

		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.

I. IDPH Facility ID Number: 0034934

Facility Name: Champaign Terrace

Address: 808 North Third Street St Joseph 61873
 Number City Zip Code

County: Champaign

Telephone Number: (217) 469-8006 **Fax #** (217) 398-0944

HFS ID Number: 37-1225266002

Date of Initial License for Current Owners: 02/03/89

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input 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 type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Sherry Newton **Telephone Number:** (217) 398-0754

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/05 to 09/30/06 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) Sherry Newton

(Title) Chief Executive Officer

Paid Preparer

(Signed) See Attached Compilation Report (Date) _____

(Print Name and Title) James B. Eisenmenger, MS, CPA
Member

(Firm Name & Address) Martin, Hood, Friese & Associates, LLC
2507 S. Neil Street, Champaign, IL 61820

(Telephone) (217) 351-2000 Fax # (217) 351-7726

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 Terrace

0034934 Report Period Beginning: 10/01/05 Ending: 09/30/06

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	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,182</u>			<u>5,182</u>
14	TOTALS	<u>5,182</u>			<u>5,182</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.73%

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

124 (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)

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

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 02/03/89

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

YES Date 02/03/89 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 09/30/06

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

Facility Name & ID Number Champaign Terrace # 0034934 Report Period Beginning: 10/01/05 Ending: 09/30/06

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	32,413		1,702	34,115		34,115		34,115		1
2	Food Purchase		23,421		23,421		23,421		23,421		2
3	Housekeeping	26,203	2,854		29,057		29,057	73	29,130		3
4	Laundry	13,102	921		14,023		14,023		14,023		4
5	Heat and Other Utilities			14,427	14,427		14,427	1,764	16,191		5
6	Maintenance			34,753	34,753		34,753	10,095	44,848		6
7	Other (specify):*										7
8	TOTAL General Services	71,718	27,196	50,882	149,796		149,796	11,932	161,728		8
	B. Health Care and Programs										
9	Medical Director		5,416	1,800	7,216		7,216	35	7,251		9
10	Nursing and Medical Records	132,608		37,206	169,814		169,814	5,989	175,803		10
10a	Therapy										10a
11	Activities	19,652	5,283		24,935		24,935	1	24,936		11
12	Social Services										12
13	CNA Training	16,146			16,146		16,146		16,146		13
14	Program Transportation			4,948	4,948		4,948	3,199	8,147		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	168,406	10,699	43,954	223,059		223,059	9,224	232,283		16
	C. General Administration										
17	Administrative	31,497		113,664	145,161		145,161	(78,425)	66,736		17
18	Directors Fees							96	96		18
19	Professional Services			4,815	4,815		4,815	1,716	6,531		19
20	Dues, Fees, Subscriptions & Promotions			5,475	5,475		5,475	671	6,146		20
21	Clerical & General Office Expenses	13,102	1,073	3,736	17,911		17,911	20,536	38,447		21
22	Employee Benefits & Payroll Taxes			62,647	62,647		62,647	21,285	83,932		22
23	Inservice Training & Education			524	524		524	830	1,354		23
24	Travel and Seminar							1,381	1,381		24
25	Other Admin. Staff Transportation			2,121	2,121		2,121	1,924	4,045		25
26	Insurance-Prop.Liab.Malpractice			6,653	6,653		6,653	2,731	9,384		26
27	Other (specify):* IL Fine			6,500	6,500		6,500	(6,500)			27
28	TOTAL General Administration	44,599	1,073	206,135	251,807		251,807	(33,755)	218,052		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	284,723	38,968	300,971	624,662		624,662	(12,599)	612,063		29

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

SEE ACCOUNTANTS' COMPILATION 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 Terrace #0034934 Report Period Beginning: 10/01/05 Ending: 09/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			13,737	13,737		13,737	13,537	27,274			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,157	2,157		2,157	9,453	11,610			32
33	Real Estate Taxes			7,331	7,331		7,331	2,097	9,428			33
34	Rent-Facility & Grounds			48,300	48,300		48,300		48,300			34
35	Rent-Equipment & Vehicles			325	325		325	579	904			35
36	Other (specify):*											36
37	TOTAL Ownership			71,850	71,850		71,850	25,666	97,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,364	44,364		44,364		44,364			42
43	Other (specify):* IL Repl Tax			(615)	(615)		(615)	615				43
44	TOTAL Special Cost Centers			43,749	43,749		43,749	615	44,364			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	284,723	38,968	416,570	740,261		740,261	13,682	753,943			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/05

Ending: 09/30/06

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	\$		\$	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,500)	27-3		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				25
26	Income Taxes and Illinois Personal Property Replacement Tax	615	43-4		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,885)		\$	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 Schedule VIII	19,567		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 19,567		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 13,682		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign Terrace

ID# 0034934

Report Period Beginning: 10/01/05

Ending: 09/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

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
See Schedule VII C		See Attached Schedule		Health Services Cons.	Champaign, IL	Consulting
				Cobblestone Rehab.	Champaign, IL	Therapy
				Specialized Dev.	Champaign, IL	Long Term Care
				Developmental Found.	Champaign, IL	Long Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

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	See Schedule VIII	\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace # 0034934 Report Period Beginning: 10/01/05 Ending: 09/30/06

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	Alan Ryle	Chairman	Administrative	0.50	All related party wages are allocations from HSC. See attached allocation spreadsheet and explanation. These individuals receive no compensation from entities other than HSC.			Administrative	\$ 849	17-7	1
2	Lynn Ryle	Director	Administrative	0.50				Administrative	886	17-7	2
3											3
4	Alan Ryle	Chairman	Directors Fees	0.50				Directors Fees	48	18-7	4
5	Lynn Ryle	Director	Directors Fees	0.50				Directors Fees	48	18-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,831		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 Terrace

0034934

Report Period Beginning:

10/01/05

Ending: 09/30/06

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 Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-3754
 Fax Number (217) 398-0944

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	10	Nursing						(26,213)	1
2	6	Maintenance						(5,680)	2
3	17	Administrative						(113,664)	3
4									4
5	3	Housekeeping	Beds	400	207	1,826	16	73	5
6	5	Heat & Utilities	Beds	400	207	44,092	16	1,764	6
7	6	Maintenance	Beds	400	207	285,846	16	15,775	7
8	9	Medical Director	Beds	400	207	869	16	35	8
9	10	Nursing	Beds	400	207	397,105	16	32,202	9
10	11	Activities	Beds	400	207		16	0	10
11	12	Social	Beds	400	207		16	0	11
12	13	Nurse Training	Beds	400	207		16	0	12
13	14	Program Transportation	Beds	400	207	79,974	16	3,199	13
14	17	Administrative	Beds	400	207	705,293	16	35,239	14
15	18	Director Fees	Beds	400	207	2,400	16	96	15
16	19	Professional Fees	Beds	400	207	42,413	16	1,697	16
17	20	Dues & Subscriptions	Beds	400	207	16,193	16	648	17
18	21	Clerical	Beds	400	207	509,439	16	20,378	18
19	22	P/R Taxes & Benefits	Beds	400	207	546,483	16	21,285	19
20	23	Inservice	Beds	400	207	20,742	16	830	20
21	24	Travel & Seminar	Beds	400	207	34,518	16	1,381	21
22	25	Administrative Transportation	Beds	400	207	48,090	16	1,924	22
23	26	Insurance	Beds	400	207	64,001	16	2,560	23
24	30	Depreciation	Beds	400	207	338,436	16	13,537	24
25	TOTALS					\$ 3,137,720	\$ 1,697,764	\$ 7,066	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/05

Ending: 09/30/06

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 Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-3754
 Fax Number (217) 398-0944

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	32	Interest	Beds	400	207	\$ 194,077	\$ 16	\$ 7,763	1
2	33	Real Estate Tax	Beds	400	207	52,435	16	2,097	2
3	34	Building Lease	Beds	400	207		16		3
4	35	Equipment Lease	Beds	400	207	14,468	16	579	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,398,700	\$ 1,697,764	\$ 17,505	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/05

Ending: 09/30/06

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 The Residential Developers, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

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	11	Activities	Beds	221	112	\$ 8	\$ 16	\$ 1	1
2	19	Professional Fees	Beds	221	112	265	16	19	2
3	20	Dues & Subscriptions	Beds	221	112	322	16	23	3
4	21	Clerical	Beds	221	112	2,186	16	158	4
5	26	Insurance	Beds	221	112	2,356	16	171	5
6	32	Interest	Beds	221	112	23,343	16	1,690	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					\$ 28,480	\$	\$ 2,062	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Ford Credit		x	Vehicle	\$945.00	10/20/05	\$ 30,696	\$ 28,538	10/21/08	6.7400	\$ 337	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Busey Bank		x	Working Capital	N/A	N/A	N/A	N/A			1,820	6								
7	Schedule VIII Allocations		x								9,453	7								
8												8								
9	TOTAL Facility Related				\$945.00		\$ 30,696	\$ 28,538			\$ 11,610	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 30,696	\$ 28,538			\$ 11,610	15								

