

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

<p>I. IDPH Facility ID Number: <u>0001636</u></p> <p>Facility Name: <u>Champaign County Nursing Home</u></p> <p>Address: <u>1701 East Main Street</u> <u>Urbana</u> <u>61802</u> Number City Zip Code</p> <p>County: <u>Champaign</u></p> <p>Telephone Number: <u>(217) 384-3784</u> Fax # <u>(217) 337-0120</u></p> <p>HFS ID Number: <u>366006910001</u></p> <p>Date of Initial License for Current Owners: <u>04/26/1905</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 789-7700</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/2005</u> to <u>11/30/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 S. Old State Capitol Plaza, Ste 200, Springfield, IL 62701</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217) 789-7700</u> (Fax) <u>(217) 753-1654</u></td> </tr> <tr> <td colspan="2">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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 S. Old State Capitol Plaza, Ste 200, Springfield, IL 62701</u>		(Telephone) <u>(217) 789-7700</u> (Fax) <u>(217) 753-1654</u>	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	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																							
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																							
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County																																							
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																							
	<input type="checkbox"/> "Sub-S" Corp.																																								
	<input type="checkbox"/> Limited Liability Co.																																								
	<input type="checkbox"/> Trust																																								
	<input type="checkbox"/> Other _____																																								
Officer or Administrator of Provider	(Signed) _____																																								
	(Date) _____																																								
	(Type or Print Name) _____																																								
	(Title) _____																																								
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																																								
	(Date) _____																																								
	(Print Name and Title) _____																																								
	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 S. Old State Capitol Plaza, Ste 200, Springfield, IL 62701</u>																																								
	(Telephone) <u>(217) 789-7700</u> (Fax) <u>(217) 753-1654</u>																																								
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' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0001636 Report Period Beginning: 12/01/2005 Ending: 11/30/2006

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	153	Skilled (SNF)	153	55,845	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5	34	Sheltered Care (SC)	34	12,410	5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,695	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	Private Pay	4 Other	5 Total	
8	SNF	7,261	657	5,610	13,528	8
9	SNF/PED					9
10	ICF	39,536	20,573		60,109	10
11	ICF/DD					11
12	SC	2,201	1,063		3,264	12
13	DD 16 OR LESS					13
14	TOTALS	48,998	22,293	5,610	76,901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.70%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Adult Day Care; Child 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 NO

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

I. On what date did you start providing long term care at this location?

Date started 1943

J. Was the facility purchased or leased after January 1, 1978?

YES Date N/A NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 153 and days of care provided 5,610

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 11/30/2006 Fiscal Year: 11/30/2006

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

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2005 Ending: 11/30/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	911,994	57,850	16,306	986,150		986,150	(5,157)	980,993		1
2	Food Purchase		552,163		552,163		552,163	(41,235)	510,928		2
3	Housekeeping	454,473	50,403		504,876		504,876	(4,831)	500,045		3
4	Laundry	139,224	29,488		168,712		168,712		168,712		4
5	Heat and Other Utilities			440,003	440,003		440,003	(42,173)	397,830		5
6	Maintenance	135,716	6,288	62,671	204,675		204,675	(6,610)	198,065		6
7	Other (specify):*										7
8	TOTAL General Services	1,641,407	696,192	518,980	2,856,579		2,856,579	(100,006)	2,756,573		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	3,853,077	288,686	715,792	4,857,555		4,857,555	(78)	4,857,477		10
10a	Therapy		493	294,217	294,710		294,710		294,710		10a
11	Activities	207,636	3,181	17	210,834		210,834		210,834		11
12	Social Services	132,551			132,551		132,551		132,551		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Day Care	248,642	1,729	113,308	363,679		363,679	(363,679)			15
16	TOTAL Health Care and Programs	4,441,906	294,089	1,127,534	5,863,529		5,863,529	(363,757)	5,499,772		16
	C. General Administration										
17	Administrative	91,110		51,555	142,665		142,665	(578)	142,087		17
18	Directors Fees										18
19	Professional Services			43,254	43,254		43,254	(1,472)	41,782		19
20	Dues, Fees, Subscriptions & Promotions			57,899	57,899		57,899	(6,935)	50,964		20
21	Clerical & General Office Expenses	393,987	20,955	79,535	494,477		494,477	(3,104)	491,373		21
22	Employee Benefits & Payroll Taxes			1,945,928	1,945,928		1,945,928	(12,100)	1,933,828		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,505	4,505		4,505		4,505		24
25	Other Admin. Staff Transportation			11,475	11,475		11,475	(129)	11,346		25
26	Insurance-Prop.Liab.Malpractice			213,058	213,058		213,058	(1,853)	211,205		26
27	Other (specify):*										27
28	TOTAL General Administration	485,097	20,955	2,407,209	2,913,261		2,913,261	(26,171)	2,887,090		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,568,410	1,011,236	4,053,723	11,633,369		11,633,369	(489,934)	11,143,435		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Champaign County Nursing Home

