FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046664

Facility Name: Champaign County Nursing 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 01/01/18 to 03/31/19 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 Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	110,565	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	110,565	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	1,294		3,089	4,383	8
9	SNF/PED					9
10	ICF	40,939	8,302	9,225	58,466	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,233	8,302	12,314	62,849	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.84%

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 [ ] 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 243 and days of care provided 2,300

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: 3/31/2019 Fiscal Year: 3/31/2019

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

Facility Name: **Champaign County Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **3/31/2019**

Schedule 2A

III. Statistical Data
Bed Days Computation

Licensure Level of Care	# of Beds	Start Date	End Date	# of Days	Bed Days Available
Skilled (SNF)	243	1/1/18	3/31/19	455	110,565
Skilled (SNF)					-
			Total - Line 1, Column 4		110,565

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	874,262	123,087	24,005	1,021,354		1,021,354	-	1,021,354			1
2	Food Purchase		490,413		490,413		490,413	(16,775)	473,638			2
3	Housekeeping	456,183	41,909	100	498,192		498,192	(181)	498,011			3
4	Laundry	74,714	25,096	-	99,810		99,810	-	99,810			4
5	Heat and Other Utilities			520,265	520,265		520,265	(2,237)	518,028			5
6	Maintenance	65,605	13,859	300,135	379,599		379,599	(39,832)	339,767			6
7	Other (specify):*	-	-	-				-				7
8	TOTAL General Services	1,470,764	694,364	844,505	3,009,633		3,009,633	(59,025)	2,950,608			8
	B. Health Care and Programs											
9	Medical Director	-	-	30,915	30,915		30,915	-	30,915			9
10	Nursing and Medical Records	5,079,383	294,185	506,073	5,879,641		5,879,641	-	5,879,641			10
10a	Therapy	-	-	-				-				10a
11	Activities	188,983	2,615	(99)	191,499		191,499	-	191,499			11
12	Social Services	245,160	-	8,514	253,674		253,674	-	253,674			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):* Adult Day Care	165,519	18,708	53,499	237,726		237,726	(237,726)				15
16	TOTAL Health Care and Programs	5,679,045	315,508	598,902	6,593,455		6,593,455	(237,726)	6,355,729			16
	C. General Administration											
17	Administrative	195,679	-	791,991	987,670		987,670	-	987,670			17
18	Directors Fees			-				-				18
19	Professional Services			540,702	540,702		540,702	46,183	586,885			19
20	Dues, Fees, Subscriptions & Promotions			21,126	21,126		21,126	(12,030)	9,096			20
21	Clerical & General Office Expenses	338,097	19,738	47,030	404,865		404,865	(291)	404,574			21
22	Employee Benefits & Payroll Taxes			1,751,613	1,751,613		1,751,613	-	1,751,613			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			1,156	1,156		1,156	-	1,156			24
25	Other Admin. Staff Transportation		-	15,706	15,706		15,706	(68)	15,638			25
26	Insurance-Prop.Liab.Malpractice			345,164	345,164		345,164	(12,175)	332,989			26
27	Other (specify):*	-	-	-				-				27
28	TOTAL General Administration	533,776	19,738	3,514,488	4,068,002		4,068,002	21,619	4,089,621			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,683,585	1,029,610	4,957,895	13,671,090		13,671,090	(275,132)	13,395,958			29

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

Facility Name & ID Number Champaign County Nursing Home #0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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			966,432	966,432		966,432	3,829	970,261			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			60,644	60,644		60,644	(1,957)	58,687			32
33	Real Estate Taxes			-				-				33
34	Rent-Facility & Grounds			-				-				34
35	Rent-Equipment & Vehicles			94,006	94,006		94,006	-	94,006			35
36	Other (specify):*			-				-				36
37	TOTAL Ownership			1,121,082	1,121,082		1,121,082	1,872	1,122,954			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	55,407	130,513	649,069	834,989		834,989	-	834,989			39
40	Barber and Beauty Shops	26,824	737	-	27,561		27,561	-	27,561			40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			762,433	762,433		762,433	-	762,433			42
43	Other (specify):* Non-Allowable Cos	54,857	-	4,507,464	4,562,321		4,562,321	(4,562,321)				43
44	TOTAL Special Cost Centers	137,088	131,250	5,918,966	6,187,304		6,187,304	(4,562,321)	1,624,983			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,820,673	1,160,860	11,997,943	20,979,476		20,979,476	(4,835,581)	16,143,895			45

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	$ (237,726)	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	(40,795)	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	7,984	30		9
10	Interest and Other Investment Income	(1,957)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(57,312)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	48,539	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,293,659)	43		24
25	Fund Raising, Advertising and Promotional	(2,716)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(12,030)	20		28
29	Other-Attach Schedule See PG5A	(207,173)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,796,845)		$	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)	(38,736)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (38,736)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,835,581)		37

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

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

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

Champaign County Nursing Home

ID# 0046664

Report Period Beginning: 01/01/18

Ending: 03/31/19

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset meal revenue against food cost	$ (852)	2	1
2	Laboratory Costs	(9,914)	43	2
3	Medicare ancillary expense	(77,830)	43	3
4	Financial Charges	(25,238)	43	4
5	Marketing Wages	(54,857)	43	5
6	Capitalize repairs & maintence	(38,482)	6	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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**	(207,173)		49

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 3,674	Champaign County Day Care Cost		$	$ (3,674)	15
16	V	2	Food	12,249	Champaign County Day Care Cost			(12,249)	16
17	V	3	Housekeeping	181	Champaign County Day Care Cost			(181)	17
18	V	5	Utilities	2,237	Champaign County Day Care Cost			(2,237)	18
19	V	6	Maintenance	1,350	Champaign County Day Care Cost			(1,350)	19
20	V	19	Professional Fees	2,356	Champaign County Day Care Cost			(2,356)	20
21	V	21	Office Expense	291	Champaign County Day Care Cost			(291)	21
22	V	25	Staff Transportation	68	Champaign County Day Care Cost			(68)	22
23	V	26	Insurance - Auto	10,671	Champaign County Day Care Cost			(10,671)	23
24	V	26	Insurance - Other	1,504	Champaign County Day Care Cost			(1,504)	24
25	V	30	Depreciation - Other	4,155	Champaign County Day Care Cost			(4,155)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,736			$ 0	$ * (38,736)	39

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Board of Directors Listing								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	193,377	193,377	$ 147,092	$	4,830	$ 3,674	1
2	2	Food	Meals	193,377	193,377	490,413		4,830	12,249	2
3	3	Housekeeping	Square Feet	67,925	67,925	42,009		292	181	3
4	5	Utilities	Square Feet	67,925	67,925	520,265		292	2,237	4
5	6	Maintenance	Square Feet	67,925	67,925	313,994		292	1,350	5
6	19	Professional Fees	Revenue	14,800,787	14,800,787	540,702		64,482	2,356	6
7	21	Office Expense	Revenue	14,800,787	14,800,787	66,768		64,482	291	7
8	25	Staff Transportation	Revenue	14,800,787	14,800,787	15,706		64,482	68	8
9	26	Insurance - Auto	Direct	1	1	10,671		1	10,671	9
10	26	Insurance - Other	Revenue	14,800,787	14,800,787	345,164		64,482	1,504	10
11	30	Depreciation - Other	Square Feet	67,925	67,925	966,432		292	4,155	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					$ 3,459,216	$		$ 38,736	25

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Interest - Bonds Payable		X	Construction	Varies	6/30/2006	$ 4,000,000	$ 2,265,000	6/30/2026	Varies	$ 49,805	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	128,898	9/29/18	Varies	10,839	6
7	Champaign County	X		General Fund Loan	Varies	9/27/16	282,802	1,752,802	9/21/18	Varies		7
8												8
9	TOTAL Facility Related						$ 5,304,559	$ 4,146,700			$ 60,644	9
	B. Non-Facility Related*											
10												10
11								Disallow nonallowable interest expense			(1,957)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,957)	14
15	TOTALS (line 9+line14)						$ 5,304,559	$ 4,146,700			$ 58,687	15

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

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

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

County nursing home exempt from real estate tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0046664

CONTACT PERSON REGARDING THIS REPORT Darleke Kloeppel

TELEPHONE (217) 384-3776 FAX #: (217) 384-3896

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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 Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	$ 722,160	40	$ 722,160	$	$ 7,129,554	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	New NH parking lot		2007	2007	189,924	-	8	-		189,924	9
10	Masonry sign		2008	2008	16,741	838	25	838		7,256	10
11	Smoke Barriers		2010	2010	89,879	3,036	37	3,036		22,266	11
12	Smoke Barriers		2011	2011	3,900	138	35.5	138		843	12
13	Boiler Repair		2011	2011	4,990		2			4,990	13
14											14
15	Boiler Upgrades-Basement		2012	2012	21,339	1,334	20	1,334		7,291	15
16	Fulton Boiler Controller-Basement		2012	2012	7,309		5			7,309	16
17	External Storage Unit		2012	2012	6,217		5			6,217	17
18	Basement Water Leak Repair		2012	2012	4,441	555	10	555		3,034	18
19	Basement Heat Trace Repair		2012	2012	2,992	375	10	375		2,049	19
20	Emergency Generator Repair		2012	2012	3,040	380	10	380		2,077	20
21											21
22	Additional Fulton Boiler Work		2013	2013	10,700	1,249	5	1,249		10,700	22
23	Water Heater Replacement		2013	2013	28,445	3,556	10	3,556		17,069	23
24	Chiller Phase Sequencers and installation		2013	2013	9,968	1,246	10	1,246		5,774	24
25	Water Mixing Valves		2013	2013	8,761	1,095	10	1,095		4,745	25
26											26
27	Fulton Pulse Boiler Repair - Mechanical Room		2014	2014	7,220	1,564	5	1,564		7,220	27
28	Heat Exchanger - Roof		2014	2014	2,547	553	5	553		2,547	28
29	Air Handler Coil - Mechanical Room		2014	2014	7,938	1,985	5	1,985		7,675	29
30											30
31	Bathroom Remodel - Unit 3 - ADA Compliant, Flooring, Fixt		2015	2015	2,948	369	10	369		1,106	31
32	ADC Flooring - Replaced tile flooring with hardwood		2015	2015	7,485	1,871	5	1,871		6,113	32
33	EMAR Installation - Facility wide		2015	2015	27,614	6,904	5	6,904		19,330	33
34	Emar Wiring - Facility Wide		2015	2015	10,669	2,668	5	2,668		7,825	34
35	4 new Hot Water Heaters - Basement Mechanical Room		2015	2015	102,692	12,836	10	12,836		39,365	35
36						-		-			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	$ 4,219	5	$ 4,219	$	$ 11,812	37
38	Water Heater Repairs - Basement Mechanical Room	2015	4,119	515	10	515		1,819	38
39									39
40	Fire Dampers - Basement Mechanical Room	2016	98,080	6,130	20	6,130		15,938	40
41	Lint Filtration System - Courtyard	2016	172,263	8,374	15	8,374		21,772	41
42	Install/Repair Doors - Throughout Building	2016	4,080	106	20	106		276	42
43	Door Closers - Throughout Builidng	2016	4,950	258	10	258		670	43
44	RTU Unit - Kitchen Area	2016	15,930	443	15	443		1,151	44
45	Nurse Call System Repair - Throughout Building	2016	4,945	258	10	258		670	45
46	Boiler Project - Basement Mechanical Room	2016	292,156	4,565	20	4,565		11,869	46
47	Water Heater Repair - Basement Mechanical Room	2016	3,300	35	10	35		91	47
48	Egress Exit Door - Emplovee Entrance	2016	2,900	30	20	30		78	48
49				-		-			49
50	2017 DISPOSAL	2017	(11,658)	-		-			50
51				-		-			51
52	Redistribute emergency power to panel - Mechanical Room	2018	12,865	-	20	402	402	402	52
53	Replace 2 Sewage Pumps - Mechanical Room	2018	3,416		10	214	214	214	53
54				-		-			54
55	Repair Cooler & Install Shelving - Kitchen	2019	9,951	-	20	311	311	311	55
56	Install Drain Lines - Kitchen	2019	2,632	-	20	82	82	82	56
57	Strip, Clean, Buff Tile Floor - Kitchen	2019	4,868	-	10	304	304	304	57
58	Install Grout - Kitchen	2019	4,750	-	10	297	297	297	58
59				-		-			59
60				-		-			60
61				-		-			61
62				-		-			62
63				-		-			63
64				-		-			64
65				-		-			65
66				-		-			66
67	To adjust to book depreciation			(6,374)		-	6,374		67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		$ 24,451,372	$ 783,268		$ 791,252	$ 7,984	$ 7,580,035	70

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	$ 1,277,243	$ 176,644	$ 176,644	$ -	Various	$ 1,088,991	71
72	Current Year Purchases				-	Various		72
73	Fully Depreciated Assets	262,165			-		262,165	73
74	Disallowed Day Care Depreciation			(4,155)	(4,155)			74
75	TOTALS	$ 1,539,408	$ 176,644	$ 172,489	$ (4,155)		$ 1,351,156	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	$ 258,635	$ 6,520	$ 6,520	$ -	5-10	$ 245,160	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ 258,635	$ 6,520	$ 6,520	$		$ 245,160	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)	$	26,502,958	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	966,432	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	970,261	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	3,829	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	9,176,351	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name: **Champaign County Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **03/31/19**

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	Actuator L211 Series Lifts	2001	537				5	537
Resident Use	05 Ford Eldorado Bus	2005	48,496					48,496
Resident Use	Transmission Repair 94 Ford Van	2005	2,484					2,484
Resident Use	96 Ford Bus	1996	36,532			-	10	36,532
Resident Use	98 Dodge Van	1998	33,746			-	10	33,746
Resident Use	Mini van with 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	6,520	6,520	-	10	38,685
						-		
TOTAL			**258,635**	**6,520**	**6,520**	**-**		**245,160**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 94,006 Description: See Sch 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ 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 Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **03/31/19**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Trash Compactor	3,870
Construction Vehicles	59
Dishwasher	6,124
Therapy	19,500
Medical Equipment	49,353
Mattresses	4,397
Respiratory Equipment	10,703
Total - Line 16	**94,006**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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

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

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

It is the policy of this facility to only hire certified nurses aides.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	39(3)		hrs	$	3,346	$ 250,927	$	3,346	$ 250,927	1
2	Licensed Speech and Language Development Therapist	39(3)		hrs		896	67,186		896	67,186	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(2),(3)		hrs		4,098	307,340	15	4,098	307,355	4
5	Physician Care			visits							5
6	Dental Care	39(1)	2108	visits	55,407				2,108	55,407	6
7	Work Related Program			hrs							7
8	Habilitation	39(3)		hrs		315	23,616		315	23,616	8
9	Pharmacy	39(2)		# of prescrpts				108,163		108,163	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Oxygen	39(2)						22,335		22,335	12
13	Other (specify):										13
14	TOTAL				$ 55,407	8,655	$ 649,069	$ 130,513	10,763	$ 834,989	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 Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 03/31/19 (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	$ 110,135	$ 110,135	1
2	Cash-Patient Deposits	32,250	32,250	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,064,581)	546,563	546,563	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(197,707)	(197,707)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See PG17 Supp	2,525,208	2,525,208	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,016,449	$ 3,016,449	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	1,101,947	1,224,178	15
16	Equipment, at Historical Cost	1,654,611	1,798,043	16
17	Accumulated Depreciation (book methods)	(8,750,016)	(9,176,351)	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)**	$ 17,479,662	$ 17,326,607	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 20,496,111	$ 20,343,056	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,773,036	$ 4,773,036	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,250	32,250	28
29	Short-Term Notes Payable	1,881,700	1,881,700	29
30	Accrued Salaries Payable	541,822	541,822	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	58,508	58,508	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)**	$ 7,287,316	$ 7,287,316	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$ 2,265,000	$ 2,265,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,552,316	$ 9,552,316	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,943,795	$ 10,790,740	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 20,496,111	$ 20,343,056	48

*(See instructions.)

Facility Name: **Champaign County Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **03/31/19**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

	Description	Operating	After Consolidation
8100011510	Interest Receivable	(23)	(23)
8100013200	Due from Other Governmental Units	2,626,577	2,626,577
8100013230	Due from IL Public Aid	(505,846)	(505,846)
8100013231	Due from IL Department of Aging-Title XX	83,725	83,725
8100013232	Due from US Treasury-Medicare	294,244	294,244
8100013235	Due From VA-Adult Daycare	8,493	8,493
8100013236	Due From VA-Nursing Home Care	17,796	17,796
8100017200	Revenues	22	22
8100020710	Due To Accounts Payable Fund	216	216
8100020850	Due to Others (Non-Government)	4	4
	Total - Line 9	**2,525,208**	**2,525,208**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 15,165,909	1
2	Restatements (describe):		2
3	Prior Period Adjustment	1,956,575	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,122,484	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,178,689)	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		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (6,178,689)	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)**	$ 10,943,795	24 *

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,138,853	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,138,853	3
	B. Ancillary Revenue		
4	Day Care	64,482	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 64,482	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	65,234	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,922	13
14	Non-Patient Meals	852	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	18,179	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 102,187	23
	D. Non-Operating Revenue		
24	Contributions	586	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 586	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	AL/IL	1,494,679	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,494,679	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,800,787	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,009,633	31
32	Health Care	6,593,455	32
33	General Administration	4,068,002	33
	B. Capital Expense		
34	Ownership	1,121,082	34
	C. Ancillary Expense		
35	Special Cost Centers	5,424,871	35
36	Provider Participation Fee	762,433	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,979,476	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,178,689)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,178,689)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,644,964	44
45	Private Pay - Net Inpatient Revenue	3,850,571	45
46	Medicare - Net Inpatient Revenue	1,380,958	46
47	Other-(specify) VA Veteran's Care	79,256	47
48	Other-(specify) Hospice and HMO	1,183,104	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,138,853	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.**

^ Entity is a cash basis taxpayer

Facility Name: **Champaign County Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **03/31/19**

Schedule 19A

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

	Description	Amount
8141031132	Current-Nursing Home Operating	1,477,910
8141034535	Patient Transportation Charges	13,011
8141036912	Vending Machine Revenue	1,801
8141036942	Miscellaneous Revenue- Worker's Compensation Reim	-
8141036990	Other Miscellaneous Revenue	1,957
	Total - Line 28	**1,494,679**

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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	2,749	3,020	$ 131,877	$ 43.67	1
2	Assistant Director of Nursing	2,726	3,515	122,100	34.74	2
3	Registered Nurses	24,748	27,043	822,705	30.42	3
4	Licensed Practical Nurses	46,055	51,054	1,368,568	26.81	4
5	CNAs & Orderlies	152,597	160,242	2,417,187	15.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,421	2,646	57,685	21.80	9
10	Activity Assistants	11,727	13,262	131,298	9.90	10
11	Social Service Workers	9,472	12,095	245,160	20.27	11
12	Dietician					12
13	Food Service Supervisor	4,478	5,117	100,660	19.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	58,068	63,712	773,602	12.14	15
16	Dishwashers					16
17	Maintenance Workers	4,183	4,641	65,605	14.14	17
18	Housekeepers	35,023	40,844	456,183	11.17	18
19	Laundry	5,056	7,003	74,714	10.67	19
20	Administrator	2,645	2,824	142,677	50.52	20
21	Assistant Administrator	1,465	1,575	53,002	33.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,746	17,371	338,097	19.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,517	2,773	43,374	15.64	31
32	Other Health Ca Adult Day Care	10,500	11,958	165,519	13.84	32
33	Other(specify) See Sch 20A	11,010	13,329	310,660	23.31	33
34	TOTAL (lines 1 - 33)	403,186	444,024	$ 7,820,673 *	$ 17.61	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 24,005	1(3)	35
36	Medical Director	Monthly	30,915	9(3)	36
37	Medical Records Consultant	Monthly	4,104	10(3)	37
38	Nurse Consultant	Monthly	610	10(3)	38
39	Pharmacist Consultant	Monthly	9,391	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	(99)	11(3)	44
45	Social Service Consultant	Monthly	8,514	12(3)	45
46	Other(specify)				46
47	TRANSPORT	Monthly	17,615	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 95,055		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,400	$ 319,395	10	50
51	Licensed Practical Nurses	1,796	91,256	10	51
52	Certified Nurse Assistants/Aides	2,134	45,628	10	52
53	TOTAL (lines 50 - 52)	9,330	$ 456,279		53

Facility Name: **Champaign County Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **03/31/19**

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	1,598	2,045	26,824	$ 13.12
Unit Secretary	1,366	1,709	19,092	$ 11.17
Dental Hygentist	1,328	2,103	55,407	$ 26.35
Care Plan Coordinator	4,524	5,068	154,480	$ 30.48
Marketing/Admissions	2,194	2,404	54,857	$ 22.82
Total - Line 33 Other (specify):	**11,010**	**13,329**	**310,660**	

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Colbrook	Administrator	0	$ 23,155
Gina Miller	Administrator	0	118,609
Edna Scofield	Administrator	0	913
Robin LeMasters	Ass't Administrator	0	53,002
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 195,679

B. Administrative - Other

Description	Amount
SAK MANAGEMENT	$ 761,773
Interim Administrator Travel Expenses	30,218
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 791,991

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C		$ 540,702
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 540,702

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 197,903
Unemployment Compensation Insurance	33,742
FICA Taxes	521,807
Employee Health Insurance	667,568
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	483,746
EMPLOYEE LABS & PHYSICALS	22,906
TOPS	(176,059)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,751,613

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,555
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 89)	2,759
Patient Background Checks	
MISC DUES	934
YELLOW PAGE ADVERTISING	12,030
MISC PUBLICATIONS	(152)
Less: Public Relations Expense	( )
Non-allowable advertising	(12,030)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,096

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,156
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,156

**See instructions.

Facility Name: **Champaign County Nursing Home**
IDPH License ID Number: **0046664**
Fiscal Year End: **03/31/19**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
CHAPMAN AND CUTLER LLP	Legal	3,400
HENNELLY, JACOB, QUINLAN & ASS	Legal	2,000
HEYL, ROYSTER, VOELKER, & ALLE	Legal	(50,327)
Mary Ann Royse Law Office	Legal	333
MEYER CAPEL	Legal	360
POLSINELLI PC	Legal	242,730
Champaign County Treasurer	Accounting	44,136
RSM US LLP	Accounting	57,858
PLANTE MORAN, LLC	Accounting	8,600
PROVIDERTRUST, INC.	Healthcare Compliance	5,301
PINNACLE CONSULTING	IT Consulting	-
AFSCME COUNCIL 31	Union Services	25
TRIAD SHREDDING CORP	Paper Shredding Services	2,588
OLIVER GROUP, THE	Predicitive Index	4,625
KAY WALLIN BRONSTON	Resident Transportation	(1,408)
QUALITY HEALTHCARE	Billing	3,577
TAMMIE DENNING	Nursing Support	3,345
MOGEL, LLC	Recruiting	8,000
MANPOWER	Temp Service	3,214
ELSBO	Laundry Consulting	471
Healthdirect	Pharmacy Consulting	14
FRONTLINE TECHNOLOGIES GROUP	Consulting	227
Illinois Department of Public Health	Permit Renewal	1,000
ILLINI DOCUMENT SERVICES	Contract Printing	295
ABILITY NETWORK INC	Computer Services	16,251
MATRIXCARE	Computer Services	83,849
County IT Services	Computer Services	98,107
Healthdirect	Computer Services	3,562
I3 Broadband	Computer Services	650
Thompson Electronics	Computer Services	(2,080)
Total (agree to Schedule V, line 19, column 3)		540,702
Less: Indirect ADC Costs		(2,356)
Less: Non-Allowable Legal Fees		48,539
Total (agree to Schedule V, line 19, column 8)		586,885

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 01/01/18 Ending: 03/31/19

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **81,893** 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 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. $ **762,433**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes, See Pg 8** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **852**

(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? **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.