

Facility Name & ID Number Champaign County Nursing Home

0046664 Report Period Beginning: 12/01/08 Ending: 11/30/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	187	Skilled (SNF)	187	68,255	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,695	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,100	18,777	7,555	50,432	8
9	SNF/PED					9
10	ICF	10,871	6,962	363	18,196	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,971	25,739	7,918	68,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.38%

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

0 (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

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES 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 7,555

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: 11/30/09 Fiscal Year: 11/30/09

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

Facility Name & ID Number Champaign County Nursing Home # 0046664 Report Period Beginning: 12/01/08 Ending: 11/30/09

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	517,011	54,332	18,596	589,939		589,939	(2,200)	587,739		1
2	Food Purchase		358,981		358,981		358,981	(15,695)	343,286		2
3	Housekeeping	384,619	57,267		441,886		441,886	(1,978)	439,908		3
4	Laundry	114,870	36,818		151,688		151,688		151,688		4
5	Heat and Other Utilities			525,404	525,404		525,404	(18,147)	507,257		5
6	Maintenance	59,094	17,294	76,986	153,374		153,374	(3,256)	150,118		6
7	Other (specify):*										7
8	TOTAL General Services	1,075,594	524,692	620,986	2,221,272		2,221,272	(41,276)	2,179,996		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	4,219,117	349,819	1,525,742	6,094,678		6,094,678		6,094,678		10
10a	Therapy	78,046	3,384	1,232,832	1,314,262		1,314,262		1,314,262		10a
11	Activities	152,508	2,427	1,603	156,538		156,538		156,538		11
12	Social Services	129,772		1,419	131,191		131,191		131,191		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Adult Day Care	159,472	12,519	66,389	238,380		238,380	(238,380)			15
16	TOTAL Health Care and Programs	4,738,915	368,149	2,832,185	7,939,249		7,939,249	(238,380)	7,700,869		16
	C. General Administration										
17	Administrative	105,055		307,774	412,829		412,829		412,829		17
18	Directors Fees										18
19	Professional Services			165,053	165,053		165,053	(2,255)	162,798		19
20	Dues, Fees, Subscriptions & Promotions			63,825	63,825		63,825	(15,317)	48,508		20
21	Clerical & General Office Expenses	252,224	31,699	61,494	345,417		345,417	(2,205)	343,212		21
22	Employee Benefits & Payroll Taxes			1,686,514	1,686,514		1,686,514		1,686,514		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,703	14,703		14,703		14,703		24
25	Other Admin. Staff Transportation			1,627	1,627		1,627	(8)	1,619		25
26	Insurance-Prop.Liab.Malpractice			343,941	343,941		343,941	(4,895)	339,046		26
27	Other (specify):*										27
28	TOTAL General Administration	357,279	31,699	2,644,931	3,033,909		3,033,909	(24,680)	3,009,229		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,171,788	924,540	6,098,102	13,194,430		13,194,430	(304,336)	12,890,094		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 County Nursing Home

#0046664

Report Period Beginning:

12/01/08

Ending:

11/30/09

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			709,335	709,335		709,335	(29,798)	679,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,520	15,520		15,520	(4,174)	11,346			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,757	32,757		32,757		32,757			35
36	Other (specify):*											36
37	TOTAL Ownership			757,612	757,612		757,612	(33,972)	723,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		231,950		231,950		231,950		231,950			39
40	Barber and Beauty Shops	35,521	803		36,324		36,324		36,324			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			2,017,121	2,017,121		2,017,121		2,017,121			42
43	Other (specify):* Non-allowable cost			104,783	104,783		104,783	(104,783)				43
44	TOTAL Special Cost Centers	35,521	232,753	2,121,904	2,390,178		2,390,178	(104,783)	2,285,395			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,207,309	1,157,293	8,977,618	16,342,220		16,342,220	(443,091)	15,899,129			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: 12/01/08

Ending: 11/30/09

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	\$ (238,380)	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	(5,298)	30		9
10	Interest and Other Investment Income	(4,174)	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	(4,290)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,922)	20		28
29	Other-Attach Schedule See PG5A	(176,027)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (443,091)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization & Pre-Operating Expense			
33				33
	Adjustments for Related Organization Costs (Schedule VII)			
34				34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (443,091)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