#0001636

Report Period Beginning:

12/01/2005

Ending:

11/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			240,816	240,816		240,816	(32,224)	208,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,702	6,702		6,702	(6,702)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,222	37,222		37,222		37,222			35
36	Other (specify):*											36
37	TOTAL Ownership			284,740	284,740		284,740	(38,926)	245,814			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	30,302	198,407		228,709		228,709		228,709			39
40	Barber and Beauty Shops	53,664	1,621		55,285		55,285		55,285			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,428	114,428		114,428		114,428			42
43	Other (specify):* Nonallowable Cost			372,388	372,388		372,388	(372,388)				43
44	TOTAL Special Cost Centers	83,966	200,028	486,816	770,810		770,810	(372,388)	398,422			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,652,376	1,211,264	4,825,279	12,688,919		12,688,919	(901,248)	11,787,671			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Champaign County Nursing Home**

0001636

Report Period Beginning:

12/01/2005

Ending:

11/30/2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (363,679)	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,654)	30		9
10	Interest and Other Investment Income	(6,702)	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	(22,750)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,935)	20		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 <u>See Schedule 5A</u>	(496,528)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (901,248)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (901,248)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

ID# 0001636

Report Period Beginning: 12/01/2005

Ending: 11/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset meal revenue against food cost	\$ (2,704)	2	1
2	Offset miscellaneous revenue against food cost	(130)	2	2
3	Offset miscellaneous revenue against medical supplies	(78)	10	3
4	Offset miscellaneous revenue against office expense	(1,676)	21	4
5	Record child daycare benefits	60,632	22	5
6	Cable TV expense	(2,208)	43	6
7	Transfers to general corp fund	(63,806)	43	7
8	Public relations expense	(762)	43	8
9	Grant match	(264,782)	43	9
10	Laboratory fees	(8,534)	43	10
11	Medicare ancillary expense	(9,546)	43	11
12	Disallow out of period legal fees	(837)	19	12
13				13
14				14
15	Disallow indirect day care costs:			15
16	Dietary	(5,157)	1	16
17	Food	(38,401)	2	17
18	Housekeeping	(4,831)	3	18
19	Utilities	(42,173)	5	19
20	Maintenance	(6,610)	6	20
21	Professional fees	(635)	19	21
22	Office expense	(1,428)	21	22
23	Employee venefits	(72,732)	22	23
24	Staff transportation	(129)	25	24
25	Insurance	(1,853)	26	25
26	Depreciation	(27,570)	30	26
27	Audit & accounting fees	(578)	17	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	(496,528)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign County Nursing Home# 0001636 Report Period Beginning:

12/01/2005

Ending: 11/30/2006

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(5,157)	0	0	0	0	0	0	0	0	0	0	(5,157)	1
2	Food Purchase	(41,235)	0	0	0	0	0	0	0	0	0	0	(41,235)	2
3	Housekeeping	(4,831)	0	0	0	0	0	0	0	0	0	0	(4,831)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(42,173)	0	0	0	0	0	0	0	0	0	0	(42,173)	5
6	Maintenance	(6,610)	0	0	0	0	0	0	0	0	0	0	(6,610)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(100,006)	0	(100,006)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(78)	0	0	0	0	0	0	0	0	0	0	(78)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(363,679)	0	0	0	0	0	0	0	0	0	0	(363,679)	15
16	TOTAL Health Care and Programs	(363,757)	0	(363,757)	16									
	C. General Administration													
17	Administrative	(578)	0	0	0	0	0	0	0	0	0	0	(578)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,472)	0	0	0	0	0	0	0	0	0	0	(1,472)	19
20	Fees, Subscriptions & Promotions	(6,935)	0	0	0	0	0	0	0	0	0	0	(6,935)	20
21	Clerical & General Office Expenses	(3,104)	0	0	0	0	0	0	0	0	0	0	(3,104)	21
22	Employee Benefits & Payroll Taxes	(12,100)	0	0	0	0	0	0	0	0	0	0	(12,100)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(129)	0	0	0	0	0	0	0	0	0	0	(129)	25
26	Insurance-Prop.Liab.Malpractice	(1,853)	0	0	0	0	0	0	0	0	0	0	(1,853)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(26,171)	0	(26,171)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(489,934)	0	(489,934)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign County Nursing Home# 0001636

Report Period Beginning:

12/01/2005 Ending:

11/30/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(32,224)	0	0	0	0	0	0	0	0	0	0	(32,224) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(6,702)	0	0	0	0	0	0	0	0	0	0	(6,702) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(38,926)	0	(38,926) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(372,388)	0	0	0	0	0	0	0	0	0	0	(372,388) 43
44	TOTAL Special Cost Centers	(372,388)	0	(372,388) 44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(901,248)	0	(901,248) 45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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 # 0001636 Report Period Beginning: 12/01/2005 Ending: 11/30/2006

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									\$	1
2										2
3	See attached list	Board of Directors	Administrative	0.00	None	<1	<1%		None	N/A
4										4
5										5
6										6
7										7
8	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business									
9	transactions with the nursing home during the reporting period.									
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning:

12/01/2005

Ending: 1/30/2006

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 NO

Name of Related Organization Champaign County
 Street Address 1776 East Washington
 City / State / Zip Code Urbana, IL 61802
 Phone Number (217) 384-3776
 Fax Number (217) 337-0120

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	218,703		\$ 74,156	15,210	\$ 5,157	1
2	2	Food	Meals	218,703		552,163	15,210	38,401	2
3	3	Housekeeping	Square Feet	63,455		50,403	6,082	4,831	3
4	5	Utilities	Square Feet	63,455		440,003	6,082	42,173	4
5	6	Maintenance	Square Feet	63,455		68,959	6,082	6,610	5
6	17	Administrative	Revenue	10,063,273		51,555	112,746	578	6
7	19	Professional Fees	Revenue	10,063,273		56,653	112,746	635	7
8	21	Office Expense	Revenue	10,063,273		127,456	112,746	1,428	8
9	22	Employee Benefits	Salaries	6,652,376		1,945,930	248,642	72,732	9
10	25	Staff Transportation	Revenue	10,063,273		11,475	112,746	129	10
11	26	Insurance - Auto	Direct	1		590	1	590	11
12	26	Insurance - Other	Revenue	10,063,273		112,746	112,746	1,263	12
13	30	Depreciation - Auto	Direct	1		5,200	1	5,200	13
14	30	Depreciation - Other	Square Feet	63,455		233,387	6,082	22,370	14
15									15
16									16
17									17
18									18
19									19
20									20
21		Day care costs eliminated on Schedule V, Column 7.							21
22									22
23									23
24									24
25	TOTALS					\$ 3,730,676	\$	\$ 202,097	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0001636 Report Period Beginning: 12/01/2005 Ending: 1/30/2006

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6	N/A								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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 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.)

\$ N/A **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<u> </u>	8
	2002	<u> </u>	9
	2003	<u> </u>	10
	2004	<u> </u>	11
	2005	<u> N/A </u>	12

County Facility: Does not pay real estate tax.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0001636

CONTACT PERSON REGARDING THIS REPORT Amanda Knight, Comptroller

TELEPHONE (217) 384 - 3784 FAX #: (217) 337 - 0120

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

0001636

Report Period Beginning:

12/01/2005 Ending:

11/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 101,931 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 2

C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

Champaign County Day Care
Adult and Child Day Care Services
6,082 Square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>1,859,520</u>	<u>1865</u>	<u>\$ 2,100</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	1,859,520		\$ 2,100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home# 0001636

Report Period Beginning:

12/01/2005 Ending: 11/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	153	1975	1973	\$ 2,085,435	\$ 52,136	40	\$ 52,136		\$ 1,733,519	4
5	56	1971	1971	734,760		25			734,760	5
6	34	1971	1971	207,240		25			207,240	6
7		1989	1989	34,891	872	40	872		15,268	7
8										8
	Improvement Type**									
9	Building improvements		1972	10,300		25			10,300	9
10	Building improvements		1973	146,645		25			146,645	10
11	Building improvements		1974	288,473		25			288,473	11
12	Building improvements		1974	18,482	462	40	462		14,954	12
13	Building improvements		1975	25,353		25			25,353	13
14	Building improvements		1976	6,342		15			6,342	14
15	Building improvements		1977	3,399		15			3,399	15
16	Building improvements		1977	8,548		25			8,548	16
17	Building improvements		1980	2,469		15			2,469	17
18	Building improvements		1981	36,818		15			36,818	18
19	Building improvements		1982	57,322		15			57,322	19
20	Building improvements		1983	31,084		10			31,084	20
21	Building improvements		1984	223,985	9,344	24	9,344		210,244	21
22	Building improvements		1985	57,958		20			57,958	22
23	Building improvements		1986	254,092	10,164	25	10,164		208,357	23
24	Building improvements		1987	81,739	4,153	20	4,153		80,992	24
25	Building improvements		1988	345,563	13,823	25	13,823		255,719	25
26	Building improvements		1989	64,947	2,598	25	2,598		45,464	26
27	Building improvements		1990	251,292	10,052	25	10,052		165,854	27
28	Building improvements		1991	163,384	6,535	25	6,535		101,296	28
29	Building improvements		1992	138,101	5,524	25	5,524		80,099	29
30	Building improvements		1993	62,716	2,509	25	2,509		33,868	30
31	Building improvements		1994	360,106	14,404	25	14,404		180,052	31
32	Building improvements		1995	28,420	1,138	25	1,138		13,084	32
33	Building improvements		1996	21,058	842	15	842		8,843	33
34	Parking lot		1977	25,035		15			25,035	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' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning:

12/01/2005 Ending: 11/30/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tree care	1981	\$ 465	\$	15	\$	\$	\$ 465	37
38	Landscaping additions	1982	1,870		10			1,870	38
39	Landscaping additions	1983	5,250		5			5,250	39
40	Landscaping additions	1987	3,491		5			3,491	40
41	Landscaping additions	1988	1,971		15			1,971	41
42	Landscaping additions	1989	6,125		15			6,125	42
43	Landscaping additions	1990	3,596		15			3,596	43
44	Landscaping additions	1991	11,069	363	15	363		11,069	44
45	Landscaping additions	1992	2,969	198	15	198		2,871	45
46	Parking lot expansion	1996	67,139	4,476	15	4,476		48,379	46
47	Smoke detectors	1997	4,524		5			4,524	47
48	Redecorating-ADC	1997	1,459		5			1,459	48
49	Sprinkler backflow preventor	1997	6,230	623	10	623		5,919	49
50	Fire door - Activity office	1997	626	63	10	63		597	50
51	Wall-Dietary	1997	705	70	10	70		667	51
52	Mini blinds - Dining area	1997	1,045		5			1,045	52
53	Tuckpointing - Administration bldg	1997	11,400	456	25	456		4,332	53
54	Flooring improvements	1997	3,306		5			3,306	54
55	Asbestos removal	1998	45,350	1,814	25	1,814		15,409	55
56	Project planning - ARD expansion	1998	35,513		5			35,513	56
57	Air conditioning - Chiller replacement	1998	193,611	9,681	20	9,681		80,063	57
58	Hot water treatment system	1998	1,422		5			1,422	58
59	Pipe insulation	1998	3,201	160	20	160		1,360	59
60	Door sensor beam	1998	567		5			567	60
61	Vanity replacement (wing)	1998	16,236	812	20	812		6,901	61
62	Shower tile replacement (B wing)	1998	1,064	71	15	71		603	62
63	Heat exchanger replacement	1998	4,417	442	10	442		3,756	63
64	Pipe insulation	1998	97	5	20	5		42	64
65	Asbestos removal	1998	4,792	192	25	192		1,631	65
66	Cable for computer	1999	7,350	490	15	490		3,675	66
67	Chiller replacement electrical	1999	3,465	173	20	173		1,298	67
68	Door alarm on B wing	1999	1,808	181	10	181		1,357	68
69	Carpet - 3 offices	1999	814		5			814	69
70	TOTAL (lines 4 thru 69)		\$ 6,228,904	\$ 154,826		\$ 154,826	\$	\$ 5,050,706	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Champaign County Nursing Home# 0001636