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

* 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' COMPILATION 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 Terrace

0034934 Report Period Beginning: 10/01/05

Ending: 09/30/06

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<u>5,936</u>	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.)			\$	<u>7,133</u>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>1,197</u>	3																			
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>6,134</u>	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.			\$	<u>7,331</u>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2001	<u>5,382</u>	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2005	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
2002	<u>6,013</u>	9																						
2003	<u>6,354</u>	10																						
2004	<u>6,932</u>	11																						
2005	<u>7,133</u>	12																						
<u>\$8,179 (estimated 2006 tax) x 9/12 = \$6,134</u>																								

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' COMPILATION REPORT

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 Terrace COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0034934

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

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. <u>28-22-11-329-002</u>	<u>Facility</u>	\$ <u>6,823.00</u>	\$ <u>6,823.00</u>
2. <u>28-22-11-329-003</u>	<u>Facility</u>	\$ <u>310.00</u>	\$ <u>310.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>7,133.00</u>	\$ <u>7,133.00</u>

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 & 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 Terrace

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories 1

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).

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: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning:

10/01/05

Ending:

09/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Leasehold Improvements		1994	1,923	49	39	49		588	9
10		Leasehold Improvements		1995	3,983	148	27	148		1,619	10
11		Carpet		1997	9,788	363	27	363		3,503	11
12		Alarm System Upgrade		1999	2,239	83	27	83		619	12
13		Bathroom Repairs		1999	1,647	61	27	61		436	13
14		Carpet		2000	5,981	222	27	222		1,219	14
15		Protective Wall Covering		2000	922	34	27	34		200	15
16		Plumbing		2002	560	21	27	21		90	16
17		Sheeting		2004	853	31	27.5	31		83	17
18		Air Conditioner		2004	1,800	65	27.5	65		147	18
19		Tile		2005	2,351	470	5	470		823	19
20		Furnace/Ductwork		2005	10,814	1,622	5	1,622		1,622	20
21		Water Heater		2006	650	33	5	33		33	21
22		Remodel Bathroom		2006	1,978	18	27.5	18		18	22
23		Remodel Bathroom		2006	4,564	28	27.5	28		28	23
24		Remodel Bathroom		2006	4,479	14	27.5	14		14	24
25		Oak Flooring		2006	1,369	183	5	183		183	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											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 Terrace

0034934

Report Period Beginning:

10/01/05

Ending:

09/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 55,901	\$ 3,443		\$ 3,443	\$	\$ 11,223	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 Terrace # 0034934 Report Period Beginning: 10/01/05 Ending: 09/30/06

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	\$ 12,929	\$ 1,856	\$ 1,856	\$	5/7	\$ 10,397	71
72	Current Year Purchases	5,824	416	416		7	416	72
73	Fully Depreciated Assets	14,101					14,101	73
74								74
75	TOTALS	\$ 32,854	\$ 2,272	\$ 2,272	\$		\$ 24,914	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	Patient Transportation	Ford Van	2005	\$ 40,111	\$ 8,022	\$ 8,022	\$	5	\$ 8,022	76
77										77
78										78
79										79
80	TOTALS			\$ 40,111	\$ 8,022	\$ 8,022	\$		\$ 8,022	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)	\$ 128,866	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,737	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,737	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 44,159	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Flora Bank & Trust: Trust No. 116

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>1988</u>	<u>15</u>	<u>02/03/89</u>	\$ <u>48,300</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1991</u>	<u>1</u>					4
5								5
6								6
7	TOTAL		16		\$ 48,300			7

10. Effective dates of current rental agreement:

Beginning 02/03/04

Ending 02/03/14

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u>09/30/2007</u>	\$ <u>51,600</u>
13.	<u>09/30/2008</u>	\$ <u>51,600</u>
14.	<u>09/30/2009</u>	\$ <u>51,600</u>

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: See Attached *

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: \$ 325 Description: Fax & Copier Lease

(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					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		5,382		5,382
4	Clinical Wages (b)		10,764		10,764
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 16,146	\$	\$ 16,146
10	SUM OF line 9, col. 1 and 2 (e)	\$	16,146		

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

- (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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 Terrace# 0034934Report Period Beginning: 10/01/05

Ending:

09/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/06

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	127,987		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 127,987	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	55,901		15
16	Equipment, at Historical Cost	72,965		16
17	Accumulated Depreciation (book methods)	(44,159)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 84,707	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 212,694	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,300		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,134		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,434	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	28,538		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)	\$ 28,538	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 38,972	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 173,722	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 212,694	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 209,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 209,335	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(29,686)	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)	\$ (29,686)	17
B. Transfers (Itemize):			
18	Transfers (to) from The Residential Developers, Inc.	(5,927)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (5,927)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 173,722	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/05

Ending: 09/30/06

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	\$ 710,575	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 710,575	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 710,575	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	149,796	31
32	Health Care	223,059	32
33	General Administration	251,807	33
B. Capital Expense			
34	Ownership	71,850	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	44,364	36
D. Other Expenses (specify):			
37	<u>IL Repl Tax</u>	(615)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 740,261	40
41	Income before Income Taxes (line 30 minus line 40)**	(29,686)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (29,686)	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. Tax return is on a 12/31 fiscal year and is on the cash basis.

*** 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.

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/05

Ending:

09/30/06

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				1	
2	Assistant Director of Nursing				2	
3	Registered Nurses				3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies				5	
6	CNA Trainees	1,800	1,800	16,146	8.97	6
7	Licensed Therapist				7	
8	Rehab/Therapy Aides				8	
9	Activity Director				9	
10	Activity Assistants	2,190	2,190	19,652	8.97	10
11	Social Service Workers				11	
12	Dietician				12	
13	Food Service Supervisor				13	
14	Head Cook	1,770	1,838	16,036	8.72	14
15	Cook Helpers/Assistants	1,825	1,825	16,377	8.97	15
16	Dishwashers				16	
17	Maintenance Workers				17	
18	Housekeepers	2,920	2,920	26,203	8.97	18
19	Laundry	1,460	1,460	13,102	8.97	19
20	Administrator				20	
21	Assistant Administrator				21	
22	Other Administrative	2,417	2,591	31,497	12.16	22
23	Office Manager				23	
24	Clerical	1,460	1,460	13,102	8.97	24
25	Vocational Instruction				25	
26	Academic Instruction				26	
27	Medical Director				27	
28	Qualified MR Prof. (QMRP)	1,272	1,534	22,438	14.63	28
29	Resident Services Coordinator				29	
30	Habilitation Aides (DD Homes)	9,439	12,276	110,170	8.97	30
31	Medical Records				31	
32	Other Health Care(specify)				32	
33	Other(specify)				33	
34	TOTAL (lines 1 - 33)	26,553	29,894	\$ 284,723 *	\$ 9.52	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	\$ 1,702	1-3	35
36	Medical Director	1,800	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	24,449	10-3	38
39	Pharmacist Consultant	192	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	5,501	10-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	3,076	10-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychologist	1,455	10-3	47
48	Dentist	139	10-3	48
49	TOTAL (lines 35 - 48)	\$ 38,314		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Terrace

0034934

Report Period Beginning: 10/01/05

Ending: 09/30/06

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	
Anna Cho	QMRP/Admin	0	\$ 503	Workers' Compensation Insurance	\$ 8,909	IDPH License Fee	\$ 2,850	
Emily Ann McCabe	QMRP/Admin	0	6,180	Unemployment Compensation Insurance	9,259	Advertising: Employee Recruitment	760	
David E. Zanton	QMRP/Admin	0	797	FICA Taxes	21,781	Health Care Worker Background Check	(Indicate # of checks performed <u>45</u>)	
Sarah R. Roper	Administrative	0	24,018	Employee Health Insurance	15,949	Patient Background Checks		
				Employee Meals	4,391	Dues & Subscriptions	1,865	
				Illinois Municipal Retirement Fund (IMRF)*		Schedule VIII Allocation	671	
				Other	2,358			
				Schedule VIII Allocation	21,285	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 31,497	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 83,932		\$ 6,146		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management & Support Staff Fee			\$ 113,664	None			Out-of-State Travel	\$
							In-State Travel	
							Schedule VIII Allocation	1,381
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 113,664	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 1,381	
C. Professional Services								
Vendor/Payee	Type	Amount						
Martin, Hood, Friese & Associates	Accounting	\$ 1,985						
Thomas, Mamer, & Haughey	Legal	1,642						
Various	Other Prof. Services	1,188						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 4,815					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Champaign Terrace

Report Period Beginning: 10/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 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

