



Facility Name & ID Number Champaign Urbana Regional Rehab Center

# 0050062 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	<u>231</u>	Skilled (SNF)	<u>213</u>	<u>77,745</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>213</u>	<u>77,745</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>34,009</u>	<u>21,349</u>	<u>13,064</u>	<u>68,422</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,009</u>	<u>21,349</u>	<u>13,064</u>	<u>68,422</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.01%

D. How many bed-hold days during this year were paid by the Department? 458 (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)  
0

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 11/04/2009

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/04/2009 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 213 and days of care provided 8,849

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Champaign Urbana Regional Rehab Center # 0050062 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

**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
	<b>A. General Services</b>										
1	Dietary	471,238	126,037	194,878	792,153		792,153	(92)	792,061		1
2	Food Purchase		411,388		411,388		411,388	(2,080)	409,308		2
3	Housekeeping		52,798	281,290	334,088		334,088		334,088		3
4	Laundry		20,472	187,527	207,999		207,999		207,999		4
5	Heat and Other Utilities			282,316	282,316		282,316		282,316		5
6	Maintenance	108,370	3,351	230,475	342,196		342,196		342,196		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	579,608	614,046	1,176,486	2,370,140		2,370,140	(2,172)	2,367,968		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			32,370	32,370		32,370		32,370		9
10	Nursing and Medical Records	4,881,224	513,864	836,962	6,232,050		6,232,050		6,232,050		10
10a	Therapy		4,983	1,263,822	1,268,805		1,268,805		1,268,805		10a
11	Activities	221,977	2,751	19,211	243,939		243,939		243,939		11
12	Social Services	121,700		4,415	126,115		126,115		126,115		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,224,901	521,598	2,156,780	7,903,279		7,903,279		7,903,279		16
	<b>C. General Administration</b>										
17	Administrative	101,841		687,467	789,308		789,308	(687,467)	101,841		17
18	Directors Fees										18
19	Professional Services			91,878	91,878		91,878	(20,024)	71,854		19
20	Dues, Fees, Subscriptions & Promotions			75,589	75,589		75,589		75,589		20
21	Clerical & General Office Expenses	298,318	64,543	55,229	418,090		418,090	(19,934)	398,156		21
22	Employee Benefits & Payroll Taxes			1,075,230	1,075,230		1,075,230	92	1,075,322		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,333	7,333		7,333		7,333		24
25	Other Admin. Staff Transportation			4,800	4,800		4,800		4,800		25
26	Insurance-Prop.Liab.Malpractice			230,574	230,574		230,574		230,574		26
27	Other (specify):* <b>Home Ofc A&amp;G</b>							533,475	533,475		27
28	<b>TOTAL General Administration</b>	400,159	64,543	2,228,100	2,692,802		2,692,802	(193,858)	2,498,944		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,204,668	1,200,187	5,561,366	12,966,221		12,966,221	(196,030)	12,770,191		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	
	<b>D. Ownership</b>											
30	Depreciation			7,761	7,761		7,761	403	8,164			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,908	133,908		133,908	(693)	133,215			32
33	Real Estate Taxes			78,412	78,412		78,412	(4,221)	74,191			33
34	Rent-Facility & Grounds			852,453	852,453		852,453	(20,400)	832,053			34
35	Rent-Equipment & Vehicles			42,792	42,792		42,792		42,792			35
36	Other (specify):* Home Ofc Cap							20,721	20,721			36
37	<b>TOTAL Ownership</b>			1,115,326	1,115,326		1,115,326	(4,190)	1,111,136			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		507,148	17,236	524,384		524,384		524,384			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,761	107,761		107,761		107,761			42
43	Other (specify):* Non-Allowable Cos			198,990	198,990		198,990	(198,990)				43
44	<b>TOTAL Special Cost Centers</b>		507,148	323,987	831,135		831,135	(198,990)	632,145			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,204,668	1,707,335	7,000,679	14,912,682		14,912,682	(399,210)	14,513,472			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$		\$	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	403	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,782)	43		19
20	Contributions	(1,189)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,723)	43		24
25	Fund Raising, Advertising and Promotional				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	(213,427)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (261,718)		\$	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)	(137,492)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (137,492)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (399,210)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign Urbana Regional Rehab Center

ID# 0050062

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Nonallowable marketing events	\$ (55,247)	43	1
2	Labs - Part A	(49,682)	43	2
3	X-Rays - Part A	(37,451)	43	3
4	Offset Vending Machine revenue	(2,080)	2	4
5	Offset Non-Allowable Legal Fees	(19,349)	19	5
6	Non-care interest expense	(693)	32	6
7	Non-Care Rent Expense	(20,400)	34	7
8	Collection Fees/Late Fees	(21,677)	43	8
9	Closing Costs	(6,173)	43	9
10	Non-Allowable Consultant	(675)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(213,427)		49

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Joseph Garff	33.33	N/A		Traditions Management	Clearwater, FL	Mgmt Co.
Ben Atkins	33.33					
Mary A Morrison	33.33					

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	17 Management Fees	\$ 687,467	Traditions Management	0.00%	\$	(687,467)	1
2	V	27 Home Office A&G		Traditions Management	0.00%	533,475	533,475	2
3	V	36 Home Office Capital		Traditions Management	0.00%	16,500	16,500	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		\$ 687,467			\$ 549,975	\$ * (137,492)	14

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

Facility Name & ID Number Champaign Urbana Regional Rehab Center # 0050062 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	<b>No compensation paid to owners</b>								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	\$		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 Urbana Regional Rehab Center # 0050062 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization Traditions Management  
 Street Address 24641 US Hwy 19 N  
 City / State / Zip Code Clearwater/FL/33763  
 Phone Number ( 727)723-3021  
 Fax Number ( 727)723-3076

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	27	Home Office A&G	Census Days	10	\$	\$	68,422	\$ 533,475	1
2	36	Home Office Capital	Census Days	10			68,422	16,500	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 549,975	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Champaign Urbana Regional Rehab Center

# 0050062

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Heartland Bank and Trust		X	Van	\$911.84	5/3/2010	\$ 38,000	\$ 32,332	5/3/2014	6.8000	\$ 1,626	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	See Sch 9A				\$31,326.57		2,044,138	1,901,973			132,282	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>				\$32,238.41		\$ 2,082,138	\$ 1,934,305			\$ 133,908	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12											Disallo Non-Allowable Interest Expense	(693)	12						
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (693)	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 2,082,138	\$ 1,934,305			\$ 133,215	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.)

Champaign Urbana Regional Rehab Center  
 FYE 12/31/2010  
 Schedule 9A

	Name of Lender	Related		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Period Interest Expense	* W/P Ref
		YES	NO				Original	Balance				
	Working Capital											
1	Premium Financing Specialist	X		Insurance	\$31,326.57	12/9/2009	274,735	117,576	10/9/2010	6.2500	6,003	1
2	TM-Fifth Third Bank		X	LOC	Interest Only	11/1/2009	150,000	150,000	LOC	5.7000	4,671	2
3	Rick Angel	X		Working Capital	Interest Only	10/30/2009	400,000	515,093	6/28/2010	7.0000	18,360	3
4	Mrs. Christiansen	X		LOC	Interest Only	11/2/2009	1,219,403	1,119,304	LOC	9.0000	103,248	4
9	TOTAL Facility Related				\$31,326.57		2,044,138	1,901,973			132,282	9

See Accountants' Compilation Report

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 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.)	2009		\$	<b>74,191</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>74,191</b>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>74,191</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	_____			8
	2006	_____			9
	2007	_____			10
	2008	_____			11
	2009	_____			12
<b>Accrual is based on prior year Real Estate Tax Bills.</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		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**



Facility Name & ID Number Champaign Urbana Regional Rehab Center

# 0050062

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Second Floor Utility Room Repair		2010		3,845		15	128	128	128
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)	\$	3,845	\$		\$ 128	\$ 128	\$ 128	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Champaign Urbana Regional Rehab Center

# 0050062

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>26,533</u>	<u>1,448</u>	<u>3,301</u>	<u>1,853</u>	<u>3-5</u>	<u>3,301</u>	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ <u>26,533</u>	\$ <u>1,448</u>	\$ <u>3,301</u>	\$ <u>1,853</u>		\$ <u>3,301</u>	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	<u>Resident Care</u>	<u>Champion Bus 2010</u>	<u>2010</u>	\$ <u>47,350</u>	\$ <u>6,313</u>	\$ <u>4,735</u>	\$ <u>(1,578)</u>	<u>5</u>	\$ <u>4,735</u>	76
77										77
78										78
79										79
80	TOTALS			\$ <u>47,350</u>	\$ <u>6,313</u>	\$ <u>4,735</u>	\$ <u>(1,578)</u>		\$ <u>4,735</u>	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)	\$ <u>77,728</u>	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ <u>7,761</u>	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ <u>8,164</u>	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ <u>403</u>	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ <u>8,164</u>	85

\*\*

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Savoy HCP

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>1975</u>	<u>231</u>	<u>11/04/2009</u>	\$ <u>826,363</u>			3
4	Additions						4
5	<u>Apt for int DON</u>	<u>N/A</u>	<u>1/15/2010</u>	<u>5,690</u>			5
6							6
7	<b>TOTAL</b>	231		\$ <b>832,053</b>			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 42,058 Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Administrative</u>	<u>Company Auto</u>	\$ <u>367.00</u>	\$ <u>734</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>367.00</b>	\$ <b>734</b>	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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.

Champaign Urbana Regional Rehab Center  
FYE 12/31/2010  
Schedule 14A

**Schedule 14A**

#16

<b>Description</b>	<b>Amount</b>
Maintenance Equipment	21,804
Dish Machine	2,150
Copiers	16,109
Shredder	1,995
Total Rental Exp.	<u>42,058</u>

**See Accountants' Compilation Report**

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

- (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	10A(3)	hrs	\$	7,106	\$ 511,600	\$	7,106	\$ 511,600	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,111	224,004		3,111	224,004	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)(3)	hrs		7,336	528,218	4,983	7,336	533,201	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				507,148		507,148	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			\$	17,553	\$ 1,263,822	\$ 512,131	17,553	\$ 1,775,953	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

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2010**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 538,062	\$ 538,062	1
2	Cash-Patient Deposits	24,978	24,978	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>47,438</u> )	1,307,110	1,307,110	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	221,400	221,400	6
7	Other Prepaid Expenses	41,771	41,771	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17</u>	500,271	500,271	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,633,592	\$ 2,633,592	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		3,845	15
16	Equipment, at Historical Cost	73,883	73,883	16
17	Accumulated Depreciation (book methods)	(7,761)	(8,164)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 66,122	\$ 69,564	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,699,714	\$ 2,703,156	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,906,513	\$ 1,906,513	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,978	24,978	28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	164,650	164,650	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,809	67,809	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
<b>Other Current Liabilities(specify):</b>				
36	<u>See Sch 17</u>	80,945	80,945	36
37	<u>See Sch 17</u>	1,751,973	1,751,973	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,146,868	\$ 4,146,868	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	32,332	32,332	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 32,332	\$ 32,332	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,179,200	\$ 4,179,200	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,479,486)	\$ (1,476,044)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,699,714	\$ 2,703,156	48

Champaign Urbana Regional Rehab Center  
 FYE 12/31/2010  
 Schedule 17A

		After
	Operating	Consolidation
Ln 9		
1 Deposits on Utilities	\$ 6,458	\$ 6,458
2 Cash - Replacement Reserve	\$ 115,500	\$ 115,500
3 Cash - Insurance Escrow	\$ 153,313	\$ 153,313
4 Cash - AR Escrow	\$ 225,000	\$ 225,000
Total	<u>\$ 500,271</u>	<u>\$ 500,271</u>
Ln 36		
1 Medicare Remittance Adjustment	\$ 2,930	\$ 2,930
2 Employee Deductions - Child Support	\$ (135)	\$ (135)
3 Accrued Accounting/Audit Fees	\$ (11,200)	\$ (11,200)
4 Prepaid Resident Rent	\$ (72,540)	\$ (72,540)
Total	<u>\$ (80,945)</u>	<u>\$ (80,945)</u>
Ln 37		
1 Due to Christiansen	\$ (1,119,304)	\$ (1,119,304)
2 Due to Trad Mgmt of USA	\$ (515,093)	\$ (515,093)
3 Due to Members	\$ (117,576)	\$ (117,576)
Total	<u>\$ (1,751,973)</u>	<u>\$ (1,751,973)</u>

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,162,468)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(317,018)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (1,479,486)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,479,486)	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign Urbana Regional Rehab Center# 0050062Report Period Beginning: 01/01/2010Ending: 12/31/2010**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,261,582	1
2	Discounts and Allowances for all Levels	(3,745,354)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,516,228	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,138,292	6
7	Oxygen	3,209	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,141,501	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals	5,995	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	363,796	16
17	Sale of Drugs	881,354	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	103,840	19
20	Radiology and X-Ray		20
21	Other Medical Services	670,476	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,026,661	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	693	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 693	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Sch 19</u>	65,131	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 65,131	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,750,214	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,370,140	31
32	Health Care	7,903,279	32
33	General Administration	2,692,802	33
<b>B. Capital Expense</b>			
34	Ownership	1,115,326	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	723,374	35
36	Provider Participation Fee	107,761	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,912,682	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,162,468)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,162,468)	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.  
\*\*LLC Members are cash basis tax payers.

\*\*\* 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 Urbana Regional Rehab Center  
FYE 12/31/2010  
Schedule 19A

Ln 28	Amount
1 Transportation - PVT	\$ 22,978
2 Transportation - MRA	\$ 960
3 Transportation - MCD	\$ 23,034
4 Transportation - Hospice	\$ 135
5 Transportation - INS	\$ 129
6 Transportation - INS	\$ 525
7 Transportation - HMO	\$ 360
8 Vending Machine Revenue	\$ 2,080
9 Miscellaneous Operating Income-Adm	\$ 14,930
	<u>\$ 65,131</u>

**See Accountants' Compilation Report**

Facility Name & ID Number Champaign Urbana Regional Rehab Center

# 0050062

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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	2,677	2,737	\$ 91,719	\$ 33.51	1
2	Assistant Director of Nursing	10,894	10,974	456,690	41.62	2
3	Registered Nurses	24,857	25,087	742,588	29.60	3
4	Licensed Practical Nurses	42,642	42,789	938,658	21.94	4
5	CNAs & Orderlies	166,685	167,021	2,316,836	13.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,480	2,503	88,578	35.39	9
10	Activity Assistants	7,613	7,704	88,435	11.48	10
11	Social Service Workers	5,799	5,781	121,700	21.05	11
12	Dietician					12
13	Food Service Supervisor	3,208	3,119	64,465	20.67	13
14	Head Cook	10,890	10,530	135,953	12.91	14
15	Cook Helpers/Assistants	25,839	24,784	270,820	10.93	15
16	Dishwashers					16
17	Maintenance Workers	6,067	6,082	108,370	17.82	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,776	1,781	101,841	57.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,626	12,706	298,318	23.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,162	2,170	45,135	20.80	31
32	Other Health C: See Sch 20	7,438	7,493	289,598	38.65	32
33	Other(specify) <u>Transportation</u>	5,861	5,989	44,964	7.51	33
34	TOTAL (lines 1 - 33)	339,514	339,250	\$ 6,204,668 *	\$ 18.29	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,540	1(3)	35
36	Medical Director	Monthly	32,370	9(3)	36
37	Medical Records Consultant	Monthly	5,727	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,602	10(3)	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	4,263	11(3)	44
45	Social Service Consultant	Monthly	4,415	12(3)	45
46	Other(specify) <u>Physician Consultant</u>	3	900	19(3)	46
47	<u>Managed Care Consultant</u>	1 Visit	196	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	3	\$ 69,013		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,956	\$ 283,227	10(3)	50
51	Licensed Practical Nurses	11,092	471,034	10(3)	51
52	Certified Nurse Assistants/Aides	20	423	10(3)	52
53	TOTAL (lines 50 - 52)	17,068	\$ 754,684		53

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign Urbana Regional Rehab Center  
FYE 12/31/2010  
Schedule 20A

	Hours Worked	Hours Paid	Salaries
1 Inservice Coordinator	684	689	\$ 26,615
2 MDS Coordinator	4147	4178	\$ 161,476
3 Ward Clerk	2582	2601	\$ 100,518
4 Nurse Liaison	25	26	\$ 989
Total	<u>7438</u>	<u>7493</u>	<u>\$ 289,598</u>

**See Accountants' Compilation Report**



Champaign Urbana Regional Rehab Center  
 FYE 12/31/2010  
 Schedule 21A

C.

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Livingston, Barger, Brandt	Legal	7,053
Howard & Howard	Legal	(487)
Wilkinson & Sadorf	Legal	1,840
McCumber, Daniels, Buntz	Legal	1,360
Helperbroom	Legal	11,279
Barbara Clark & Company	401K & Financial Audit	12,970
Chris Pape CPA	Taxes	4,000
RSM McGladrey	Cost Reporting	4,200
My Innerview	Patient Surveys	4,375
Paychex	Payroll processing Fees	32,401
McGladrey	Consulting	3,000
GHR Engineers & Associates	Engineer Consultant	1,584
Kaufman	Physician Consultant	900
Ronnie Diederichs	Employee Benefit Coordinator	6,727
Various	Marketing Consultant	675
	<b>Total</b>	<b><u>91,878</u></b>
TOTAL (agree to Schedule V, line 19, column 3)		
	Non-Allowable Legal Fees	-19349
	Non-Allowable Consultant	-675
	<b>Total</b>	<b><u>71,854</u></b>
TOTAL (agree to Schedule V, line 19, column 8)		

**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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