Report Period Beginning:

12/01/2005 Ending: 11/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,228,904	\$ 154,826		\$ 154,826	\$	\$ 5,050,706	1
2	Door alarm hook-up	1999	50	5	10	5		38	2
3	Stainless steel wall coverings	1999	1,382	69	20	69		518	3
4	Flipper cabinet w/ hanging tracks	1999	297	20	15	20		150	4
5	Flipper cabinet w/ hanging tracks	1999	1,216	81	15	81		608	5
6	Door magnets (door alarms)	1999	144	14	10	14		106	6
7	Ceramic flooring	1999	3,192	160	20	160		1,199	7
8	Carpet in 2 offices	1999	918		5			918	8
9	Hollow metal door	1999	788	39	20	39		293	9
10	Annunciator	1999	400	40	10	40		300	10
11	Unit heater for bus ban	1999	569	38	15	38		285	11
12	Privacy panels & hardware	1999	518		5			518	12
13	A-wing nursing station	1999	4,333	289	15	289		2,130	13
14	Hook-up call system	1999	734	49	15	49		367	14
15	Computer cable	2000	810	54	15	54		365	15
16	Stainless folding for shower rooms	2000	578	58	15	58		391	16
17	Vinyl flooring	2000	960		10			960	17
18	Concrete fountain	2000	1,000	40	25	40		260	18
19	Remodel Annex corner	2001	443	67	5	71	4	443	19
20	Conversion of Activity room to Dining	2001	2,079	311	5	311		2,079	20
21	Major repair-Walk-in refrigerator	2001	526	53	5	53		430	21
22	Vinyl flooring	2001	898	90	5	90		727	22
23	Stairway treads	2001	1,495	150	5	150		1,209	23
24	Carpet - Canopy walkway	2001	980	180	5	180		980	24
25	Tree removal	2001	975	98	10	98		546	25
26	Fire alarm update	2001	1,273	127	10	127		741	26
27	Dishwasher fan	2001	4,285	429	10	429		2,431	27
28	ADC alarm	2001	566	57	10	57		323	28
29	Activity room phone system	2001	110	11	10	11		59	29
30	Wing door alarm	2001	886	89	10	89		489	30
31	Door alarm system	2001	857	86	10	86		466	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,262,166	\$ 157,530		\$ 157,534	\$ 4	\$ 5,071,035	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Champaign County Nursing Home# 0001636

Report Period Beginning:

