

Facility Name & ID Number Champaign County Nursing Home

0046664 Report Period Beginning: 12/01/2006 Ending: 11/30/2007

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 06/01/2007

	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)	187	60,067	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5	34	Sheltered Care (SC)		6,188	5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	86,695	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	Total	
8	SNF	1,616	1,037	4,618	7,271	8
9	SNF/PED					9
10	ICF	40,970	19,045		60,015	10
11	ICF/DD					11
12	SC	439	195		634	12
13	DD 16 OR LESS					13
14	TOTALS	43,025	20,277	4,618	67,920	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.34%

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 2006

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 187 and days of care provided 4,618

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: 11/30/2007 Fiscal Year: 11/30/2007

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/2006 Ending: 11/30/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	829,563	70,176	16,013	915,752		915,752	(1,426)	914,326		1
2	Food Purchase		461,793		461,793		461,793	(13,253)	448,540		2
3	Housekeeping	532,580	79,971		612,551		612,551	(2,762)	609,789		3
4	Laundry	137,743	28,495		166,238		166,238		166,238		4
5	Heat and Other Utilities			540,109	540,109		540,109	(18,655)	521,454		5
6	Maintenance	144,076	17,021	75,929	237,026		237,026	(3,210)	233,816		6
7	Other (specify):*										7
8	TOTAL General Services	1,643,962	657,456	632,051	2,933,469		2,933,469	(39,306)	2,894,163		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	3,523,265	302,906	1,341,382	5,167,553		5,167,553		5,167,553		10
10a	Therapy	57,171	288	567,495	624,954		624,954		624,954		10a
11	Activities	154,838	3,568	1,125	159,531		159,531		159,531		11
12	Social Services	160,846			160,846		160,846		160,846		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Day Care	174,002	2,083	85,334	261,419		261,419	(261,419)			15
16	TOTAL Health Care and Programs	4,070,122	308,845	1,999,536	6,378,503		6,378,503	(261,419)	6,117,084		16
	C. General Administration										
17	Administrative	92,456		34,093	126,549		126,549	(206)	126,343		17
18	Directors Fees										18
19	Professional Services			94,986	94,986		94,986	(1,174)	93,812		19
20	Dues, Fees, Subscriptions & Promotions			58,551	58,551		58,551	(26,056)	32,495		20
21	Clerical & General Office Expenses	452,768	26,992	53,900	533,660		533,660	10,130	543,790		21
22	Employee Benefits & Payroll Taxes			1,870,949	1,870,949		1,870,949	(51,564)	1,819,385		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,298	9,298		9,298		9,298		24
25	Other Admin. Staff Transportation			10,487	10,487		10,487	(63)	10,424		25
26	Insurance-Prop.Liab.Malpractice			332,000	332,000		332,000	(3,285)	328,715		26
27	Other (specify):*										27
28	TOTAL General Administration	545,224	26,992	2,464,264	3,036,480		3,036,480	(72,218)	2,964,262		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,259,308	993,293	5,095,851	12,348,452		12,348,452	(372,943)	11,975,509		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.

#

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			609,215	609,215		609,215	(90,419)	518,796			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,306	4,306		4,306	748,803	753,109			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,022	25,022		25,022		25,022			35
36	Other (specify):*											36
37	TOTAL Ownership			638,543	638,543		638,543	658,384	1,296,927			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,131		128,131		128,131		128,131			39
40	Barber and Beauty Shops	54,208	1,575		55,783		55,783		55,783			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,760	128,760		128,760		128,760			42
43	Other (specify):* Non-allowable Cos			2,536,058	2,536,058		2,536,058	(2,536,058)				43
44	TOTAL Special Cost Centers	54,208	129,706	2,664,818	2,848,732		2,848,732	(2,536,058)	312,674			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,313,516	1,122,999	8,399,212	15,835,727		15,835,727	(2,250,617)	13,585,110			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

0046664

Report Period Beginning:

12/01/2006

Ending:

11/30/2007

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	BHF USE ONLY	
1	Day Care	\$ (261,419)	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	(66,119)	30		9
10	Interest and Other Investment Income	(4,306)	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	(6,500)	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	(21,903)	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 See Pg. 5A	(1,903,749)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,263,996)		\$	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)	13,379		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,379		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,250,617)		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# 0046664

Report Period Beginning: 12/01/2006

Ending: 11/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset miscellaneous revenue	\$ (2,759)	21	1
2	Offset meal revenue against food cost	(5,615)	2	2
3	Cable TV expense	(20,616)	43	3
4	Transfers to general corp fund	(51,774)	43	4
5	Public relations expense	(191)	43	5
6	Grant match	(2,443,475)	43	6
7	Laboratory fees	(11,074)	43	7
8	Medicare ancillary expense	(2,428)	43	8
9	Disallow retainer legal fees	(500)	19	9
10	Non-allowable Lobbying Dues	(4,153)	20	10
11	Bond interest on building from county	753,109	32	11
12	Disallow indirect day care costs:			12
13	Dietary	(1,426)	1	13
14	Food	(7,638)	2	14
15	Housekeeping	(2,762)	3	15
16	Utilities	(18,655)	5	16
17	Maintenance	(3,210)	6	17
18	Administrative	(206)	17	18
19	Professional Fees	(674)	19	19
20	Office	(490)	21	20
21	Employee Benefirs	(51,564)	22	21
22	Staff Transportation	(63)	25	22
23	Insurance - Auto	(1,276)	26	23
24	Insurance - Other	(2,009)	26	24
25	Depreciation - Auto	(3,375)	30	25
26	Depreciation - Other	(20,925)	30	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	(1,903,749)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006

Ending:

11/30/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(1,426)	0	0	0	0	0	0	0	0	0	0	(1,426)	1
2	Food Purchase	(13,253)	0	0	0	0	0	0	0	0	0	0	(13,253)	2
3	Housekeeping	(2,762)	0	0	0	0	0	0	0	0	0	0	(2,762)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(18,655)	0	0	0	0	0	0	0	0	0	0	(18,655)	5
6	Maintenance	(3,210)	0	0	0	0	0	0	0	0	0	0	(3,210)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(39,306)	0	0	0	0	0	0	0	0	0	0	(39,306)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(261,419)	0	0	0	0	0	0	0	0	0	0	(261,419)	15
16	TOTAL Health Care and Programs	(261,419)	0	0	0	0	0	0	0	0	0	0	(261,419)	16
	C. General Administration													
17	Administrative	(206)	0	0	0	0	0	0	0	0	0	0	(206)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,174)	0	0	0	0	0	0	0	0	0	0	(1,174)	19
20	Fees, Subscriptions & Promotions	(26,056)	0	0	0	0	0	0	0	0	0	0	(26,056)	20
21	Clerical & General Office Expenses	(3,249)	13,379	0	0	0	0	0	0	0	0	0	10,130	21
22	Employee Benefits & Payroll Taxes	(51,564)	0	0	0	0	0	0	0	0	0	0	(51,564)	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	(63)	0	0	0	0	0	0	0	0	0	0	(63)	25
26	Insurance-Prop.Liab.Malpractice	(3,285)	0	0	0	0	0	0	0	0	0	0	(3,285)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(85,597)	13,379	0	(72,218)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(386,322)	13,379	0	(372,943)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006

Ending:

11/30/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(90,419)	0	0	0	0	0	0	0	0	0	0	(90,419)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	748,803	0	0	0	0	0	0	0	0	0	0	748,803	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	658,384	0	0	0	0	0	0	0	0	0	0	658,384	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):*	(2,536,058)	0	0	0	0	0	0	0	0	0	0	(2,536,058)	43
44	TOTAL Special Cost Centers	(2,536,058)	0	0	0	0	0	0	0	0	0	0	(2,536,058)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,263,996)	13,379	0	(2,250,617)	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	21 Computer Assistance		Champaign County	100.00%	13,379	13,379	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 13,379	\$ * 13,379	14

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

Facility Name & ID Number

Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006

Ending:

11/30/2007

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									8
9	transactions with the nursing home during the reporting period.									9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0046664 Report Period Beginning: 12/01/2006

Ending: 1/30/2007

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	203,392		\$ 86,189	\$ 3,364	\$ 1,426	1
2	2	Food	Meals	203,392		461,793	3,364	7,638	2
3	3	Housekeeping	Square Feet	135,500		79,971	4,680	2,762	3
4	5	Utilities	Square Feet	135,500		540,109	4,680	18,655	4
5	6	Maintenance	Square Feet	135,500		92,950	4,680	3,210	5
6	17	Administrative	Revenue	13,430,850		34,093	81,289	206	6
7	19	Professional Fees	Revenue	13,430,850		111,356	81,289	674	7
8	21	Office Expense	Revenue	13,430,850		80,892	81,289	490	8
9	22	Employee Benefits	Salaries	6,313,516		1,870,949	174,002	51,564	9
10	25	Staff Transportation	Revenue	13,430,850		10,487	81,289	63	10
11	26	Insurance - Auto	Direct	1		1,276	1	1,276	11
12	26	Insurance - Other	Revenue	13,430,850		332,000	81,289	2,009	12
13	30	Depreciation - Auto	Direct	1		3,375	1	3,375	13
14	30	Depreciation - Other	Square Feet	135,500		605,840	4,680	20,925	14
15	21	Computer assistance	Direct	1		13,379	10,622	13,379	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,324,659	\$ 10,622	\$ 127,652	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006

Ending:

11/30/2007

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	Capital Lease	X		Lifts	\$945.00	12/15/05	\$ 22,614	\$ 9,553	11/15/08	0.2878	\$ 4,306	1								
2	Bondholders	X		Construction of New Facility	\$69,583.00						753,109	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$70,528.00		\$ 22,614	\$ 9,553			\$ 757,415	9								
B. Non-Facility Related*																				
10							Interest income offset				(4,306)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(4,306)	14								
15	TOTALS (line 9+line14)						\$ 22,614	\$ 9,553			\$ 753,109	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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 2006 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.)	2006	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	N/A
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:	2002	N/A	8
	2003		9
	2004		10
	2005		11
	2006		12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0046664

CONTACT PERSON REGARDING THIS REPORT 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006 Ending:

11/30/2007

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Adult Day Care Services
4,680 Square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Facility, 670,000, 2007, \$, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 670,000, (blank), \$, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006 Ending: 11/30/2007

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	243	2007	2007	\$ 23,227,194	\$ 511,114	40	\$ 435,510	\$ (75,604)	\$ 483,994	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Land Improvements for new building		2007	443,467	30,980	20	16,630	(14,350)	30,396	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

*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

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)	\$ 23,670,661	\$ 542,094		\$ 452,140	\$ (89,954)	\$ 514,390	70

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	\$ 874,451	\$ 63,610	\$ 87,445	\$ 23,835	10	\$ 273,864	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Disallow indirect day care cost			(24,300)	(24,300)			74
75	TOTALS	\$ 874,451	\$ 63,610	\$ 63,145	\$ (465)		\$ 273,864	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	\$	\$	\$	10	\$ 36,532	76
77	Resident Use	98 Dodge Van	1998	33,746	3,375	3,375		10	32,060	77
78	Resident Use	Lift for Van	2001	537				5	537	78
79	Resident Use	97 Ford	2002	1,358	136	136		10	713	79
80	TOTALS			\$ 72,173	\$ 3,511	\$ 3,511	\$		\$ 69,842	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)	\$ 24,617,285	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 609,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 518,796	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (90,419)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 858,096	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' 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

00
00

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: N/A *

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.	_____/2008	\$ _____
13.	_____/2009	\$ _____
14.	_____/2010	\$ _____

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: \$ 25,022 Description: Trash compactor-3484; Mattresses-11477; Wound vac.-1498; Concentrator-1935; O2 cylinders-742;

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Dishwasher-3327; Tools-2559

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	hrs	\$	4,274	\$ 256,452	\$	4,274	\$ 256,452	1
2	Licensed Speech and Language Development Therapist	L10A C2	hrs		1,264	75,841		1,264	75,841	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C2,3	hrs		3,920	235,202	288	3,920	235,490	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				128,131		128,131	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			\$	9,458	\$ 567,495	\$ 128,419	9,458	\$ 695,914	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

0046664

Report Period Beginning: 12/01/2006

Ending: 11/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2007

(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	\$ 148,202	\$ 148,202	1
2	Cash-Patient Deposits	10,875	10,875	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,365)	2,011,433	2,011,433	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	29,543	29,543	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other receivables	357,765	357,765	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,557,818	\$ 2,557,818	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	23,227,194	23,227,194	14
15	Leasehold Improvements, at Historical Cost	443,467	443,467	15
16	Equipment, at Historical Cost	946,624	946,624	16
17	Accumulated Depreciation (book methods)	(858,096)	(858,096)	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)	\$ 23,759,189	\$ 23,759,189	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,317,007	\$ 26,317,007	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 988,510	\$ 988,510	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,875	10,875	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	728,078	728,078	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	See Schedule 17A	919,217	919,217	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,646,680	\$ 2,646,680	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)	\$ 2,646,680	\$ 2,646,680	46
47	TOTAL EQUITY(page 18, line 24)	\$ 23,670,327	\$ 23,670,327	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 26,317,007	\$ 26,317,007	48

Champaign County Nursing Home

Provider #: 0001636

12/1/2006 to 11/30/2007

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Other Current Liabilities - Line 36		
Due to General Corp Fund	361,015	361,015
Due to Other Funds	548,649	548,649
Obligations Under Capital Lease	9,553	9,553
	<u>919,217</u>	<u>919,217</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,971,737	1
2	Restatements (describe):		2
3	Prior Period Adj.	237,623	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,209,360	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	21,460,967	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)	\$ 21,460,967	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)	\$ 23,670,327	24 *

* 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	\$ 13,349,561	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,349,561	3
	B. Ancillary Revenue		
4	Day Care	81,289	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 81,289	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	153,074	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	45,515	13
14	Non-Patient Meals	5,615	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	75,248	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 279,452	23
	D. Non-Operating Revenue		
24	Contributions	22,378,211	24
25	Interest and Other Investment Income***	27,610	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,405,821	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	852,759	28
28a	Interfund transfer from General Corp.	327,812	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,180,571	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 37,296,694	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,933,469	31
32	Health Care	6,378,503	32
33	General Administration	3,036,480	33
	B. Capital Expense		
34	Ownership	638,543	34
	C. Ancillary Expense		
35	Special Cost Centers	2,719,972	35
36	Provider Participation Fee	128,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,835,727	40
41	Income before Income Taxes (line 30 minus line 40)**	21,460,967	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 21,460,967	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.

*** 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

12/1/2006 to 11/30/2007

Schedule 19A

XVII. Income Statement

Line 28 Other Income(specify):

<u>Description</u>	<u>Amount</u>
Taxes - Current Operating	838,790
Other Operating Taxes	234
Mobile Home Tax	1,164
Payment in Lieu of Taxes	372
Resident Transportation	3,150
Late charges	6,290
Misc Income	2,759
Total - Line 28	<u>852,759</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0046664

Report Period Beginning:

12/01/2006

Ending:

11/30/2007

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	2,087	2,115	\$ 70,214	\$ 33.20	1
2	Assistant Director of Nursing	2,082	2,041	60,183	29.48	2
3	Registered Nurses	17,593	18,020	468,147	25.98	3
4	Licensed Practical Nurses	26,255	25,933	570,900	22.01	4
5	CNAs & Orderlies	159,011	158,400	2,068,303	13.06	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	6,083	6,037	57,171	9.47	8
9	Activity Director	2,085	1,999	40,539	20.28	9
10	Activity Assistants	10,290	9,760	114,299	11.71	10
11	Social Service Workers	10,105	9,783	160,846	16.44	11
12	Dietician	0	0			12
13	Food Service Supervisor	3,870	4,045	95,413	23.59	13
14	Head Cook	2,499	2,498	43,390	17.37	14
15	Cook Helpers/Assistants	71,134	70,698	690,760	9.77	15
16	Dishwashers	0	0			16
17	Maintenance Workers	8,263	8,379	144,076	17.19	17
18	Housekeepers	48,882	49,939	532,580	10.66	18
19	Laundry	15,127	15,221	137,743	9.05	19
20	Administrator	2,088	2,215	92,456	41.73	20
21	Assistant Administrator	1,979	2,710	77,371	28.55	21
22	Other Administrative	0	0			22
23	Office Manager	0	0			23
24	Clerical	22,811	24,072	375,397	15.59	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	0	0			28
29	Resident Services Coordinator	0	0			29
30	Habilitation Aides (DD Homes)	0	0			30
31	Medical Records	2,146	2,220	24,453	11.02	31
32	Other Health C: See Sch 20A	24,957	24,845	435,067	17.51	32
33	Other(specify) Barber and Beaut	4,809	4,838	54,208	11.20	33
34	TOTAL (lines 1 - 33)	444,157	445,769	\$ 6,313,516 *	\$ 14.16	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	389	\$ 16,013	L1 C3	35
36	Medical Director	Monthly	4,200	L9 C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	17,418	L10 C3	38
39	Pharmacist Consultant	Monthly	3,300	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	Monthly	1,108	L11 C3	44
45	Social Service Consultant				45
46	Other(specify) MDS Consultant	Monthly	27,826	L10 C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	389	\$ 69,865		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9,532	\$ 410,451	L10 C3	50
51	Licensed Practical Nurses	18,913	651,082	L10 C3	51
52	Certified Nurse Assistants/Aides	9,929	216,315	L10 C3	52
53	TOTAL (lines 50 - 52)	38,374	\$ 1,277,848		53

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

Provider #: 0046664

12/01/2006 to 11/30/2007

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	2,072	2,559	68,752	26.86
Other Nursing Supervisors	5,472	4,722	121,586	25.75
Dental Hygienist	1,547	1,591	36,036	22.64
Adult Day Care	12,493	12,610	174,002	13.80
Unit Secretary	3,374	3,363	34,691	10.32
Total - Line 32	<u>24,957</u>	<u>24,845</u>	<u>435,067</u>	<u>17.51</u>

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount			
Andrew Buffenbarger	Administrator	0	\$ 92,456	Workers' Compensation Insurance		\$ 194,178	IDPH License Fee		\$ 995			
				Unemployment Compensation Insurance		104,194	Advertising: Employee Recruitment		14,685			
				FICA Taxes		457,814	Health Care Worker Background Check (Indicate # of checks performed <u>93</u>)		2,500			
				Employee Health Insurance		573,218	Patient Background Checks <u>100</u>		2,574			
				Employee Meals		0	Illinois Health Care Assn. dues		14,168			
				Illinois Municipal Retirement Fund (IMRF)*		474,323	Marketing, Public Relations Expense		21,903			
				Child Day Care Benefit		0	Miscellaneous dues & publications		1,225			
				Employee Morale		5,659	Miscellaneous licenses & fees		501			
				Employee Labs & Physicals		9,999	Less: Public Relations Expense		(21,903)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,456	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,819,385	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 32,495			
B. Administrative - Other												
Description			Amount									
Champaign County - Audit & Accounting Services			\$ 34,093				Yellow page advertising ()					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 34,093									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount			
Champaign County Treasurer	Accounting		\$ 25,682	N/A			Out-of-State Travel		\$			
RSM/McGladrey & Pullen	Accounting		8,685				In-State Travel					
Duane Morris LLP	Consulting		5,670				Inservice Training		3,216			
Elvidge Kelley	Legal		1,864				Seminar Expense		6,082			
Ernat & Associates	Legal		6,108				Entertainment Expense ()					
G.A.K. Consulting	Legal		4,200				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 9,298			
Heyl, Royster, Voelker & Allen	Legal		26,466									
Hasselberg, Rock, Bell	Legal		2,109									
Jennifer Scully	Legal		2,738									
North Shore Associates	Legal		2,100									
AT&T	Computer		585									
Scc Schedule 21A	Various		8,779									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 94,986	TOTAL		\$						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Champaign County Nursing Home

Provider #: 0001636

12/1/2006 to 11/30/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Brought forward from page 21		86,207
<u>Vendor</u>	<u>Type</u>	
Egix, Inc.	Computer	48
Lifecare Software Solutions, Inc.	Computer	690
Champaign County Auditor	Computer	20
Ivans	Computer	7,639
Insight Communications	Computer	382
<hr/>		
	Subtotal	<u>8,779</u>
Total agreeing to Schedule V, Line 19, Col 3		94,986
Allocated to Day Care and eliminated		(674)
Disallowed Legal Fees Retainer		(500)
Total (agree to Schedule V, line 19, column 8)		<u><u>93,812</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A							N/A					
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# 0046664Report Period Beginning: 12/01/2006Ending: 11/30/2007**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-14168
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 72,787 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. \$ 128,760
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? Yes Indicate the amount. \$ 5,615
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT