FOR BHF USE

LL1

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: 0052217

Facility Name: Champaign Urbana Nursing and Rehab, LP

Address: 302 Burwash Avenue (Number) Savoy (City) 61874 (Zip Code)

County: Champaign

Telephone Number: (217) 402-9700 **Fax #** (217) 402-9750

HFS ID Number:

Date of Initial License for Current Owners: 41275

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/2018 to 12/31/2018 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	213	Skilled (SNF)	213	77,745	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	213	TOTALS	213	77,745	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			10,503	10,503	8
9	SNF/PED					9
10	ICF	28,113	3,463		31,576	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,113	3,463	10,503	42,079	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.12%

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)
None

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 [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 213 and days of care provided 7,130

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	361,490	18,538	33,151	413,179		413,179		413,179			1
2	Food Purchase		296,645		296,645		296,645	(1,837)	294,808			2
3	Housekeeping	214,781	31,369		246,150		246,150		246,150			3
4	Laundry	86,377	23,334		109,711		109,711		109,711			4
5	Heat and Other Utilities			207,308	207,308		207,308	648	207,956			5
6	Maintenance	79,758		139,543	219,301		219,301	(6,977)	212,324			6
7	Other (specify):* Waste Removal			23,959	23,959		23,959		23,959			7
8	**TOTAL General Services**	742,406	369,886	403,961	1,516,253		1,516,253	(8,166)	1,508,087			8
	B. Health Care and Programs											
9	Medical Director			59,500	59,500		59,500		59,500			9
10	Nursing and Medical Records	3,330,420	360,687	131,683	3,822,790		3,822,790	44,756	3,867,546			10
10a	Therapy	145,322	4,194	54,652	204,168		204,168		204,168			10a
11	Activities	97,813		8,377	106,190		106,190		106,190			11
12	Social Services	133,859		4,047	137,906		137,906		137,906			12
13	CNA Training											13
14	Program Transportation			11,694	11,694		11,694		11,694			14
15	Other (specify):* Mgmt Co Benefits Alloc							11,198	11,198			15
16	**TOTAL Health Care and Programs**	3,707,414	364,881	269,953	4,342,248		4,342,248	55,954	4,398,202			16
	C. General Administration											
17	Administrative	142,353			142,353		142,353	44,747	187,100			17
18	Directors Fees											18
19	Professional Services			411,364	411,364		411,364	6,495	417,859			19
20	Dues, Fees, Subscriptions & Promotions			31,146	31,146		31,146	784	31,930			20
21	Clerical & General Office Expenses	354,082	47,925	97,473	499,480		499,480	123,857	623,337			21
22	Employee Benefits & Payroll Taxes			740,952	740,952		740,952		740,952			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,522	8,522		8,522	57	8,579			24
25	Other Admin. Staff Transportation			47,331	47,331		47,331	(2,396)	44,935			25
26	Insurance-Prop.Liab.Malpractice			282,444	282,444		282,444		282,444			26
27	Other (specify):* Mgmt Co Benefits Alloc							34,870	34,870			27
28	**TOTAL General Administration**	496,435	47,925	1,619,232	2,163,592		2,163,592	208,414	2,372,006			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,946,255	782,692	2,293,146	8,022,093		8,022,093	256,202	8,278,295			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Urbana Nursing and Rehab, LP #0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			114,800	114,800		114,800	359,824	474,624			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			107,547	107,547		107,547	847,874	955,421			32
33	Real Estate Taxes			95,841	95,841		95,841		95,841			33
34	Rent-Facility & Grounds			1,374,932	1,374,932		1,374,932	(1,358,271)	16,661			34
35	Rent-Equipment & Vehicles			70,186	70,186		70,186	5,714	75,900			35
36	Other (specify):*											36
37	TOTAL Ownership			1,763,306	1,763,306		1,763,306	(144,859)	1,618,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		530,361	1,408,165	1,938,526		1,938,526		1,938,526			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			305,495	305,495		305,495		305,495			42
43	Other (specify):* Disallowed Costs	106,086	8,830	1,351,795	1,466,711		1,466,711	(1,466,711)				43
44	TOTAL Special Cost Centers	106,086	539,191	3,065,455	3,710,732		3,710,732	(1,466,711)	2,244,021			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,052,341	1,321,883	7,121,907	13,496,131		13,496,131	(1,355,368)	12,140,763			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$		$	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	(38,559)	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	(438,358)	30		9
10	Interest and Other Investment Income	(4,706)	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	(205,328)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(447)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,144,882)	43		24
25	Fund Raising, Advertising and Promotional	(12,979)	43		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 See Page 5A	(115,494)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,960,753)		$	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)	605,385		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 605,385		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,355,368)		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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Champaign Urbana Nursing and Rehab, LP

ID# 0052217

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (1,837)	2	1
2	Prior Year Charitable Contribution reversal	9,900	43	2
3	Marketing Salary	(106,086)	43	3
4	Expense Repairs under $2,500	2,492	6	4
5	Disallow Marketing Travel costs	(3,007)	25	5
6	Correct Agency Nursing Invoice Amount	(7,356)	10	6
7	Capitalize Repairs over $2,500	(9,600)	6	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
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22				22
23				23
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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**	(115,494)		49

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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)	
1	V	20	Licenses		Champaign Urbana Realty	100.00%	$ 200	$ 200	1
2	V	30	Depreciation		Champaign Urbana Realty	100.00%	798,182	798,182	2
3	V	32	Interest		Champaign Urbana Realty	100.00%	852,580	852,580	3
4	V	34	Rent-Facility & Grounds	1,374,932	Champaign Urbana Realty	100.00%		(1,374,932)	4
5	V	43	Late Fees		Champaign Urbana Realty	100.00%	31,223	31,223	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			$ 1,374,932			$ 1,682,185	$ * 307,253	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 648	$ 648	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	131	131	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	52,112	52,112	17
18	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0		18
19	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	11,198	11,198	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	27,703	27,703	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	17,044	17,044	22
23	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	6,942	6,942	23
24	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	584	584	24
25	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	123,857	123,857	25
26	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	57	57	26
27	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	611	611	27
28	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	31,208	31,208	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	3,662	3,662	29
30	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	16,661	16,661	30
31	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	5,714	5,714	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 298,132	$ * 298,132	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Knopf	0.028	Gardenview Manor	Danville	Premier Healthcare	Skokie	Management Co.	1
2	Ayelet Knopf	0.028	Gilman Healthcare Center	Gilman	Management, LLC			2
3	Naomi Lopin	0.028	Courtyard Healthcare	Berwyn	Premier Healthcare	Skokie	Medical Supply	3
4	Yisroel Lopin	0.028	Winfield Woods Healthcare Center	Winfield	Supplies, LLC			4
5	Michael & Carol Knopf	0.009	Pershing Gardens Healthcare Center	Stickney	Champaign Urbana	Savoy	Lessor	5
6	Isaac & Rachel Knopf	0.005	Norridge Gardens	Norridge	Realty			6
7	BDS Whampoa LLC	0.009	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN	REX Therapeutics	Skokie	Therapy	7
8	Orsheve Enterprises	0.033	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	Razie Indich	0.005	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10	Jerry & Deena Cheplowitz	0.005	Premier Healthcare of Connersville, LLC	Connersville, IN				10
11	Leonard & Felice Frand	0.005	Premier Healthcare of New Harmony, LLC	New Harmony, IN				11
12	Waxcap, Inc.	0.122						12
13	Barak Baver	0.347						13
14	David Cheplowitz	0.348						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	David Cheplowitz	Shareholder	Administrative	0.35	See Att Sch 7A	4.73	11.83	Alloc Salary	$ 640	17-7	1
2	Barak Baver	Shareholder	Administrative	0.35	See Att Sch 7A	4.73	11.83	Alloc Salary	640	17-7	2
3	Sara Baver	Relative	Clerical	0.00	See Att Sch 7A	4.73	11.83	Alloc Salary	5,229	21-7	3
4	Yocheved Baver	Relative	Consulting	0.00	See Att Sch 7A			Consulting	9,450	19-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 15,959		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	5	Heat and Other Utilities	Census Days	355,708	12	$ 5,481	$	42,079	$ 648	1
2	6	Maintenance	Census Days	355,708	12	1,104		42,079	131	2
3	10	Nursing and Medical Records	Illinois Census Days	299,107	7	370,422	370,422	42,079	52,112	3
4	10	Nursing and Medical Records	Indiana Census Days	56,601	5	115,384	115,384		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	299,107	7	79,596		42,079	11,198	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	56,601	5	24,794			0	6
7	17	Administrative	Census Days	355,708	12	234,180	234,180	42,079	27,703	7
8	17	Administrative	Illinois Census Days	299,107	7	121,153	121,153	42,079	17,044	8
9	19	Professional Services	Census Days	355,708	12	58,680		42,079	6,942	9
10	20	Dues, Fees, Subs & Promo	Census Days	355,708	12	4,939		42,079	584	10
11	21	Clerical & Gen Office Expenses	Census Days	355,708	12	1,047,000	993,525	42,079	123,857	11
12	24	Travel and Seminar	Census Days	355,708	12	481		42,079	57	12
13	25	Other Admin. Staff Trans	Census Days	355,708	12	5,164		42,079	611	13
14	27	Emp Benefit Alloc-Gen Admin	Census Days	355,708	12	263,809		42,079	31,208	14
15	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	299,107	7	26,033		42,079	3,662	15
16	34	Rent-Facility & Grounds	Census Days	355,708	12	140,839		42,079	16,661	16
17	35	Equipment Rental	Census Days	355,708	12	48,305		42,079	5,714	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,547,364	$ 1,834,664		$ 298,132	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	First Midwest Bank		X	Mortgage		7/25/2014	$ 16,100,000	$ 13,809,736	8/5/2017		$ 852,580	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit		12/31/14		1,736,262	3/31/17		104,510	6
7												7
8												8
9	TOTAL Facility Related						$ 16,100,000	$ 15,545,998			$ 957,090	9
	B. Non-Facility Related*											
10												10
11								Other Interest			3,037	11
12								Offset Interest Income			(4,706)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,669)	14
15	TOTALS (line 9+line14)						$ 16,100,000	$ 15,545,998			$ 955,421	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.**		$ 91,276	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	$ 91,276	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.)		$ 95,841	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.		$ 95,841	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	82,903	8
2014	84,303	9
2015	84,687	10
2016	82,598	11
2017	91,276	12

Accrual based on prior year tax bill.

Adjusted Beg accrual to actual-prior year post closing adjustment

	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign Urbana Nursing and Rehab, LP COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0052217

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ( )

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.	03-20-25-300-004	Long Term Care Property	$ 91,276.74	$ 91,276.74
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 91,276.74	$ 91,276.74

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 X 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 Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,118 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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).

None

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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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		2015	$ 945,720	1
2					2
3	TOTALS			$ 945,720	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	213		2015	1975	$ 9,141,960	$	35	$ 261,199	$ 261,199	$ 1,044,796	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Skilled Unit: Reroute Power In Therapy, Dialysis Room Outlets			2014	14,697		20	735	735	3,614	9
10	New Floor, Wall Tiles, Paint In 2 Shower Rooms			2014	12,750		20	638	638	3,083	10
11	Paint 15 Units, Including Bathrooms			2014	4,500		20	225	225	1,088	11
12	Gym Flooring & Cove Base			2014	23,343		20	1,167	1,167	5,641	12
13	Dialysis Room Carpet			2014	9,271		20	464	464	2,165	13
14	Plumbing			2014	3,282		20	164	164	752	14
15	Install Generator Controller			2014	23,115		20	1,156	1,156	5,202	15
16	Water Supply Line & Piping			2014	3,690		20	185	185	909	16
17	Replace Compressor			2014	4,630		20	232	232	1,005	17
18	Install Dome Lights & Pull Cords In Rehab Area Bathrooms			2014	3,815		20	191	191	811	18
19	Change Two 85 Gallon/500,000 Btu Water Heaters			2015	30,687		20	1,534	1,534	6,136	19
20	Install 2' Gas Main To 4 Water Heaters/Fix Gas Leak In Basement			2015	5,300		20	265	265	830	20
21	Addition Of 4 Circuilts For New Dialysis Machinesl/Gfci Breaker			2015	5,015		20	251	251	1,004	21
22	Remove/Install High & Low Slow Mixing Valve			2015	3,248		20	162	162	648	22
23	Install Epdm Rubber Roof At East/Center Of Building			2015	5,635		20	282	282	1,128	23
24	Security System			2015	10,195		20	510	510	2,040	24
25	Dialysis Room - Electrical, Wall boxes, paint, cabinets and faucets			2016	2,680		20	134	134	335	25
26	Flooring in Rehab Nurses station, Rms 105-113, Lobby, Hallway,			2016	51,174		20	2,559	2,559	6,397	26
27	South Corridor and Dialysis Den Room										27
28	Install Two 85 Gallon BTU Water Heating Units			2016	29,497		20	1,475	1,475	3,687	28
29	Boiler Repair			2016	3,239		20	162	162	405	29
30	Reapirs on 3 Boilers - Replace Pumps, Motors, Blades & Contactors			2017	5,084		20	254	254	381	30
31	Install 2 new ASI Controls with Sensors,AAON RTUs, Pumps and Exhaus			2017	15,800		20	790	790	1,185	31
32	Replaced Blower Motors and Circuit Boards on 3 PTAC units			2017	2,862		20	143	143	215	32
33	Repair Water Damaged Fire Alarm System			2017	2,769		20	138	138	207	33
34	Electrical Wiring and Circuts for new Dialysis Room			2017	7,097		20	355	355	532	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Sprinkler Repair-Replace Compressor	2018	$ 3,775	$	20	$ 94	$ 94	$ 94	37
38	Replace Compressor in Sprinkler System	2018	2,654		20	66	66	66	38
39	Six PTAC Units	2018	4,925		20	198	198	198	39
40	Four PTAC Units	2018	3,863		20	97	97	97	40
41	Repair Two Boilers	2018	5,737		20	143	143	143	41
42									42
43									43
44									44
45	Financial Statement Depreciation Expense			114,800			(114,800)		45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54	Allocated from Premier Healthcare Management, LLC	2013	3,945		20	197	197	1,024	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)		$ 9,450,234	$ 114,800		$ 276,165	$ 161,365	$ 1,095,818	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 1,981,449	$	$ 198,144	$ 198,144	10	$ 873,003	71
72	Current Year Purchases	12,587		315	315	10	315	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,994,036	$	$ 198,459	$ 198,459		$ 873,318	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				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 12,389,990	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 114,800	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 474,624	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 359,824	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,969,136	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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:				$			3
4	Additions							4
5	Allocated from Management Co.				16,661			5
6								6
7	TOTAL				$ 16,661 **			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: $ 67,869 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2014 Ford Elkhart	$ 772.39	$ 2,317	17
18					18
19	Allocated from Management Co			5,714	19
20					20
21	TOTAL		$ 772.39	$ 8,031	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Champaign Urbana Nursing and Rehab, LP**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2018**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	35,322
Dietary Equipment	10,160
Office Equipment	22,387
Total - Line 16	**67,869**

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 480,408	$		$ 480,408	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			255,630			255,630	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2),(3),39(3)	hrs			643,585	4,194		647,779	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				518,875		518,875	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached Sch 16A					48,916	11,486		60,402	13
14	TOTAL			$		$ 1,428,539	$ 534,555		$ 1,963,094	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Champaign Urbana Nursing and Rehab, LP**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2018**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	37,423
Dialysis	39(3)	7,161
Outside MD Service-MCA	39(3)	4,332
Medical Supplies - MCA	39(2)	11,486
Total - Line 13		**60,402**

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 8,790	$ 8,790	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,899,557)	1,774,462	1,774,462	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	159,436	159,436	6
7	Other Prepaid Expenses	877,640	877,640	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to Others	12,927	12,927	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,833,255	$ 2,833,255	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		945,720	13
14	Buildings, at Historical Cost		9,141,960	14
15	Leasehold Improvements, at Historical Cost	291,450	308,274	15
16	Equipment, at Historical Cost	685,084	1,994,036	16
17	Accumulated Depreciation (book methods)	(528,921)	(1,969,136)	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): See Attached Schedule 17A	57,967	238,066	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 505,580	$ 10,658,920	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,338,835	$ 13,492,175	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,905,701	$ 2,905,701	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,736,262	1,736,262	29
30	Accrued Salaries Payable	145,487	145,487	30
31	Accrued Taxes Payable (excluding real estate taxes)	663,136	663,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,841	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	154,894	154,894	36
37	Due to Related Parties	1,609,799	2,421,477	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,215,279	$ 8,122,798	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,809,736	40
41	Bonds Payable			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)**	$	$ 13,809,736	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,215,279	$ 21,932,534	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,876,444)	$ (8,440,359)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,338,835	$ 13,492,175	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Champaign Urbana Nursing and Rehab, LP**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2018**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs	57,967	57,967
Loan Origination Fees - CUR		364,728
Amortization - CUR		(292,317)
Capital Impr Reserve - CUR		90,383
RE Tax Escrow - CUR		17,305
Total - Line 23	**57,967**	**238,066**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	51,097	51,097
Accrued Bed Tax	29,391	29,391
Payroll Withholdings	74,406	74,406
Total - Line 36	**154,894**	**154,894**

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 126,737	1
2	Restatements (describe):		2
3	**Post closing adjustments - Bad Debt Expense**	(1,393,825)	3
4	**Post closing adjustments - Depreciation/Amortization**	(155,723)	4
5	**Post closing adjustments - Penalties & Other Misc**	(179,074)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,601,885)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,274,559)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,274,559)	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)**	$ (3,876,444)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 9,512,053	1
2	Discounts and Allowances for all Levels	1,011,517	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,523,570	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	522,689	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 522,689	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	1,837	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(18,995)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(441)	20
21	Other Medical Services	250	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (17,349)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,706	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,706	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income - Prior Yr Accrued Expense Corrections**	187,956	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 187,956	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,221,572	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,516,253	31
32	Health Care	4,342,248	32
33	General Administration	2,163,592	33
	B. Capital Expense		
34	Ownership	1,763,306	34
	C. Ancillary Expense		
35	Special Cost Centers	3,405,237	35
36	Provider Participation Fee	305,495	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,496,131	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,274,559)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,274,559)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,452,039	44
45	Private Pay - Net Inpatient Revenue	898,886	45
46	Medicare - Net Inpatient Revenue	4,608,071	46
47	Other-(specify) Insurance	539,846	47
48	Other-(specify) Veterans	24,728	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,523,570	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,958	2,150	$ 86,236	$ 40.11	1
2	Assistant Director of Nursing	4,137	4,257	171,207	40.22	2
3	Registered Nurses	31,518	33,240	1,037,629	31.22	3
4	Licensed Practical Nurses	25,240	26,761	766,199	28.63	4
5	CNAs & Orderlies	76,003	79,450	1,067,110	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,931	6,477	145,322	22.44	8
9	Activity Director					9
10	Activity Assistants	5,423	5,846	97,813	16.73	10
11	Social Service Workers	4,308	4,502	86,365	19.18	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,088	38,629	18.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,723	25,434	322,861	12.69	15
16	Dishwashers					16
17	Maintenance Workers	3,980	4,295	79,758	18.57	17
18	Housekeepers	18,100	19,000	214,781	11.30	18
19	Laundry	7,781	8,258	86,377	10.46	19
20	Administrator	1,664	1,990	92,353	46.41	20
21	Assistant Administrator	976	1,040	50,000	48.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,325	19,336	354,082	18.31	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	1,345	1,502	26,795	17.84	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	11,078	11,788	328,824	27.89	33
34	TOTAL (lines 1 - 33)	243,530	257,414	$ 5,052,341 *	$ 19.63	34

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	$ 33,151	L1, C3	35
36	Medical Director	Monthly	59,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,763	L10, C3	39
40	Physical Therapy Consultant	Monthly	10,278	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	4,047	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	24,000	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 147,739		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9	$ 487	L10, C3	50
51	Licensed Practical Nurses	656	25,443	L10, C3	51
52	Certified Nurse Assistants/Aides	2,365	81,634	L10, C3	52
53	TOTAL (lines 50 - 52)	3,030	$ 107,564		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Champaign Urbana Nursing and Rehab, LP

Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		5,026	5,344	175,244	32.79
Transportation		2,742	2,926	47,494	16.23
Marketing		3,310	3,518	106,086	30.16
	TOTAL	11,078	11,788	328,824	

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steven Territo	Administrator	0	$ 21,691
Darla Coit	Administrator	0	26,462
Kevin Rickard	Administrator	0	2,500
Brenda Reed	Administrator	0	12,115
Marquez Woods	Administrator	0	19,854
Jeremy Reiman	Administrator	0	9,731
Pamela Jacobson	Asst Admin	0	50,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 142,353

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 60,268
Richard Peelo & Associates, Inc	Accounting	2,800
CohnReznick LLP	Accounting	43,311
Templin Healthcare Accounting	Accounting	2,650
Plante & Moran, PLLC	Accounting	13,150
Marcum LLP	Accounting	3,090
Ability Network Inc.	Data Processing	4,378
Pathway Health Services	LTC Management Consultant	90,000
HDSI	Data Processing	4,988
MatrixCare	Data Processing	47,877
Singer Networks, LLC	Data Processing	19,628
See Attached Schedule 21A		119,224
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 411,364

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 164,688
Unemployment Compensation Insurance	59,040
FICA Taxes	376,973
Employee Health Insurance	131,442
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,712
Physical Exams	97
TOTAL (agree to Schedule V, line 22, col.8)	$ 740,952

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,983
Health Care Worker Background Check	
(Indicate # of checks performed 705)	7,058
Patient Background Checks 48	484
Dues & Subscriptions	2,075
Licenses & Permits	1,408
Health Care Council of Illinois	9,138
Allocated from Bldg Company	200
Allocated from Management Co.	584
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,930

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,522
Allocated from Management Co.	57
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,579

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Champaign Urbana Nursing and Rehab, LP**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2018**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
M & M Financial	Financial Consultant	500
Resolute Healthcare Solutions	Healthcare Billing	38,880
LTC Consulting Services	Consulting Fees	2,813
Personnel Planners	Unemployment Consultants	2,375
Terrill Consulting Services, Inc.	Billing Consultant	4,676
GCHMO, Inc	Managed Care Contracting Services	14,150
MGKappy Consulting Inc.	Financial Services Consultant	17,750
Yocheved Baver	Website Services	9,450
Change Healthcare	Data Processing	335
eSolutions, Inc	Data Processing	1,860
National Datacare Corporation	Resident Fund Mgmt	227
Paycor/Propay	Payroll Processing	27,894
TaxSaver Plan	Benefits Administration	655
Quickbooks	Accounting Software	503
Sedgwick CMS	Claims Management	333
Prior Year Accrual Corrections	Data Processing	(4,346)
Prior Year Accrual Corrections	Accounting	1,169
Total		**119,224**

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **9,138 Health Care Council of Illinois**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,256** 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. $ **305,495**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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? **No** 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? **N/A** Indicate the amount. $ **N/A**

(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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

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