12/01/2005 Ending: 11/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,262,166	\$ 157,530		\$ 157,534	\$ 4	\$ 5,071,035	1
2	Hollow doors (3)	2002	635	32	20	32		157	2
3	Hollow door (1)	2002	514	26	20	26		123	3
4	Smoke detectors in ductwork	2002	23,325	2,333	10	2,333		11,146	4
5	Ductwork repair per Life Safety survey	2002	20,469	2,046	10	2,046		9,720	5
6	Smoke detectors in ductwork	2002	15,829	1,583	10	1,583		7,190	6
7	Air conditioner condensing unit	2002	971	65	15	65		282	7
8	Garage Door Repairs	2002	565	38	15	38		162	8
9	Removal of trees	2002	1,800	180	10	180		740	9
10	Sprinkler System Repair	2003	1,569	63	25	63		252	10
11	Compressor - Air Conditioner	2003	27,800	1,853	15	1,853		6,486	11
12	Heat Exchanger Repair	2003	5,559	371	15	371		1,143	12
13									13
14	Compressor - Walk in Cooler	2004	575	192	3	192		544	14
15	11 Sentry Door Alarms	2004	851	85	10	85		234	15
16	Security Lights	2004	6,526	653	40	653		1,741	16
17	Roof Repair	2004	2,600	260	10	260		650	17
18	Heating System Upgrade/Repair	2004	8,908	594	15	594		1,485	18
19	Door Alarms	2004	732	73	10	73		170	19
20	Land Improvements - Water Line Repair	2004	2,845	114	25	114		256	20
21									21
22	Hot Water Repair	2005	9,068	453	20	453		832	22
23									23
24	Boiler Repair	2006	4,196	157	20	105	(52)	105	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Less: Allocated to Day Care								32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,397,503	\$ 168,701		\$ 168,653	\$ (48)	\$ 5,114,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 541,506	\$ 58,651	\$ 57,718	\$ (933)	3-20	\$ 313,228	71
72	Current Year Purchases	42,562	8,056	4,383	(3,673)	5-7	4,383	72
73	Fully Depreciated Assets	1,550,123					1,550,123	73
74	Disallow indirect day care cost			(27,570)	(27,570)			74
75	TOTALS	\$ 2,134,191	\$ 66,707	\$ 34,531	\$ (32,176)		\$ 1,867,734	75

D. Vehicle Depreciation (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	Resident Use	96 Ford Bus	1996	\$ 36,532	\$ 1,825	\$ 1,825	\$	10	\$ 36,532	76
77	Resident Use	98 Dodge Van	1998	33,746	3,375	3,375		10	28,685	77
78	Resident Use	Lift for Van	2001	537	72	72		5	537	78
79	Resident Use	97 Ford	2002	1,358	136	136		10	577	79
80	TOTALS			\$ 72,173	\$ 5,408	\$ 5,408	\$		\$ 66,331	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)		\$ 8,605,967	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 240,816	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 208,592	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (32,224)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 7,048,512	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	New Facility	\$ 338,999	92
93			93
94			94
95		\$ 338,999	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' COMPILATION REPORT

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:				\$ <u>N/A</u>			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: _____ *

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: \$ 37,222 Description: Trash compactor-3216; Mattresses-15549; Wound vac.-11263; Compressor-2905; O2 cylinders-4289

(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			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A C2,3	hrs	\$	2,152	\$ 129,111	\$ 159	2,152	\$ 129,270	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		708	42,496		708	42,496	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C2,3	hrs		2,043	122,610	334	2,043	122,944	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				182,345		182,345	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	L39 C1,2	1901 hrs	30,302			16,062	1,901	46,364	12
13	Other (specify):									13
14	TOTAL			\$ 30,302	4,903	\$ 294,217	\$ 198,900	6,804	\$ 523,419	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' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning: 12/01/2005

Ending: 11/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 92,064	\$ 92,064	1
2	Cash-Patient Deposits	13,553	13,553	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 17,469)	1,492,630	1,492,630	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	39,979	39,979	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other receivables</u>	352	352	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,638,578	\$ 1,638,578	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,100	13
14	Buildings, at Historical Cost	6,261,902	6,261,902	14
15	Leasehold Improvements, at Historical Cost	135,601	135,601	15
16	Equipment, at Historical Cost	2,208,464	2,206,364	16
17	Accumulated Depreciation (book methods)	(7,053,167)	(7,048,512)	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 (spec <u>Constr-in-process</u>)	338,999	338,999	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,891,799	\$ 1,896,454	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,530,377	\$ 3,535,032	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 738,263	\$ 738,263	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,553	13,553	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	599,248	599,248	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	207,576	207,576	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,558,640	\$ 1,558,640	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,558,640	\$ 1,558,640	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,971,737	\$ 1,976,392	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,530,377	\$ 3,535,032	48

Champaign County Nursing Home

Provider #: 0001636

12/1/2005 to 11/30/2006

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Other Current Liabilities - Line 36		
Due from Other Funds	191,119	191,119
Obligations Under Capital Lease	16,457	16,457
	<u>207,576</u>	<u>207,576</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,114,845	1
2	Restatements (describe):		2
3	Post year end adjustments	9,976	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,124,821	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(153,084)	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)	\$ (153,084)	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)	\$ 1,971,737	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,063,273	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,063,273	3
	B. Ancillary Revenue		
4	Day Care	112,746	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 112,746	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	153,174	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	46,856	13
14	Non-Patient Meals	2,704	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	98,717	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 301,451	23
	D. Non-Operating Revenue		
24	Contributions	19,849	24
25	Interest and Other Investment Income***	14,255	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,104	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	794,479	28
28a	Interfund transfer from General Corp.	1,229,782	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,024,261	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,535,835	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,856,579	31
32	Health Care	5,863,529	32
33	General Administration	2,913,261	33
	B. Capital Expense		
34	Ownership	284,740	34
	C. Ancillary Expense		
35	Special Cost Centers	656,382	35
36	Provider Participation Fee	114,428	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,688,919	40
41	Income before Income Taxes (line 30 minus line 40)**	(153,084)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (153,084)	43

* 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. Facility files as part of County return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Champaign County Nursing Home

Provider #: 0001636

12/1/2005 to 11/30/2006

Schedule 19A

XVII. Income Statement

Line 28 Other Income(specify):

<u>Description</u>	<u>Amount</u>
Taxes - Current Operating	781,859
Other Operating Taxes	462
Mobile Home Tax	1,098
Payment in Lieu of Taxes	458
Resident Transportation	5,340
Late charges	3,377
Interfund Transfer from General Fund	<u>1,885</u>
Total - Line 28	<u><u>794,479</u></u>

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning: 12/01/2005

Ending: 11/30/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,088	2,212	\$ 73,926	\$ 33.42	1
2	Assistant Director of Nursing	2,088	2,157	63,088	29.25	2
3	Registered Nurses	14,240	14,442	358,256	24.81	3
4	Licensed Practical Nurses	34,014	34,014	651,297	19.15	4
5	CNAs & Orderlies	169,109	170,754	2,173,131	12.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,091	2,161	46,733	21.63	9
10	Activity Assistants	15,672	15,876	160,903	10.13	10
11	Social Service Workers	6,302	6,503	132,551	20.38	11
12	Dietician					12
13	Food Service Supervisor	2,091	1,983	51,584	26.01	13
14	Head Cook	5,054	5,310	103,077	19.41	14
15	Cook Helpers/Assistants	77,867	80,200	757,333	9.44	15
16	Dishwashers					16
17	Maintenance Workers	7,672	7,700	135,716	17.63	17
18	Housekeepers	41,442	41,801	454,473	10.87	18
19	Laundry	13,669	13,745	139,224	10.13	19
20	Administrator	2,088	2,203	91,110	41.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,188	21,773	393,987	18.10	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	2,109	2,161	23,807	11.02	31
32	Other Health Care(specify)	46,878	47,192	788,516	16.71	32
33	Other(specify) <u>Barber & Beauty</u>	4,746	4,771	53,664	11.25	33
34	TOTAL (lines 1 - 33)	470,408	476,958	\$ 6,652,376 *	\$ 13.95	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 16,306	L1 C3	35
36	Medical Director	Monthly	4,200	L9 C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,800	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,306		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,301	\$ 314,979	L10 C3	50
51	Licensed Practical Nurses	7,522	258,391	L10 C3	51
52	Certified Nurse Assistants/Aides	6,375	138,407	L10 C3	52
53	TOTAL (lines 50 - 52)	21,198	\$ 711,777		53

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

Provider #: 0001636

12/1/2005 to 11/30/2006

Schedule 20A

XVIII. Staffing & Salary Costs

Line 32 Other Health Care (specify):

Description	Hours Worked	Hours Paid	Total Wages	Ave Hrly Wage
Care Plan Coordinators	3,831	3,763	79,042	21.01
Other Nursing Supervisors	14,368	14,179	318,318	22.45
Dental Hygienist	1,569	1,655	34,044	20.57
Adult Day Care	13,382	14,538	179,248	12.33
Child Day Care	4,650	3,806	50,923	13.38
Unit Secretary	6,771	6,922	103,620	14.97
Volunteer Coordinator	1,683	1,705	16,821	9.87
Settlement	624	624	6,500	10.42
Total - Line 32	46,878	47,192	788,516	16.71