ID# 0046664

Report Period Beginning: 12/01/08

Ending: 11/30/09

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Offset miscellaneous revenue	\$ (1,752)	21	1
2	Offset meal revenue against food cost	(4,867)	2	2
3	Cable TV expense	(24,920)	43	3
4				4
5	Non-allowable dues	(91)	20	5
6				6
7	Laboratory fees	(27,464)	43	7
8	Medicare ancillary expense	(46,625)	43	8
9				9
10	Non-allowable Lobbying Dues	(304)	20	10
11	Loss on disposal	(1,170)	43	11
12	Public relations expense	(314)	43	12
13				13
14	Disallow Indirect Adult Day Care Costs:			14
15	Dietary	(2,200)	1	15
16	Food	(10,828)	2	16
17	Housekeeping	(1,978)	3	17
18	Utilities	(18,147)	5	18
19	Maintenance	(3,256)	6	19
20	Professional Fees	(880)	19	20
21	Office	(453)	21	21
22	Staff Transportation	(8)	25	22
23	Insurance - Auto	(3,119)	26	23
24	Insurance - Other	(1,776)	26	24
25	Depreciation - Other	(24,500)	30	25
26				26
27				27
28				28
29				29
30	Out-of-Period Legal Exp	(1,375)	19	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	(176,027)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign County Nursing Home# 0046664 Report Period Beginning:

12/01/08

Ending:

11/30/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(2,200)	0	0	0	0	0	0	0	0	0	0	(2,200)	1
2	Food Purchase	(15,695)	0	0	0	0	0	0	0	0	0	0	(15,695)	2
3	Housekeeping	(1,978)	0	0	0	0	0	0	0	0	0	0	(1,978)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(18,147)	0	0	0	0	0	0	0	0	0	0	(18,147)	5
6	Maintenance	(3,256)	0	0	0	0	0	0	0	0	0	0	(3,256)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(41,276)	0	0	0	0	0	0	0	0	0	0	(41,276)	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):*	(238,380)	0	0	0	0	0	0	0	0	0	0	(238,380)	15
16	TOTAL Health Care and Programs	(238,380)	0	0	0	0	0	0	0	0	0	0	(238,380)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,255)	0	0	0	0	0	0	0	0	0	0	(2,255)	19
20	Fees, Subscriptions & Promotions	(15,317)	0	0	0	0	0	0	0	0	0	0	(15,317)	20
21	Clerical & General Office Expenses	(2,205)	0	0	0	0	0	0	0	0	0	0	(2,205)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	25
26	Insurance-Prop.Liab.Malpractice	(4,895)	0	0	0	0	0	0	0	0	0	0	(4,895)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,680)	0	0	0	0	0	0	0	0	0	0	(24,680)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(304,336)	0	0	0	0	0	0	0	0	0	0	(304,336)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign County Nursing Home# 0046664

Report Period Beginning:

12/01/08 Ending:

11/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(29,798)	0	0	0	0	0	0	0	0	0	0	(29,798)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,174)	0	0	0	0	0	0	0	0	0	0	(4,174)	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	(33,972)	0	0	0	0	0	0	0	0	0	0	(33,972)	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):*	(104,783)	0	0	0	0	0	0	0	0	0	0	(104,783)	43
44	TOTAL Special Cost Centers	(104,783)	0	0	0	0	0	0	0	0	0	0	(104,783)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(443,091)	0	0	0	0	0	0	0	0	0	0	(443,091)	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
Champaign County	100	N/A	N/A	Champaign County	Urbana	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	3
4											4
5											5
6											6
7											7
8											8
9	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business 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:

12/01/08

Ending: 11/30/09

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 Day Care Cost
 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	207,237	\$ 72,928	\$	6,251	\$ 2,200	1
2	2	Food	Meals	207,237	358,981		6,251	10,828	2
3	3	Housekeeping	Square Feet	135,500	57,267		4,680	1,978	3
4	5	Utilities	Square Feet	135,500	525,404		4,680	18,147	4
5	6	Maintenance	Square Feet	135,500	94,280		4,680	3,256	5
6	19	Professional Fees	Revenue	16,205,933	170,452		83,669	880	6
7	21	Office Expense	Revenue	16,205,933	87,794		83,669	453	7
8	25	Staff Transportation	Revenue	16,205,933	1,627		83,669	8	8
9	26	Insurance - Auto	Direct	1	3,119		1	3,119	9
10	26	Insurance - Other	Revenue	16,205,933	343,941		83,669	1,776	10
11	30	Depreciation - Other	Square Feet	135,500	709,335		4,680	24,500	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				\$ 2,425,128	\$		\$ 67,145	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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	N/A						\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Interfund Loan		X	Champaign County							15,520	6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$ 15,520	9						
B. Non-Facility Related*																		
10												10						
11										Offset interest income	(4,174)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (4,174)	14						
15	TOTALS (line 9+line14)						\$	\$			\$ 11,346	15						

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

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

1. Real Estate Tax accrual used on 2008 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.)	2008	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	N/A 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	N/A	8
	2005		9
	2006		10
	2007		11
	2008		12
County nursing home. Exempt from real estate tax.			
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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

Term Care Facilities with Real Estate Tax Rates RE: 2008 REAL ESTATE TAX COST DOCUMENTATION

et the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax bills, as well as copies of your original real estate tax bills for calendar 2008.

plete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Finance Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

if these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at 330.

2008 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 2008 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 2008.

(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>N/A</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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? (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).

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 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: N/A
 (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	<u>Facility</u>	<u>670,000</u>	<u>2007</u>	<u>\$ 253,543</u>	1
2					2
3	TOTALS	670,000		\$ 253,543	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 577,728	40	\$ 580,680	\$ 2,952	\$ 1,645,354	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	New NH parking lot		2007		189,924	36,155	20	22,173	(13,982)	74,742	10
11	Masonry sign		2008		16,740	670	25	670		1,005	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)	\$ 23,433,858	\$ 614,553		\$ 603,523	\$ (11,030)	\$ 1,721,101	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	\$ 906,153	\$ 89,139	\$ 93,785	\$ 4,646	10	\$ 458,265	71
72	Current Year Purchases	77,718	4,231	5,181	950	5-10	5,181	72
73	Fully Depreciated Assets							73
74	Disallowed Day Care Depreciation			(24,500)	(24,500)			74
75	TOTALS	\$ 983,871	\$ 93,370	\$ 74,466	\$ (18,904)		\$ 463,446	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				\$	\$	\$	\$		\$	76
77	See Sch13A	See Sch13A	See Sch13A	156,853	1,412	1,548	136	5-10	73,213	77
78										78
79										79
80	TOTALS			\$ 156,853	\$ 1,412	\$ 1,548	\$ 136		\$ 73,213	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)	\$ 24,828,125	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 709,335	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 679,537	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,798)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,257,760	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

Champaign County Nursing Home

Provider #: 0001636

12/1/2008 to 11/30/2009

Schedule 13A

XI. OWNERSHIP COSTS (continued)

D. Vehicle Depreciation (See instructions.)*

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Life in Years	Accumulated Depreciation
Resident Use	96 Ford Bus	1996	36,532			0	10	36,532
Resident Use	98 Dodge Van	1998	33,746			0	10	33,746
Resident Use	Lift for Van	2001	537			0	5	537
Resident Use	97 Ford	2002	1,358		136	136	10	984
Resident Use	Mini Van Paratransit w/ ramp	2009	33,104	552	552	0	5	552
Resident Use	09 Ford Eldorado Van	2009	51,576	860	860	(0)	5	860
			156,853	1,412	1,548	136		73,211

Facility Name & ID Number Champaign County Nursing Home

0046664

Report Period Beginning: 12/01/08

Ending: 11/30/09

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

**

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

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

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

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: \$ 32,757

Description: See Sch14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

Provider #: 0001636

12/1/2008 to 11/30/2009

Schedule 14A

XII. RENTAL COSTS

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

16. Rental Amount for movable equipment:

Description	Amount
Trash Compactor	3,484
Cleaner	28
Arjo	669
Wound Vac	12,218
Oxygen Cylinders	1,895
Mattresses	3,147
CPM	5,677
Dishwasher	4,851
Miscellaneous	788
	<u>32,757</u>

To PG14, Ln 16

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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			
	1	2	3	4
	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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10A(2,3)	hrs	\$	7,415	\$ 556,123	\$ 2,411	7,415	\$ 558,534	1
2	Licensed Speech and Language Development Therapist	10A(2,3)	hrs		1,968	147,579	246	1,968	147,825	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		7,055	529,130	727	7,055	529,857	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				231,950		231,950	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	16,438	\$ 1,232,832	\$ 235,334	16,438	\$ 1,468,166	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

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	\$ 691,171	\$ 691,171	1
2 Cash-Patient Deposits	12,264	12,264	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance (51,349)	1,009,082	1,009,082	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	30,465	30,465	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Due to/from Other Funds	667,799	667,799	9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,410,781	\$ 2,410,781	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		253,543	13
14 Buildings, at Historical Cost	23,101,203	23,227,194	14
15 Leasehold Improvements, at Historical Cos	459,207	206,664	15
16 Equipment, at Historical Cost	1,139,367	1,140,724	16
17 Accumulated Depreciation (book methods)	(2,177,140)	(2,257,760)	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): CIP	31,161	31,161	23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,553,798	\$ 22,601,526	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,964,579	\$ 25,012,307	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 1,995,347	\$ 1,995,347	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	12,264	12,264	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	659,109	659,109	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 Due to General Corporate Fund	1,333,142	1,333,142	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,999,862	\$ 3,999,862	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
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,999,862	\$ 3,999,862	46
TOTAL EQUITY(page 18, line 24)	\$ 20,964,717	\$ 21,012,445	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 24,964,579	\$ 25,012,307	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,085,736	1
2	Restatements (describe):		2
3	Prior Period Adjustment	15,268	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 21,101,004	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(136,287)	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)	\$ (136,287)	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)	\$ 20,964,717	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	\$ 14,762,616	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,762,616	3
B. Ancillary Revenue			
4	Day Care	83,669	4
5	Other Care for Outpatients	81,319	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 164,988	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	132,137	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	29,560	13
14	Non-Patient Meals	4,867	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	113,375	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 279,939	23
D. Non-Operating Revenue			
24	Contributions	6,202	24
25	Interest and Other Investment Income***	4,174	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,376	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	988,014	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 988,014	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,205,933	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	2,221,272	31
32	Health Care	7,939,249	32
33	General Administration	3,033,909	33
B. Capital Expense			
34	Ownership	757,612	34
C. Ancillary Expense			
35	Special Cost Centers	373,057	35
36	Provider Participation Fee	2,017,121	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,342,220	40
41	Income before Income Taxes (line 30 minus line 40)**	(136,287)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (136,287)	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.
Government Entity - part of county

*** 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

12/1/2008 to 11/30/2009

Schedule 19A

XVII. Income Statement

Line 28 Other Income(specify):

<u>Description</u>	<u>Amount</u>
Taxes - Current Operating	938,250
Other Operating Taxes	743
Mobile Home Tax	1,095
Payment in Lieu of Taxes	1,023
Local Government Reimbursement	15,847
Resident Transportation	11,208
Late charges	18,096
Misc Income	1,752
Total - Line 28	<u>988,014</u>

Facility Name & ID Number Champaign County Nursing Home

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	1,775	3,241	\$ 116,069	\$ 35.81	1
2	Assistant Director of Nursing	1,893	2,088	63,346	30.34	2
3	Registered Nurses	53,893	56,796	1,311,397	23.09	3
4	Licensed Practical Nurses	26,088	28,269	678,850	24.01	4
5	CNAs & Orderlies	142,798	149,702	1,986,914	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,437	6,082	78,046	12.83	8
9	Activity Director	2,005	2,088	41,619	19.93	9
10	Activity Assistants	11,843	13,062	110,889	8.49	10
11	Social Service Workers	7,946	8,531	129,772	15.21	11
12	Dietician					12
13	Food Service Supervisor	5,296	6,094	106,240	17.43	13
14	Head Cook	6,862	8,019	84,995	10.60	14
15	Cook Helpers/Assistants	28,671	33,476	325,776	9.73	15
16	Dishwashers					16
17	Maintenance Workers	4,530	5,270	59,094	11.21	17
18	Housekeepers	28,780	32,233	384,619	11.93	18
19	Laundry	8,377	10,267	114,870	11.19	19
20	Administrator	2,080	2,080	105,055	50.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,791	15,706	252,224	16.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,204	25,605	11.62	31
32	Other Health Care See Sch 20A	10,990	12,452	196,408	15.77	32
33	Other(specify) Barber & Beauty	2,833	3,086	35,521	11.51	33
34	TOTAL (lines 1 - 33)	367,808	400,746	\$ 6,207,309 *	\$ 15.49	34

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	440	\$ 18,596	1(3)	35
36	Medical Director	Monthly	4,200	9(3)	36
37	Medical Records Consultant	12	1,200	10(3)	37
38	Nurse Consultant	Monthly	107,173	10(3)	38
39	Pharmacist Consultant	Monthly	6,903	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	207	10(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,603	11(3)	44
45	Social Service Consultant	Monthly	1,419	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	458	\$ 141,301		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,967	\$ 234,436	10(3)	50
51	Licensed Practical Nurses	17,678	637,095	10(3)	51
52	Certified Nurse Assistants/Aides	22,546	538,727	10(3)	52
53	TOTAL (lines 50 - 52)	45,191	\$ 1,410,258		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Champaign County Nursing Home

Provider #: 0001636

12/1/2008 to 11/30/2009

Schedule 20A

XVIII. Staffing & Salary Costs

Line 32 Other Health Care (specify):

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Total Wages</u>	<u>Ave Hrly Wage</u>
Dental Hygienist	1,407	1,569	36,936	23.54
Adult Day Care	9,584	10,883	159,472	14.65
Total - Line 32	<u>10,991</u>	<u>12,452</u>	<u>196,408</u>	<u>15.77</u>

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	
Andrew Buffenbarger	Administrator	0	\$ 105,055	Workers' Compensation Insurance	\$ 216,411	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	71,797	Advertising: Employee Recruitment	36,148	
				FICA Taxes	452,415	Health Care Worker Background Check		
				Employee Health Insurance	506,324	(Indicate # of checks performed <u>197</u>)	1,970	
				Employee Meals		Patient Background Checks	108	
				Illinois Municipal Retirement Fund (IMRF)*	409,040		1,080	
				Employee Morale	2,565	See Sch21A	22,637	
				Employee Labs & Physicals	27,962			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 105,055	TOTAL (agree to Schedule V, line 22, col.8)		\$ 48,508		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(91)	
Management Performance (Management Fees)			307,774				Non-allowable advertising	
							(304)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 307,774				Yellow page advertising	
							(14,922)	
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
See Sch21A	See Sch21A		\$ 165,053	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	14,703
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 165,053	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 14,703	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Champaign County Nursing Home

Provider #: 0001636

12/1/2008 to 11/30/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Brought forward from page 21

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Evans, Froehlich, Beth & Chamley	Legal	2,750
Elvidge Kelley	Legal	6,706
Polsinelli Shughart	Legal	28,117
Heyl, Royster, Voelker & Allen	Legal	1,469
Champaign County Treasurer	Legal	40,589
Champaign County Treasurer	Accounting	37,617
Champaign County Treasurer	Financial Services	2,178
Medline Industries	Enteral Feedings	550
Dr. Stephen L. Hayford	Arbitrator	550
McGladrey & Pullen, LLP	Cost Report	7,147
RSM McGladrey	Accounting	775
Satori Pathway LLC	Dementia Services	1,729
Triad Shredding	Document Shredding	245
Polsinelli Shughart	Survey	4,909
Comcast	Computer Services	809
AT&T	Computer Services	760
IVANS	Computer Services	1,431
Lifecare Software Solutions	Computer Services	100
Activity Connection Com	Computer Services	143
MDI Achieve	Computer Services	8,444
Florida Micro LLC	Computer Services	517
Champaign County Treasurer	Computer Services	22
AccountTemps	Employment Services	14,020
Marvin F. Hill Jr	Employment Services	650
Matthew W. Finkin	Employment Services	600
Deborah M. Brodsky	Employment Services	1,931
AFSCME Council 31	Employment Services	225
Registry of Interpreters for the Deaf	Interpreter	70

Total agreeing to Schedule V, Line 19, Col 3 165,053 To PG21

Allocated to Day Care and eliminated	(880)
Out-of-Period Legal Exp	(1,375)
Total (agree to Schedule V, line 19, column 8)	<u><u>162,798</u></u>

F. Dues, Fees, Subscriptions and Promotions

<u>Description</u>	<u>Amount</u>
Illinois Health Care Association	1,012
Life Services Network	2,790
Yellow Page Advertising	14,922
Public Relations	405
Miscellaneous Dues	1,182
Miscellaneous Publications	2,327
TOTAL (agree to Sch. V, line 20, col. 8)	<u><u>22,637</u></u> To PG21

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							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: 12/01/08Ending: 11/30/09**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 -\$1,012; LSN - \$2,790
- (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? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 84,624 Line 10(2)
- (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. \$ 2,017,121
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. \$ _____
- (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? Yes
Firm Name: Bray, Drake, Liles & Richardson LLP
- (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