	Description of service provided (BASED ON REVIEW OF INVOICES)	Allowable?
7650.00	8141053303	Administration - Attorney Fees	HENNELLY, JACOB, QUINLAN & ASSOC.	Medicaid Application Services For 1/17	1,000.00	*Application support*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Charles Coleman	35.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	683.14	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	1,069.07	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Kesler V. CCNH	2,642.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	POLSINELLI PC	Professional Services	4,027.50	*Pathways contract support*	Y
7650.00	8141053303	Administration - Attorney Fees	HENNELLY, JACOB, QUINLAN & ASSOC.	Medicaid Application Services For 2/17	3,000.00	*Application support*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	420.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	35.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	332.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	157.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	787.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	1,592.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Charles Coleman	1,050.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	420.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	507.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	437.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Reva Ingram	1,295.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Donald Keeler	402.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Mary Keeler	402.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo V. CCNH	1,470.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	1,417.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs. Mildred, Barrington, Cynthia Coleman	6,464.59	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Kesler V. CCNH	4,725.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Mary Keeler	1,680.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CCNH Vs Donald Keeler	1,365.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo Vs. CCNH	7,685.43	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Scalzo Vs. CCNH	1,557.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Mildred, Barrington, Cynthia Coleman Vs. CCNH	1,120.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Kesler/Ingram Vs. CCNH	857.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Keeler Vs. CCNH	2,292.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	D. Keeler Vs. CCNH	2,485.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Shearer Vs. CCNH	437.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	Kington Vs. CCNH	1,750.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	Mary Ann Royse Law Office	Legal Services	3,030.50	*Zoning related issues*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	4,200.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	3,150.00	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	7,407.17	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	2,782.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	6,284.95	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	10,067.17	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	(4,200.00)	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	(3,150.00)	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	(7,407.17)	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERV	(2,782.50)	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERV	(6,284.95)	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERVICES	(10,067.17)	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PROF SERV C. SCALZO	10,067.17	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	D. YONKE	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	JESSIE KING	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	SUSAN LAKER	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	MAGNOLIA JAMERSON	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	BARBARA WILLIFORD	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	DELORES ARCEO	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	SAVANNAH DAVIS	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	OLIVER FOSTER	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	ELMA GILLINS	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	JUNE ROSE BRUCE	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	SHELLEY BUTTJER	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	LOIS OWENS	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	MARJORIE PAULSMEYER	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	ROBERT POLK	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	PATRICIA WELLS	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	CHARLES COLEMAN	52.50	*Defense of suit by estate of former resident*	Y
7650.00	8141053303	Administration - Attorney Fees	HEYL, ROYSTER, VOELKER, & ALLEN	MILDRED COLEMAN	1,067.50	*Defense of suit by estate of former resident*	Y
					70,609.90		

Facility Name & ID Number Champaign County Nursing Hom #0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			777,974	777,974		777,974	(3,344)	774,630			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,669	47,669		47,669		47,669			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,096	3,096		3,096		3,096			35
36	Other (specify):*											36
37	**TOTAL Ownership**			828,739	828,739		828,739	(3,344)	825,395			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	64,621	26,686	305,923	397,230		397,230		397,230			39
40	Barber and Beauty Shops	47,421	358		47,779		47,779		47,779			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			429,186	429,186		429,186		429,186			42
43	Other (specify):* **Non-Reimbursable**	130,204	12,517	30,030	172,751		172,751	(172,751)				43
44	**TOTAL Special Cost Centers**	242,246	39,561	765,139	1,046,946		1,046,946	(172,751)	874,195			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,228,591	1,175,805	6,226,657	13,631,053		13,631,053	(733,858)	12,897,195			45

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ (142,781)	43	$	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	(32,154)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(46,984)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(78,087)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(222,550)	21		24
25	Fund Raising, Advertising and Promotional	(84,734)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(126,568)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (733,858)		$	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)		VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (733,858)		37

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

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

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

Champaign County Nursing Hom

ID# 0046664

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing, B&B, Adult Day C	(61,687)	22	2
3	Lobbying Expense	0		3
4	Adult Day Care - Dietary	(63)	1	4
5	Adult Day Care - Food	(753)	2	5
6	Adult Day Care - Housekeeping	(174)	3	6
7	Adult Day Care - Utilities	(2,558)	5	7
8	Adult Day Care - Maintenance	(1,081)	6	8
9	Adult Day Care - Professional Fees	(6,628)	19	9
10	Adult Day Care - Office Expense	(5,478)	21	10
11	Adult Day Care - Staff Transportation	0	25	11
12	Adult Day Care - Insurance - Auto	(10,671)	26	12
13	Adult Day Care - Insurance - Other	(4,161)	26	13
14	Adult Day Care - Depreciation - Other	(3,344)	30	14
15	OTHER NON REIMB	(29,970)	43	15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(126,568)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign County Nursing Hom **#** 0046664 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(63)	0	0	0	0	0	0	0	0	0	0	(63)	1
2	Food Purchase	(753)	0	0	0	0	0	0	0	0	0	0	(753)	2
3	Housekeeping	(174)	0	0	0	0	0	0	0	0	0	0	(174)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(34,712)	0	0	0	0	0	0	0	0	0	0	(34,712)	5
6	Maintenance	(1,081)	0	0	0	0	0	0	0	0	0	0	(1,081)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(36,783)	0	0	0	0	0	0	0	0	0	0	(36,783)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(84,715)	0	0	0	0	0	0	0	0	0	0	(84,715)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(275,012)	0	0	0	0	0	0	0	0	0	0	(275,012)	21
22	Employee Benefits & Payroll Taxes	(61,687)	0	0	0	0	0	0	0	0	0	0	(61,687)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(14,832)	0	0	0	0	0	0	0	0	0	0	(14,832)	26
27	Other (specify):*	(84,734)	0	0	0	0	0	0	0	0	0	0	(84,734)	27
28	**TOTAL General Administration**	(520,980)	0	0	0	0	0	0	0	0	0	0	(520,980)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(557,763)	0	0	0	0	0	0	0	0	0	0	(557,763)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign County Nursing Hom **#** 0046664 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,344)	0	0	0	0	0	0	0	0	0	0	(3,344)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,344)	0	0	0	0	0	0	0	0	0	0	(3,344)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(172,751)	0	0	0	0	0	0	0	0	0	0	(172,751)	43
44	**TOTAL Special Cost Centers**	(172,751)	0	0	0	0	0	0	0	0	0	0	(172,751)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(733,858)	0	0	0	0	0	0	0	0	0	0	(733,858)	45

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Champaign County	100	N/A	N/A	Champaign County	Urbana	Government

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

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

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

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 PG7-BOD TAB								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Champaign County Board Members
2016-2018

DISTRICT 1

R - **Brooks Marsh - Term Ending 11/30/2018**
701 Kimela Dr.
Mahomet, IL 61853
(217) 621-2772
jbrooks@mchsi.com

R - **Jim Goss – Term Ending 11/30/2018**
Home: 1007 Marietta Dr.
Mahomet, IL 61853
Office: 2805 S. Boulder Dr.
Urbana, IL 61802
Phone: (217) 202-6557
Email: jegoss64@gmail.com

DISTRICT 2

R - **Jack Anderson – Term Ending 11/30/2018**
Home: 425 Cemetery Road
Rantoul IL 61866
Home: 419-3595
Email:
jackanderson@frontier.com

R - **John Clifford – Term Ending 11/30/2018**
Home: 1370 CR 2850 N
Rantoul IL 61866
Cell: 841-0804
Email: johnclifford033@gmail.com

DISTRICT 3

R - **Aaron Esry – Term Ending 11/30/2018**
Home: 1987 County Road 1400 N
St. Joseph, IL 61873
Home: 552-6470
Email: ale7496@yahoo.com

R- **Stanley C. Harper – Term Ending 11/30/2020**
Home: 1947 County Rd 2700 E
Ogden, IL 61859
Home: 369-2986
Email: stancharper@gmail.com

DISTRICT 4

R- **Bradley Clemmons – Term Ending 11/30/2020**
821 CR 900N
Champaign 61822
369-8930
Blackandgrey84@gmail.com

R- **Jim McGuire – Term Ending 11/30/2018**
Home: 2606 Copper Tree Dr.
Champaign, IL 61822
Phone: 649-7641
Email: jimmcgu1@gmail.com

DISTRICT 5

R- **Jon Rector - Term Ending 11/30/2020**
Home: 4302 Summerfield Road
Champaign, Illinois 61822
Home: 351-8272
Cell: 369-5641
jwrector@gmail.com

R - **Max Mitchell – Term Ending 11/30/2018**
Home: 3345 Stoneybrook Drive
Champaign, IL 61822
Home: 359-4244
Office: 2009 Fox Drive
Champaign, IL 61820
Office: 373-4804
Fax: 352-0501
Cell: 369-0376
Email: Max@MaxMitchell.com

DISTRICT 6

D - **Pattsi Petrie - Term Ending 11/30/2018**
Home: 503 S. Chicago Ave.
Champaign IL 61821
Email: pattsi2@gmail.com

D - **Josh Hartke – Term Ending 11/30/2020**
Home: 303 S Fair Street
Champaign, IL, 61821
Email: jthartke713@yahoo.com

DISTRICT 7

D - **C. Pius Weibel – Term 11/30/2018**
Home: 709 W. Green Street
Champaign IL 61820
Home: 398-6117
Cell: 840-5367
cweibel@co.champaign.il.us

D - **Kyle Patterson – Term Ending 11/30/2020**
Home: 617 W. Springfield Ave. Apt. 3-S
Champaign, IL 61820
840-2317
Email: kyle.patterson1216@gmail.com

DISTRICT 8

D- **Stephanie Fortado - Term Ending 11/30/201**
Home: 305 W. Columbia Ave.
Champaign, IL 61820
217-722-7544
fortadoccb@gmail.com

D - **Giraldo Rosales – Term Ending 11/30/2020**
Home: 618 West Hill Street
Champaign IL 61820
Home: 766-6109
Email: grosales@nitrogenlabs.com

DISTRICT 9

D - **Shana Jo Crews – Term Ending 11/30/2018**
Home: PO Box 21 Savoy
IL 61874
Cell: 309-645-6909
Email: sjh1818@gmail.com

D - **Steve Summers – Term Ending 11/30/2020**
Home: 24 Montclair Rd.
Urbana, IL 61801
ssummers@co.champaign.il.us

DISTRICT 10

D - **Chris Stohr – Term Ending 11/30/2018**
Home: 405 E. High St.
Urbana, IL 61801
Home: 328-4071
Email: cstohr.ccbd10@gmail.com

D - **Robert Allen King – Term Ending 11/30/2020**
Home: 608 E. Oregon St.
Urbana, IL 61801
860-778-7799
Email: rking1045@gmail.com

DISTRICT 11

D- **James B. Tinsley – Term Ending 11/30/2020**
Home: 1304 W. Beardsley Ave.
Urbana, IL 61801
200-6501
jbtinsley3@gmail.com

D - **Lorraine Cowart – Term Ending 11/30/2018**
Home: 601 E. Bradley
Champaign IL 61820
Home: 355-9042
lcowart@co.champaign.il.us

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	155,094	155094	$ 41,463	$ 0	235	$ 63	1
2	2	Food	Meals	155,094	155094	497,135	0	235	753	2
3	3	Housekeeping	Square Feet	67,925	67925	40,571	0	292	174	3
4	5	Utilities	Square Feet	67,925	67925	595,034	0	292	2,558	4
5	6	Maintenance	Square Feet	67,925	67925	251,361	0	292	1,081	5
6	19	Professional Fees	Revenue	12,275,425	12275424.93	419,616	0	193,883	6,628	6
7	21	Office Expense	Revenue	12,275,425	12275424.93	346,858	0	193,883	5,478	7
8	25	Staff Transportation	Revenue	12,275,425	12275424.93	0	0	193,883	0	8
9	26	Insurance - Auto	Direct	1	1	10,671	0	1	10,671	9
10	26	Insurance - Other	Revenue	12,275,425	12275424.93	263,426	0	193,883	4,161	10
11	30	Depreciation - Other	Square Feet	67,925	67925	771,245	0	292	3,315	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					$ 3,237,380	$		$ 34,882	25

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	6/30/2006	$ 4,000,000	$ 2,265,000	6/30/2026	Varies	$ 42,690	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Commerce Bank		X	Tax Anticipation Warrants	Varies	12/1/16	1,021,757	128,935	9/29/18	Varies	4,979	6
7	Champaign County	X		General Fund Loan	Varies	9/27/16	282,802	226,802	9/21/18	Varies		7
8												8
9	TOTAL Facility Related						$ 5,304,559	$ 2,620,737			$ 47,669	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,304,559	$ 2,620,737			$ 47,669	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	N/A	8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Hom COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0046664

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 135,500 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

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).

ADULT 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 Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$	$ 6,407,394	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		6,418	10
11	Smoke Barriers			2010	89,879	2,429	37	2,429		19,230	11
12	Smoke Barriers			2011	3,900	110	35.5	110		705	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		5,957	15
16	Fulton Boiler Controller-Basement			2012	7,309	1,462	5	1,462		7,919	16
17	External Storage Unit			2012	6,217	1,244	5	1,244		6,737	17
18	Basement Water Leak Repair			2012	4,441	444	10	444		2,479	18
19	Basement Heat Trace Repair			2012	2,992	300	10	300		1,674	19
20	Emergency Generator Repair			2012	3,040	304	10	304		1,697	20
21											21
22	Additional Fulton Boiler Work			2013	10,700	1,783	5	1,783		9,451	22
23	Water Heater Replacement			2013	28,445	2,845	10	2,845		13,513	23
24	Chiller Phase Sequencers and installation			2013	9,968	997	10	997		4,528	24
25	Water Mixing Valves			2013	8,761	876	10	876		3,650	25
26											26
27	Fulton Pulse Boiler Repair - Mechanical Room			2014	7,220	1,444	5	1,444		5,656	27
28	Heat Exchanger - Roof			2014	2,547	509	5	509		1,994	28
29	Air Handler Coil - Mechanical Room			2014	7,938	1,588	5	1,588		5,690	29
30											30
31	Bathroom Remodel - Unit 3 - ADA Compliant, Flooring, Fixtures			2015	2,948	295	10	295		737	31
32	ADC Flooring - Replaced tile flooring with hardwood			2015	7,485	1,497	5	1,497		4,242	32
33	EMAR Installation - Facility wide			2015	27,614	5,523	5	5,523		12,426	33
34	Emar Wiring - Facility Wide			2015	10,669	2,134	5	2,134		5,157	34
35	4 new Hot Water Heaters - Basement Mechanical Room			2015	102,692	10,269	10	10,269		26,529	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$	$ 7,593	37
38	Water Heater Repairs - Basement Mechanical Room	2015	4,119	412	10	412		1,304	38
39									39
40	Fire Dampers - Basement Mechanical Room	2016	98,080	4,904	20	4,904		9,808	40
41	Lint Filtration System - Courtyard	2016	172,263	6,699	15	6,699		13,398	41
42	Install/Repair Doors - Throughout Building	2016	4,080	85	20	85		170	42
43	Door Closers - Throughout Builidng	2016	4,950	206	10	206		412	43
44	RTU Unit - Kitchen Area	2016	15,930	354	15	354		708	44
45	Nurse Call System Repair - Throughout Building	2016	4,945	206	10	206		412	45
46	Boiler Project - Basement Mechanical Room	2016	292,156	3,652	20	3,652		7,304	46
47	Water Heater Repair - Basement Mechanical Room	2016	3,300	28	10	28		56	47
48	Egress Exit Door - Employee Entrance	2016	2,900	24	20	24		48	48
49									49
50	2017 DISPOSAL	2017	(11,658)						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)		$ 24,412,890	$ 635,463		$ 635,463	$	$ 6,789,910	70

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 1,264,539	$ 133,275	$ 133,275	$	VARIOUS	$ 908,330	71
72	Current Year Purchases	12,703	4,020	4,020		VARIOUS	4,020	72
73	Fully Depreciated Assets	262,165					262,165	73
74								74
75	TOTALS	$ 1,539,407	$ 137,295	$ 137,295	$		$ 1,174,515	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 PG13 SUPP	See PG13 SUPP	See PG13 SUPP	$ 258,636	$ 5,216	$ 5,216	$	5-10	$ 238,641	76
77										77
78										78
79										79
80	TOTALS			$ 258,636	$ 5,216	$ 5,216	$		$ 238,641	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)	$ 26,464,476	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 777,974	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 777,974	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,203,066	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Champaign County Nursing Hom
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12/31/2017

VEHICLE DETAIL

AssetID	Description	Category	Acquired	NetAmount	Months	Current	YTD	TotalToDate
AUT0101	Acutator L211 Series Lifts	AUT	08/31/2001	537.00	60		0.00	537.00
AUT0201	1997 Ford Crown	AUT	09/12/2002	0.00	120	0.00	0.00	0.00
AUT0501	2005 Ford Eldorado Bus	AUT	09/09/2005	48,496.00	60		0.00	48,496.00
AUT0502	Transmission Repr 94 Ford Van	AUT	02/04/2005	2,483.72	36	2,032.40	0.00	2,483.72
AUT0901	Mini Van Paratransit With Ramp	AUT	04/30/2009	33,104.00	60		0.00	33,104.00
AUT0902	2009 FORD ELDORADO VAN	AUT	11/04/2009	51,576.44	60	0.00	0.00	51,576.44
AUT1101	2011 Ford Van	AUT	11/30/2011	52,160.00	120	434.67	5,216.04	32,165.58
AUT9603	Ford Bus 1996	AUT	06/01/1996	36,228.00	120		0.00	36,228.00
AUT9604	Ford Bus License & Title	AUT	06/01/1996	21.00	120		0.00	21.00
AUT9605	Ford Bus 1996 Sign	AUT	06/01/1996	164.00	120		0.00	164.00
AUT9606	Ford Bus 1996 Radio	AUT	06/01/1996	119.48	120		0.00	119.48
AUT9801	1998 Dodge 3500 Van	AUT	06/01/1998	33,426.00	120		0.00	33,426.00
AUT9802	Accessories 1998 Dodge Van	AUT	06/01/1998	320.00	120		0.00	320.00
				258,635.64			5,216.04	238,641.22

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 3,096 Description:
(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 & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	V10A	0.00	hrs	$ 0	3,465	$ 232,454	$ 0	3,465	$ 232,454	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	609	54,784	0	609	54,784	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	3,254	210,685	81	3,254	210,766	4
5	Physician Care			visits							5
6	Dental Care		1219	visits	37,924				1,219	37,924	6
7	Work Related Program			hrs							7
8	Habilitation	V39	4507	hrs	64,621	0	0	17,699	4,507	82,320	8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	226,895		226,895	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	23,405		23,405	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	26,686		26,686	13
14	TOTAL				$ 102,545	7,328	$ 497,923	$ 294,766	13,054	$ 895,234	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 Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 (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	$ 265,893	$ 265,893	1
2	Cash-Patient Deposits	15,830	15,830	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 946,310)	3,795,989	3,795,989	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	128,443	128,443	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See PG17 Supp	1,143,465	1,143,465	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,349,620	$ 5,349,620	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	23,473,120	14
15	Leasehold Improvements, at Historical Cost	1,083,202	1,083,202	15
16	Equipment, at Historical Cost	1,654,611	1,654,611	16
17	Accumulated Depreciation (book methods)	(8,203,066)	(8,203,066)	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)**	$ 18,007,867	$ 18,261,410	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 23,357,487	$ 23,611,030	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,008,200	$ 5,008,200	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,830	15,830	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	523,878	523,878	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,933	22,933	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)**	$ 5,570,841	$ 5,570,841	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	355,737	355,737	39
40	Mortgage Payable			40
41	Bonds Payable	2,265,000	2,265,000	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)**	$ 2,620,737	$ 2,620,737	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,191,578	$ 8,191,578	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 15,165,909	$ 15,419,452	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 23,357,487	$ 23,611,030	48

***(See instructions.)**

Champaign County Nursing Hom
0046664
12/31/2017

PG 17 Line 9 DETAIL

MCDACT	CLIENT_ACT	DESC	DEBIT	DESC
1070.10	8100011510	Interest Receivable	(9.57)	Other Receivables
1070.10	8100011520	Property Tax Revenue Receivable	269,881.61	Other Receivables
1070.10	8100013200	Due from Other Governmental Units	1,373,589.45	Other Receivables
1070.10	8100020730	Due to General Corporate Fund	(726,802.00)	Other Receivables
1070.10	8100020850	Due to Others (Non-Government)	3.68	Other Receivables
			916,663.17	
			226,802.00	*General Fund Loan Reclassified to Notes Payable*
			1,143,465.17	
			1,143,465.00	*PG17 line 9 balance*
			0.17	

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,517,153	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,517,153	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,355,627)	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) **PRIOR PERIOD ADJUSTMENT**	4,383	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,351,244)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	0	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 15,165,909	24 *

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

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 10,639,446	1
2	Discounts and Allowances for all Levels	(1,017,643)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,621,803	3
	B. Ancillary Revenue		
4	Day Care	193,883	4
5	Other Care for Outpatients		5
6	Therapy	1,043,615	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,237,498	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,945	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	115,330	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,302	19
20	Radiology and X-Ray	12,103	20
21	Other Medical Services	26,686	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 188,366	23
	D. Non-Operating Revenue		
24	Contributions	1,684	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,684	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL		28
28a	Misc Revenue	1,226,075	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,226,075	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,275,426	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,465,013	31
32	Health Care	5,584,389	32
33	General Administration	3,705,966	33
	B. Capital Expense		
34	Ownership	828,739	34
	C. Ancillary Expense		
35	Special Cost Centers	617,760	35
36	Provider Participation Fee	429,186	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,631,053	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,355,627)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,355,627)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,527,611	44
45	Private Pay - Net Inpatient Revenue	2,703,543	45
46	Medicare - Net Inpatient Revenue	1,124,549	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	1,283,742	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,017,643)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,621,803	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	912	912	$ 39,462	$ 43.27	1
2	Assistant Director of Nursing	1,694	2,155	71,296	33.08	2
3	Registered Nurses	12,301	14,388	453,536	31.52	3
4	Licensed Practical Nurses	38,833	50,103	1,304,712	26.04	4
5	CNAs & Orderlies	115,197	135,606	2,186,957	16.13	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	3,412	4,507	64,621	14.34	8
9	Activity Director	1,891	2,080	44,886	21.58	9
10	Activity Assistants	10,579	11,387	122,307	10.74	10
11	Social Service Workers	5,736	6,815	124,137	18.22	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	744	744	23,607	31.73	13
14	Head Cook	8,666	10,815	128,963	11.92	14
15	Cook Helpers/Assistants	24,697	29,638	323,542	10.92	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	6,282	7,301	125,651	17.21	17
18	Housekeepers	22,231	26,542	287,447	10.83	18
19	Laundry	7,887	9,295	102,016	10.98	19
20	Administrator	1,040	1,040	55,000	52.88	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	4,569	5,003	114,351	22.86	22
23	Office Manager	0	0	0		23
24	Clerical	9,404	10,569	128,202	12.13	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	1,265	1,360	30,546	22.46	29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,287	3,901	49,581	12.71	31
32	Other Health Care(specify)	9,582	11,153	205,230	18.40	32
33	Other(specify)	13,444	14,788	242,541	16.40	33
34	TOTAL (lines 1 - 33)	303,653	360,102	$ 6,228,591 *	$ 17.30	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	42,740	9	36
37	Medical Records Consultant	Monthly	2,277	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,143	10	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	1,505	11	44
45	Social Service Consultant	Monthly	6,168	12	45
46	Other(specify) RISK MGMT	Monthly	8,894	10	46
47	TRANSPORT	Monthly	12,509	10	47
48	MDS	Monthly	127,158	10	48
49	TOTAL (lines 35 - 48)		$ 205,394		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	971	$ 57,429	10	50
51	Licensed Practical Nurses	236	11,992	10	51
52	Certified Nurse Assistants/Aides	6,094	130,268	10	52
53	TOTAL (lines 50 - 52)	7,301	$ 199,689		53

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Colbrook	Administrator	0	$ 55,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,000

B. Administrative - Other

Description	Amount
MANAGEMENT PERFORMANCE ASSOCIATES, INC	$ 195,702
SAK MANAGEMENT	298,244
TOTAL (agree to Schedule V, line 17, col. 3)	$ 493,946
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE PG21-SUPP		$ 419,616
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 419,616

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,708
Unemployment Compensation Insurance	86,714
FICA Taxes	370,622
Employee Health Insurance	672,886
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	465,575
EMPLOYEE MORAL	352
LESS NON ALLOWABLE	(61,687)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,697,170

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
MISC DUES	360
LEADING AGE IL	26,643
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,003

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,303
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,303

* Attach copy of IMRF notifications

**See instructions.

Champaign County Nursing Hom
0046664
12/31/2017

PG 21 C DETAIL

SUMMARY BY VENDOR FOR PG21

VENDOR	SERVICE	AMOUNT	
ABILITY NETWORK INC	Computer Services	9,573.60	
ACCURATE BIOMETRICS	Figerprinting service	1,215.20	
CHAMPAIGN COUNTY TREASURER - Gen Corp	Accounting and General Services	71,887.04	
DANA PAYTON	Consulting	6,843.35	
FRONTLINE TECHNOLOGIES GROUP, LLC	Consulting	460.41	
GHR ENGINEERS & ASSOCIATE'S INC	Engineering	2,132.38	
HENNELLY, JACOB, QUINLAN & ASSOC.	Legal	7,000.00	
HEYL, ROYSTER, VOELKER, & ALLEN	Legal	59,551.90	
I3 BROADBAND	Computer Services	119.94	
ILLINOIS STATE POLICE - BUREAU OF	Figerprinting service	1,554.25	
KAY WALLIN BRONSTON	Consulting	1,408.00	
Mary Ann Royse Law Office	Legal	3,030.50	
MATRIXCARE	Computer Services	55,243.38	
MEADE, ROACH & ANNULIS, LLP	Legal	187.50	
NOFFKE, KAREN	Consulting	374.50	
OLIVER GROUP, THE	Predicitive Index	9,250.00	
PINNACLE CONSULTING	IT Consulting	3,266.00	
POLSINELLI PC	Legal	70,256.63	
PROVIDERTRUST, INC.	Healthcare Compliance	2,065.15	
RSM US LLP	Account	91,880.55	
SHER, LLP	Legal	11,272.50	
STRICKLIN & ASSOCIATES	Legal	3,333.30	
TAMMIE DENNING	Consulting	1,419.00	
TAYLOR, PIGUE, MARCHETTI & BLAIR, PLLC	Legal	397.50	
THE SPYGLASS GROUP	IT Consulting	1,932.96	
THOMPSON ELECTRONICS CO.	Computer Services	2,080.00	
TRIAD SHREDDING CORP	Paper Shredding Services	1,880.00	
		419,615.54	
		419,616.00	*PER PG 3*
		(0.46)	*ROUNDING*

Facility Name & ID Number Champaign County Nursing Hom # 0046664 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. **Leading Age $26,643**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **67,636** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **429,186**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **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. $ **733**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
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
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

PM STAFF - > COPY IN FROM TB FILE, IL MCD CR ENTRY TAB

PG 1 & 2

IDPH License ID Number:	0046664
Facility Name:	Champaign County Nursing Home
Street	500 S Art Bartell Dr
City	Urbana
Zip Code	61802.00
County	Champaign
Telephone Number:	217.384.3784
Fax #	217.337.0120
HFS ID Number:	0.00
Date of Initial License for Current Owners:	1943.00
VOLUNTARY,NON-PROFIT	
Charitable Corp.	
Trust	
IRS Exemption Code	
PROPRIETARY	
Individual	
Partnership	
Corporation	
"Sub-S" Corp.	
Limited Liability Co.	
Trust	
Other	
Other	
GOVERNMENTAL	x
State	
County	x
Other	
Other	
Name:	0.00
Telephone Number:	0.00
Email Address:	0.00
Beds at Beginning	
Skilled (SNF)	243.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Beds at End	
Skilled (SNF)	243.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Licensed Bed Days	
Skilled (SNF)	88695.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
MCD Census	
Skilled (SNF)	760.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	28808.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Private Pay Census	
Skilled (SNF)	81.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	11262.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
All Other Census	
Skilled (SNF)	3674.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	7113.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Medicare Days	2367.00

PG 3 & 4

A. General Services	Salary/Wage	Supplies	Other	Reclass	Adjustment
Dietary	476,113	34,541	6,922	-	(63)
Food Purchase	-	497,135	-	-	(753)
Housekeeping	287,447	40,571	-	-	(174)
Laundry	102,016	13,318	1,511	-	-
Heat and Other Utilities	-	-	595,034	-	(34,712)
Maintenance	125,651	243,013	8,348	-	(1,081)
Other (specify):*	-	-	33,393	-	-
TOTAL General Services					
B. Health Care and Programs					
Medical Director	0.00	0.00	42740.00	0.00	0.00
Nursing and Medical Records	4298925.00	########	156949.00	0.00	0.00
Therapy	0.00	81.00	497923.00	0.00	0.00
Activities	167193.00	4050.00	1505.00	0.00	0.00
Social Services	124137.00	0.00	6168.00	0.00	0.00
CNA Training	0.00	0.00	0.00	0.00	0.00
Program Transportation	42394.00	0.00	0.00	0.00	0.00
Other (specify):*	0.00	0.00	0.00	0.00	0.00
TOTAL Health Care and Programs					
C. General Administration					
Administrative	55000.00	0.00	493946.00	0.00	0.00
Directors Fees	0.00	0.00	0.00	0.00	0.00
Professional Services	0.00	0.00	419616.00	0.00	-84715.00
Dues, Fees, Subscriptions & Promotions	0.00	0.00	27003.00	0.00	0.00
Clerical & General Office Expenses	242552.00	61211.00	285647.00	0.00	########
Employee Benefits & Payroll Taxes	0.00	0.00	########	0.00	-61687.00
Inservice Training & Education	0.00	0.00	0.00	0.00	0.00
Travel and Seminar	0.00	0.00	3303.00	0.00	0.00
Other Admin. Staff Transportation	0.00	0.00	0.00	0.00	0.00
Insurance-Prop.Liab.Malpractice	0.00	0.00	274097.00	0.00	-14832.00
Other (specify):*	64917.00	0	19817	0	-84734
D. Ownership					
Depreciation	0.00	0.00	777974.00	0.00	-3344.00
Amortization of Pre-Op. & Org.	0.00	0	0	0	0
Interest	0.00	0	47669	0	0
Real Estate Taxes	0.00	0	0	0	0
Rent-Facility & Grounds	0.00	0	0	0	0
Rent-Equipment & Vehicles	0.00	0	3096	0	0
Other (specify):*	0.00	0	0	0	0
TOTAL Ownership					
Ancillary Expense					
E. Special Cost Centers					
Medically Necessary Transportation	0.00	0	0	0	0
Ancillary Service Centers	64621.00	26686	305923	0	0
Barber and Beauty Shops	47421.00	358	0	0	0
Coffee and Gift Shops	0.00	0	0	0	0
Provider Participation Fee	0.00	0	429186	0	0
Other (specify):*	130204.00	12517	30030	0	-172751

PG 5 & 5A

Day Care	-142781.06			
Other Care for Outpatients	0.00			
Governmental Sponsored Special Programs	0.00			
Non-Patient Meals	0.00			
Telephone, TV & Radio in Resident Rooms	-32154.17			
Rented Facility Space	0.00			
Sale of Supplies to Non-Patients	0.00			
Laundry for Non-Patients	0.00			
Non-Straightline Depreciation	0.00			
Interest and Other Investment Income	0.00			
Discounts, Allowances, Rebates & Refunds	0.00			
Non-Working Officer's or Owner's Salary	0.00			
Sales Tax	0.00			
Non-Care Related Interest	0.00			
Non-Care Related Owner's Transactions	0.00			
Personal Expenses (Including Transportatio	0.00			
Non-Care Related Fees	0.00			
Fines and Penalties	-46984.34			
Entertainment	0.00			
Contributions	0.00			
Owner or Key-Man Insurance	0.00			
Special Legal Fees & Legal Retainers	-78087.00	19		
Malpractice Insurance for Individuals	0.00			
Bad Debt	-222550.36			
Fund Raising, Advertising and Promotional	-84734.00			
Property Replacement Tax	0.00			
CNA Training for Non-Employees	0.00			
Yellow Page Advertising	0.00			
Other-Attach Schedule	-126568.00			
Non-Paid Workers-Attach Schedule*	0.00			
Donated Goods-Attach Schedule*	0.00			
Pre-Operating Expense	0.00			
Costs (Schedule VII)		VII-B		
Other- Attach Schedule	0.00			
PG5A Line 1	Independent Livi	0	43	
PG5A Line 2	Non-Allowable B	-61687	22	
PG5A Line 3	Lobbying Expen:	0		
PG5A Line 4	Adult Day Care -	-62.8252		1
PG5A Line 5	Adult Day Care -	-753.264		2
PG5A Line 6	Adult Day Care -	-174.409		3
PG5A Line 7	Adult Day Care -	-2557.97		5
PG5A Line 8	Adult Day Care -	-1080.57		6
PG5A Line 9	Adult Day Care -	-6627.59		19
PG5A Line 10	Adult Day Care -	-5478.42		21
PG5A Line 11	Adult Day Care -	0		25
PG5A Line 12	Adult Day Care -	-10671.3		26
PG5A Line 13	Adult Day Care -	-4160.65		26
PG5A Line 14	Adult Day Care -	-3344		30
PG5A Line 15	OTHER NON RE	-29970		43
PG5A Line 16		0		
PG5A Line 17		0		
PG5A Line 18		0		
PG5A Line 19		0		
PG5A Line 20		0		
PG5A Line 21		0		
PG5A Line 22		0		
PG5A Line 23		0		
PG5A Line 24		0		
PG5A Line 25		0		
PG5A Line 26		0		
PG5A Line 27		0		
PG5A Line 28		0		
PG5A Line 29		0		
PG5A Line 30		0		
PG5A Line 31		0		
PG5A Line 32		0		
PG5A Line 33		0		
PG5A Line 34		0		
PG5A Line 35		0		
PG5A Line 36		0		
PG5A Line 37		0		
PG5A Line 38		0		
PG5A Line 39		0		
PG5A Line 40		0		
PG5A Line 41		0		
PG5A Line 42		0		
PG5A Line 43		0		
PG5A Line 44		0		
PG5A Line 45		0		
PG5A Line 46		0		
PG5A Line 47		0		
PG5A Line 48		0		

PG 16

Licensed Occupational Therapist	V10A
Licensed Occupational Therapist	0.00
Licensed Occupational Therapist	0.00
Licensed Occupational Therapist	3465.00
Licensed Occupational Therapist	232455.00
Licensed Occupational Therapist	0.00
Licensed Speech and Language	V10A
Licensed Speech and Language	0.00
Licensed Speech and Language	0.00
Licensed Speech and Language	609.00
Licensed Speech and Language	54784.00
Licensed Speech and Language	0.00
Licensed Recreational Therapist	V10A
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Physical Therapist	V10A
Licensed Physical Therapist	0.00
Licensed Physical Therapist	0.00
Licensed Physical Therapist	3254.00
Licensed Physical Therapist	210685.00
Licensed Physical Therapist	81.00
Habilitation	V39
Habilitation	4506.50
Habilitation	64621.00
Habilitation	0.00
Habilitation	0.00
Habilitation	17699.00
Pharmacy	V39
Pharmacy	0.00
Pharmacy	0.00
Pharmacy	0.00
Pharmacy	0.00
Pharmacy	226895.00
LAB/RADIOLOGY	V39
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	23405.00
BILLABLE SUPPLIES/IV THERAPY/ETC	V39
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	26686.00

PG 17

Cash on Hand and in Banks	265893.00
Cash-Patient Deposits	15830.00
Accounts & Short-Term Notes Receivable-	3795989.00
Patients (less allowance	946309.93
Supply Inventory (priced at	0.00
Short-Term Investments	0.00
Prepaid Insurance	0.00
Other Prepaid Expenses	128443.00
Accounts Receivable (owners or related par	0.00
Other(specify):	1143465.00
Long-Term Notes Receivable	0.00
Long-Term Investments	0.00
Land	0.00
Buildings, at Historical Cost	23473120.00
Leasehold Improvements, at Historical Cost	1083202.00
Equipment, at Historical Cost	1654611.00
Accumulated Depreciation (book methods)	-8203066.00
Deferred Charges	0.00
Organization & Pre-Operating Costs	0.00
Accumulated Amortization - Organization &	0.00
Restricted Funds	0.00
Other Long-Term Assets (specify):	0.00
Other(specify):	0.00
Accounts Payable	5008200.00
Officer's Accounts Payable	0.00
Accounts Payable-Patient Deposits	15830.00
Short-Term Notes Payable	0.00
Accrued Salaries Payable	523878.00
Accrued Taxes Payable	0.00
Accrued Real Estate Taxes(Sch.IX-B)	0.00
Accrued Interest Payable	22933.00
Deferred Compensation	0.00
Federal and State Income Taxes	0.00
Other 1	0.00
Other 2	0.00
Long-Term Notes Payable	355737.00
Mortgage Payable	0.00
Bonds Payable	2265000.00
Deferred Compensation	0.00
Other 1	0.00
Other 2	0.00

PG 18

Balance at Beginning of Year, as Previously	16517153.00	
Restatement 1	0.00	0
Restatement 2	0.00	0
Restatement 3	0.00	0
A. Additions (deductions):		
Aquisitions of Pooled Companies	0.00	
Proceeds from Sale of Stock	0.00	
Stock Options Exercised	0.00	
Contributions and Grants	0.00	
Expenditures for Specific Purposes	0.00	
Dividends Paid or Other Distributions to Ow	0.00	
Donated Property, Plant, and Equipment	0.00	
Other (describe)	4386.00	PRIOR PERIOD ADJUSTMENT
Other (describe)	0.00	0
B. Transfers (Itemize):		
Transfer1	0.02	ILU net asset activity for the year
Transfer2	0.00	0
Transfer3	0.00	0
Transfer4	0.00	0
Transfer5	0.00	0

PG 19			
Gross Revenue -- All Levels of Care	10639446.00		
Discounts and Allowances for all Levels	-1017643.00		
Day Care	193883.00		
Other Care for Outpatients	0.00		
Therapy	1043615.00		
Oxygen	0.00		
Payments for Education	0.00		
Other Government Grants	0.00		
CNA Training Reimbursements	0.00		
Gift and Coffee Shop	0.00		
Barber and Beauty Care	22945.00		
Non-Patient Meals	0.00		
Telephone, Television and Radio	0.00		
Rental of Facility Space	0.00		
Sale of Drugs	115330.00		
Sale of Supplies to Non-Patients	0.00		
Laboratory	11302.00		
Radiology and X-Ray	12103.00		
Other Medical Services	26686.00		
Laundry	0.00		
Contributions	1684.00		
Interest and Other Investment Income***	0.00		
Settlement Income (Insurance, Legal, Etc.)	0.00		
OTHER1	0.00	AL/IL	
OTHER2	1226075.00	Misc Revenue	
General Services	2465013.00		
Health Care	5584389.00		
General Administration	3705966.00		
Ownership	828739.00		
Special Cost Centers	617760.00		
Provider Participation Fee	429186.00		
OTHER1	0.00	0	
OTHER2	0.00	0	
OTHER3	0.00	0	
Income Taxes	0.00		
Medicaid - Net Inpatient Revenue	5527611.39		
Private Pay - Net Inpatient Revenue	2703543.36		
Medicare - Net Inpatient Revenue	1124549.31		
Other-(specify)	1283741.62	ALL OTHER SNF/SCF IP REVENUE	
Other-(specify)	-1017643.00	C/A ANCILLARY ACCOUNTS	
PG 20	**Worked**	**Accrued**	**Wages**
Director of Nursing	912.00	912	39462
Assistant Director of Nursing	1694.00	2155	71296
Registered Nurses	12301.00	14388	453536
Licensed Practical Nurses	38833.00	50103	1304712
CNAs & Orderlies	115197.00	135606	2186957
CNA Trainees	0.00	0.00	0.00
Licensed Therapist	0.00	0.00	0.00
Rehab/Therapy Aides	3412.00	4507.00	64621.00
Activity Director	1891.00	2080	44886
Activity Assistants	10579.00	11387	122307
Social Service Workers	5736.00	6815	124137
Dietician	0.00	0.00	0.00
Food Service Supervisor	744.00	744	23607
Head Cook	8666.00	10815	128963
Cook Helpers/Assistants	24697.00	29638	323542
Dishwashers	0.00	0.00	0.00
Maintenance Workers	6282.00	7301	125651
Housekeepers	22231.00	26542	287447
Laundry	7887.00	9295	102016
Administrator	1040.00	1040	55000
Assistant Administrator	0.00	0	0
Other Administrative	4569.00	5003.00	114351.00
Office Manager	0.00	0.00	0.00
Clerical	9404.00	10569	128202
Vocational Instruction	0.00	0.00	0.00
Academic Instruction	0.00	0.00	0.00
Medical Director	0.00	0.00	0.00
Qualified MR Prof. (QMRP)	0.00	0.00	0.00
Resident Services Coordinator	1265.00	1360.00	30546.00
Habilitation Aides (DD Homes)	0.00	0.00	0.00
Medical Records	3287.00	3901	49581
Other Health Care(specify)	9582.00	11153.00	205230.00
Other(specify)	13444.00	14788	242542