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Andrew Buffenbarger</u>	<u>Administrator</u>	<u>0</u>	\$ <u>91,110</u>	<u>Workers' Compensation Insurance</u>	\$ <u>204,949</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>124,514</u>	<u>Advertising: Employee Recruitment</u>	<u>31,264</u>	
				<u>FICA Taxes</u>	<u>473,989</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>575,489</u>	(Indicate # of checks performed <u>93</u>)	<u>950</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>1,000</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>	<u>474,982</u>	<u>Illinois Health Care Assn. dues</u>	<u>11,132</u>	
				<u>Child Day Care Benefit</u>	<u>60,632</u>	<u>Other advertising</u>	<u>6,935</u>	
				<u>Employee Morale</u>	<u>12,896</u>	<u>County Nursing Home Assn.</u>	<u>2,020</u>	
				<u>Employee Labs & Physicals</u>	<u>6,377</u>	<u>Miscellaneous dues & publications</u>	<u>1,896</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>91,110</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>1,933,828</u>	
(List each licensed administrator separately.)				TOTAL (agree to Sch. V, line 20, col. 8)			\$ <u>50,964</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description	Line #	Amount	Description	Amount
<u>Champaign County - Audit & Accounting Services</u>	\$ <u>51,555</u>						<u>Out-of-State Travel</u>	\$ _____
							<u>In-State Travel</u>	_____
TOTAL (agree to Schedule V, line 17, col. 3)	\$ <u>51,555</u>						<u>Seminar Expense</u>	<u>4,505</u>
(Attach a copy of any management service agreement)							<u>Entertainment Expense</u>	(_____)
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type			\$ _____			\$ <u>4,505</u>	
<u>Medline</u>	<u>Medicare billing services</u>	\$ <u>910</u>						
<u>RSM McGladrey, Inc.</u>	<u>Accounting</u>	<u>395</u>						
<u>Altschuler, Melvoin & Glasser LLP</u>	<u>Accounting</u>	<u>7,183</u>						
<u>Champaign County Treasurer</u>	<u>Accounting</u>	<u>453</u>						
<u>Federick & Hagle</u>	<u>Legal</u>	<u>795</u>						
<u>Heyl, Royster, Voelker & Allen</u>	<u>Legal</u>	<u>13,799</u>						
<u>Duane Morris LLP</u>	<u>Legal</u>	<u>6,084</u>						
<u>Auler Law Offices</u>	<u>Legal</u>	<u>87</u>						
<u>Lawrence Johnson & Assoc.</u>	<u>Legal</u>	<u>500</u>						
<u>Smart Documents Solutions, Inc.</u>	<u>Legal</u>	<u>418</u>						
<u>Van Ostrand & Elvidge Kelley</u>	<u>Regulatory issues</u>	<u>3,237</u>						
<u>Scc Schedule 21A</u>	<u>Various</u>	<u>9,393</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>43,254</u>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Champaign County Nursing Home

Provider #: 0001636

12/1/2005 to 11/30/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Brought forward from page 21		33,861
<u>Vendor</u>	<u>Type</u>	
Egix, Inc.	Internet services	180
Lifecare Software Solutions, Inc.	Software support	6,920
SBC/ATT	Internet services	736
Champaign County Auditor	Internet connection	111
Ivans	Software support	1,446
<hr/>		
	Subtotal	<u>9,393</u>
Total agreeing to Schedule V, Line 19, Col 3		43,254
Allocated to Day Care and eliminated		(635)
Disallowed Out of Period Legal Fees		(837)
Total (agree to Schedule V, line 19, column 8)		<u><u>41,782</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home# 0001636Report Period Beginning: 12/01/2005Ending: 11/30/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-11132; INHAA-100; CNHA-2020
- (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? 6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 70,013 Line L10 C2
- (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. \$ 114,428
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. 8A 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. \$ None Has any meal income been offset against related costs? No 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? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: Audited by Champaign County Auditor The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet complete.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT