

		FOR BHF USE					

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**2012**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2012)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0052217</u></p> <p><b>Facility Name:</b> <u>Champaign Urbana Nrsg &amp; Rehab</u></p> <p><b>Address:</b> <u>302 Burwash Avenue</u> <u>Savoy</u> <u>61874</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Champaign</u></p> <p><b>Telephone Number:</b> <u>(217)402-9700</u> <b>Fax #</b> <u>(727)723-3076</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>11/4/2009</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Melissa Miller</u> <b>Telephone Number:</b> <u>(727)724-2403</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Lynda Hebbeln</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lynda Hebbeln</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lynda Hebbeln</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )							

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

# 0052217 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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>213</u>	Skilled (SNF)	<u>213</u>	<u>77,958</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>213</u>	TOTALS	<u>213</u>	<u>77,958</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>29,817</u>	<u>19,907</u>	<u>10,486</u>	<u>60,210</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>29,817</u>	<u>19,907</u>	<u>10,486</u>	<u>60,210</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.23%

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

442 (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

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 6,417

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name &amp; ID Number

Champaign Urbana Nrsg &amp; Rehab

# 0052217

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**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		50,378	999,861	1,050,239		1,050,239	(3,196)	1,047,043		1
2	Food Purchase										2
3	Housekeeping		44,217	282,061	326,278		326,278		326,278		3
4	Laundry		16,599	192,553	209,152		209,152		209,152		4
5	Heat and Other Utilities			259,228	259,228		259,228	(21,314)	237,914		5
6	Maintenance	69,311	454	130,884	200,649		200,649		200,649		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	69,311	111,648	1,864,587	2,045,546		2,045,546	(24,510)	2,021,036		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			44,743	44,743		44,743		44,743		9
10	Nursing and Medical Records	4,219,459	368,993	20,921	4,609,373		4,609,373		4,609,373		10
10a	Therapy		2,928	824,471	827,399		827,399		827,399		10a
11	Activities	167,948	2,891	12,482	183,321		183,321		183,321		11
12	Social Services	96,067			96,067		96,067		96,067		12
13	CNA Training										13
14	Program Transportation	30,851	305	9,960	41,116		41,116		41,116		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,514,325	375,117	912,577	5,802,019		5,802,019		5,802,019		16
	<b>C. General Administration</b>										
17	Administrative	115,099		586,915	702,014		702,014	(586,915)	115,099		17
18	Directors Fees										18
19	Professional Services			116,128	116,128		116,128	(73,328)	42,800		19
20	Dues, Fees, Subscriptions & Promotions			42,581	42,581		42,581		42,581		20
21	Clerical & General Office Expenses	208,265	25,988	65,541	299,794		299,794	(7,799)	291,995		21
22	Employee Benefits & Payroll Taxes			915,916	915,916		915,916		915,916		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,533	8,533		8,533		8,533		24
25	Other Admin. Staff Transportation			1,637	1,637		1,637		1,637		25
26	Insurance-Prop.Liab.Malpractice			198,568	198,568		198,568	(9,081)	189,487		26
27	Other (specify):*							402,146	402,146		27
28	<b>TOTAL General Administration</b>	323,364	25,988	1,935,819	2,285,171		2,285,171	(274,977)	2,010,194		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,907,000	512,753	4,712,983	10,132,736		10,132,736	(299,487)	9,833,249		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

#0052217

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

## 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			12,985	12,985		12,985	329,266	342,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			217,059	217,059		217,059	310,361	527,420			32
33	Real Estate Taxes			72,247	72,247		72,247	77,000	149,247			33
34	Rent-Facility & Grounds			870,910	870,910		870,910	(870,910)				34
35	Rent-Equipment & Vehicles			64,960	64,960		64,960		64,960			35
36	Other (specify):*							47,810	47,810			36
37	<b>TOTAL Ownership</b>			1,238,161	1,238,161		1,238,161	(106,473)	1,131,688			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		413,045	35,548	448,593		448,593	(35,548)	413,045			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			472,834	472,834		472,834		472,834			42
43	Other (specify):*			718,418	718,418		718,418	(648,830)	69,588			43
44	<b>TOTAL Special Cost Centers</b>		413,045	1,226,800	1,639,845		1,639,845	(684,378)	955,467			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,907,000	925,798	7,177,944	13,010,742		13,010,742	(1,090,338)	11,920,404			45

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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

# 0052217

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

**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	(3,196)	1		4
5	Telephone, TV & Radio in Resident Rooms	(21,314)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	128	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	(2,128)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(315,732)	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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (342,242)		\$	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)	(191,566)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (191,566)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (533,808)		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

## Champaign Urbana Nrsg &amp; Rehab

ID# 0052217

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable Marketing Expenses	\$ (87,709)	43	1
2	Lab Fees - Part A	(47,781)	43	2
3	X-Rays - Part A	(55,226)	43	3
4	Collection/Late Fees	(109,189)	43	4
5	State Income Taxes	(1,795)	43	5
6	Nonreimbursable expense	(30,000)	43	6
7	Offset Vending Machine Revenue	(8,026)	21	7
8	Offset Interest Income	(5,390)	32	8
9	Non-Care Related Rent Expense	(20,400)	34	9
10	Non-Allowable Consultant	(225)	19	10
11	Non-Allowable Legal Fees	(85,121)	19	11
12	Offset Loss from Foreign Exchange Rate	135,377	27	12
13	Offset Loss on Sale of Fixed Assets	70,945	27	13
14	Remove Physician services	(35,548)	39	14
15	Remove Reimbursement lost/stolen items	(11,800)	26	15
16	Offset Miscellaneous Income	(264,642)	27	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>		(556,530)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign Urbana Nrsg & Rehab# 0052217

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(3,196)	0	0	0	0	0	0	0	0	0	0	(3,196)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(21,314)	0	0	0	0	0	0	0	0	0	0	(21,314)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(24,510)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(24,510)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(586,915)	0	0	0	0	0	0	0	0	0	(586,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(85,346)	12,018	0	0	0	0	0	0	0	0	0	(73,328)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(8,026)	227	0	0	0	0	0	0	0	0	0	(7,799)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(11,800)	2,719	0	0	0	0	0	0	0	0	0	(9,081)	26
27	Other (specify):*	(58,320)	460,466	0	0	0	0	0	0	0	0	0	402,146	27
28	<b>TOTAL General Administration</b>	<b>(163,492)</b>	<b>(111,485)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(274,977)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(188,002)</b>	<b>(111,485)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(299,487)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number Champaign Urbana Nrsg & Rehab# 0052217

Report Period Beginning:

1/1/2012 Ending:

Summary B

12/31/2012

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	128	329,138	0	0	0	0	0	0	0	0	0	329,266	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,390)	315,751	0	0	0	0	0	0	0	0	0	310,361	32
33	Real Estate Taxes	0	77,000	0	0	0	0	0	0	0	0	0	77,000	33
34	Rent-Facility & Grounds	(20,400)	(850,510)	0	0	0	0	0	0	0	0	0	(870,910)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	47,810	0	0	0	0	0	0	0	0	0	47,810	36
37	<b>TOTAL Ownership</b>	<b>(25,662)</b>	<b>(80,811)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(106,473)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(35,548)	0	0	0	0	0	0	0	0	0	0	(35,548)	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):*	(649,560)	730	0	0	0	0	0	0	0	0	0	(648,830)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(685,108)</b>	<b>730</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(684,378)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(898,772)</b>	<b>(191,566)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(1,090,338)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Ben Atkins</u>	<u>33.33</u>	<u>N/A</u>		<u>Traditions Sr Mgmt</u>	<u>Clearwater, FL</u>	<u>Mgmt Company</u>
<u>Morrison Family LTD Partnership, LLP</u>	<u>20</u>			<u>Savoy HCP I, LLC</u>	<u>Clearwater, FL</u>	<u>Real Estate</u>
<u>Careen, LLC</u>	<u>13.33</u>					
<u>Adam Garff</u>	<u>33.33</u>					

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
<u>1</u>	<u>V</u>	<u>17 Management Fees</u>	<u>\$ 586,915</u>	<u>Traditions Management</u>		<u>\$</u>	<u>\$ (586,915)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>27 Home Office A&amp;G</u>		<u>Traditions Management</u>		<u>460,466</u>	<u>460,466</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>36 Home Office Capital</u>		<u>Traditions Management</u>		<u>47,810</u>	<u>47,810</u>	<u>3</u>
<u>4</u>	<u>V</u>							<u>4</u>
<u>5</u>	<u>V</u>	<u>34 Rent Expense</u>	<u>850,510</u>	<u>Savoy HCP I, LLC</u>			<u>(850,510)</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>19 Accounting Fees</u>		<u>Savoy HCP I, LLC</u>		<u>12,018</u>	<u>12,018</u>	<u>6</u>
<u>7</u>	<u>V</u>	<u>43 Bank Service Charges</u>		<u>Savoy HCP I, LLC</u>		<u>580</u>	<u>580</u>	<u>7</u>
<u>8</u>	<u>V</u>	<u>21 Office Expense</u>		<u>Savoy HCP I, LLC</u>		<u>227</u>	<u>227</u>	<u>8</u>
<u>9</u>	<u>V</u>	<u>43 Loan Costs</u>		<u>Savoy HCP I, LLC</u>		<u>150</u>	<u>150</u>	<u>9</u>
<u>10</u>	<u>V</u>	<u>32 Interest Expense</u>		<u>Savoy HCP I, LLC</u>		<u>315,751</u>	<u>315,751</u>	<u>10</u>
<u>11</u>	<u>V</u>	<u>26 Mortgage Insurance</u>		<u>Savoy HCP I, LLC</u>		<u>2,719</u>	<u>2,719</u>	<u>11</u>
<u>12</u>	<u>V</u>	<u>33 Taxes</u>		<u>Savoy HCP I, LLC</u>		<u>77,000</u>	<u>77,000</u>	<u>12</u>
<u>13</u>	<u>V</u>	<u>30 Depreciation Expense</u>		<u>Savoy HCP I, LLC</u>		<u>329,138</u>	<u>329,138</u>	<u>13</u>
<u>14</u>	<b>Total</b>		<b>\$ 1,437,425</b>			<b>\$ 1,245,859</b>	<b>\$ * (191,566)</b>	<b>14</b>

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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab # 0052217 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	No compensation paid to owners								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

# 0052217

Report Period Beginning:

1/1/2012

Ending: 2/31/2012

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 Traditions Senior Management  
 Street Address 24641 US Hwy 19 N  
 City / State / Zip Code Clearwater/FL/33763  
 Phone Number ( 727)724-2403  
 Fax Number ( 727)723-3076

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	27	Home Office A&G	Direct Cost	82,653,681	12	\$ 3,020,262	\$ 1,820,688	12,601,288	\$ 460,466	1
2	36	Home Office Capital	Direct Cost	82,653,681	12	313,593	1,820,688	12,601,288	47,810	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					\$ 3,333,855	\$ 3,641,376		\$ 508,276	25

**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		8	9	10	11						
		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	4/22/10	\$ 38,000	\$	12/31/12	7.0000	\$ 1,356	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	See Sch 9A						2,317,990				215,703	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$911.84		\$ 2,355,990	\$			\$ 217,059	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,355,990	\$			\$ 217,059	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.)

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

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

	Name of Lender Working Capital	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				
1	TM - Fifth Third bank		X	LOC	Interest Only	11/1/2009	150,000	0	LOC	5.700	10,476	
2	Mrs. Christiansen	X		LOC	Interest Only	11/2/2009	1,219,403	0	LOC	9.000	127,690	
3	Owner	X		Working Capital	Interest Only	7/1/2011	648,587	0	6/30/2012	10.000	50,067	
4	Ben Atkins	X		LOC	Interest Only	7/5/2011	300,000	0	LOC	9.000	27,470	
9	TOTAL Facility Related						2,317,990	0			215,703	

**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 2011 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.)		\$	75,643		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	75,643		3										
4. Real Estate Tax accrual used for 2012 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.		\$	75,643		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2007 _____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>			<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2008 _____	9													
	2009 _____	10													
	2010 _____	11													
	2011 _____	12													

**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.**



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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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.**

**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	<b>TOTALS</b>			\$	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	213		2009	1983	\$ 3,445,797	\$ 329,138	25	\$ 329,138	\$	\$
5										
6										
7										
8										
	<b>Improvement Type**</b>									
9	Second Floor Utility Room Repair		2010		3,845		15	128	128	
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

# 0052217

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,449,642	\$ 329,138		\$ 329,266	\$ 128	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 88,795	\$ 22,532	\$ 22,532	\$	3-5	\$	71
72	Current Year Purchases	27,799	6,236	6,236		3-5		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 116,594	\$ 28,768	\$ 28,768	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Champion Bus 2010	2010	\$ 47,350	\$ (15,783)	\$ (15,783)	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 47,350	\$ (15,783)	\$ (15,783)	\$		\$	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)	\$ 3,613,586	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 342,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 342,251	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 128	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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.

**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>11/4/09</u>	\$ <u>870,910</u>	<u>10</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>231</u>		\$ <u>870,910</u>			7

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

13. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

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: \$ 64,960 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

#16	Description	Amount
	Medical Equipment (Acct 410765)	39,730
	Dish Machine (Acct 440960)	3,792
	Copier Lease (Acct 560906)	16,434
	Shredder (Acct 560960)	<u>5,004</u>
	Total Rental Exp	<u><u>64,960</u></u>

Facility Name & ID Number Champaign Urbana Nrsg & Rehab # 0052217 Report Period Beginning: 1/1/2012 Ending: 12/31/2012  
**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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,052	\$ 336,410	\$	5,052	\$ 336,410	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,672	124,298		4,672	124,298	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2)(3)	hrs		1,726	363,763	2,928	1,726	366,691	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				413,045		413,045	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	<b>TOTAL</b>			\$	11,450	\$ 824,471	\$ 415,973	11,450	\$ 1,240,444	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.**

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

# 0052217

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(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	\$ 1,527,506	\$ 1,527,506	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>313,571</u> )	2,674,404	2,674,404	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,236	24,236	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17</u>	306,634	306,634	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,532,780	\$ 4,532,780	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,532,780	\$ 4,532,780	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 2,179,740	\$ 2,179,740	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	747,525	747,525	29
30	Accrued Salaries Payable	162,139	162,139	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,992	69,992	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>	8,091	8,091	36
37	<u>See Sch 17</u>	1,075,133	1,075,133	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,242,620	\$ 4,242,620	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	892,115	892,115	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>	\$ 892,115	\$ 892,115	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,134,735	\$ 5,134,735	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (601,955)	\$ (601,955)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,532,780	\$ 4,532,780	48

\*(See instructions.)

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

		After	
		Operating	Consolidation
Ln 9			
	1 Deposits on Utilities	6,458	6,458
	2 Cash - Sale Escrow	300,000	300,000
	3 Due from CP Toledo	176	176
	Total	<u>306,634</u>	<u>306,634</u>
Ln 36			
	1 Employee Deductions - Garnishments	(14)	(14)
	2 Employee Deductions - 401K	5,021	5,021
	3 Employee Deductions - Misc	84	84
	4 Accrued Accounting/Audit Fees	3,000	3,000
	Total	<u>8,091</u>	<u>8,091</u>
Ln 37			
	1 Due to Members	<u>1,075,133</u>	<u>1,075,133</u>
	Total	<u>1,075,133</u>	<u>1,075,133</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,123,532)	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	837,918	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <b>Retained Earnings</b>	(316,341)	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (601,955)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (601,955)	24 *

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

**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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$	12,486,598	1
2	Discounts and Allowances for all Levels		(5,179,988)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$	7,306,610	3
<b>B. Ancillary Revenue</b>				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		2,143,460	6
7	Oxygen		1,930	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	2,145,390	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		3,196	14
15	Telephone, Television and Radio			15
16	Rental of Facility Space		426,924	16
17	Sale of Drugs		1,056,408	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory		192,260	19
20	Radiology and X-Ray		129,049	20
21	Other Medical Services		515,397	21
22	Laundry			22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	2,324,434	23
<b>D. Non-Operating Revenue</b>				
24	Contributions			24
25	Interest and Other Investment Income***		5,390	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	5,390	26
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>			27
28	<u>See Sch 19</u>		105,386	28
28a				28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	105,386	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$	11,887,210	30

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services		2,039,263	31
32	Health Care		5,816,542	32
33	General Administration		2,276,931	33
<b>B. Capital Expense</b>				
34	Ownership		1,238,161	34
<b>C. Ancillary Expense</b>				
35	Special Cost Centers		1,167,011	35
36	Provider Participation Fee		472,834	36
<b>D. Other Expenses (specify):</b>				
37				37
38				38
39				39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$	13,010,742	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>		(1,123,532)	41
42	<b>Income Taxes</b>			42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$	(1,123,532)	43

III. Net Inpatient Revenue detailed by Payer Source				
44	Medicaid - Net Inpatient Revenue	\$		44
45	Private Pay - Net Inpatient Revenue			45
46	Medicare - Net Inpatient Revenue			46
47	Other-(specify)			47
48	Other-(specify)			48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$		49

\* 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.

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

**Champaign Regional Rehab Center**  
**FYE 12/31/12**  
**Schedule 19A**

Line 28

1 Transportation - PVT	23,685
2 Transportation - MCD	15,255
3 Transportation - Hospice	15
4 Transportation - INS	87
5 Vending Machine Revenue	8,025
6 Miscellaneous Income-Admin	264,642
7 Loss from Foreign Exchange Rate	(135,377)
8 Loss on Sale of Fixed Assets	<u>(70,945)</u>
	<u><u>105,387</u></u>

Facility Name & ID Number Champaign Urbana Nrsng & Rehab

# 0052217

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

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	1,973	2,016	\$ 85,572	\$ 42.45	1
2	Assistant Director of Nursing	7,309	7,942	225,150	28.35	2
3	Registered Nurses	17,160	17,668	497,019	28.13	3
4	Licensed Practical Nurses	45,942	47,466	1,116,245	23.52	4
5	CNAs & Orderlies	147,924	151,298	1,992,404	13.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,260	3,585	74,332	20.73	9
10	Activity Assistants	8,392	8,795	93,615	10.64	10
11	Social Service Workers	4,360	4,683	96,067	20.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,698	8,252	112,022	13.58	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,012	2,188	123,278	56.34	20
21	Assistant Administrator					21
22	Other Administrative	1,932	2,051	35,188	17.16	22
23	Office Manager	4,782	5,274	96,098	18.22	23
24	Clerical	4,150	4,690	34,268	7.31	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	1,923	2,128	39,960	18.78	31
32	Other Health C: See Sch 20	10,253	11,142	254,931	22.88	32
33	Other(specify) <u>Transportation</u>	2,371	2,555	30,851	12.07	33
34	TOTAL (lines 1 - 33)	271,441	281,733	\$ 4,907,000 *	\$ 17.42	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	\$ 999,861	1(3)	35
36	Medical Director	Monthly	44,743	9(3)	36
37	Medical Records Consultant	Monthly	2,540	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,506	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	2,357	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Managed Care Consultant</u>	per patient day	1,616	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,065,623		49

C. CONTRACT NURSES

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function				Description	Amount	Description	Amount			
Lorraine Bellinger	Administrator			Workers' Compensation Insurance	\$ 213,740	IDPH License Fee	\$				
Lisa Niehaus	Administrator			Unemployment Compensation Insurance	198,546	Advertising: Employee Recruitment		11,163			
Jamie Patton	Administrator			FICA Taxes	371,434	Health Care Worker Background Check					
Kay Ross	Administrator			Employee Health Insurance	93,826	(Indicate # of checks performed <u>481</u> )		6,196			
				Employee Meals		Patient Background Checks					
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits		19,577			
				Employee Benefits/Expenses	30,462	Miscellaneous Dues & Subscriptions		4,316			
				Employee Life Insurance	4,417	Pre-Employment Physicals		1,329			
				Employee Dental Insurance	1,798						
				Employee Vision Insurance	1,693						
						Less: Public Relations Expense	(				
						Non-allowable advertising	(				
						Yellow page advertising	(				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 115,099	TOTAL (agree to Schedule V, line 22, col.8)			\$ 915,916	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 42,581
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description				Amount	Description	Line #	Amount	Description	Amount		
Management Fees "Eliminated in Col 7"				\$ 586,915				Out-of-State Travel	\$		
								In-State Travel	4,244		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 586,915				Seminar Expense	4,289		
C. Professional Services								Entertainment Expense	(		
Vendor/Payee	Type		Amount					(agree to Sch. V, line 24, col. 8)			
See Sch 21A			\$ 116,128	TOTAL		\$		TOTAL	\$ 8,533		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 116,128							

\* Attach copy of IMRF notifications

\*\*See instructions.

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

C.

Vendor/Payee	Type	Amount	
CT Corporation	Legal	515	
McCumber, Daniels Buntz	Legal	2,335	
Helperbroom	Legal	312	
Wilkinson & Sadorf	Legal	2,099	
Cooper, Yehling	Legal	75,000	
Petty Cash	Legal	25	misposted to legal account
Broad and Cassel	Legal	4,860	
Spherion	HR Temp	3,604	
Barbara Clark & Company	401K & Financial Audit	13,188	
My Innerview	Patient Surveys	124	
Paychex	Payroll Processing Fees	20,966	
GHR Engineers & Assoc	Door Relocations	1,313	
Mystery Shoppers, Inc	Marketing Consultant	225	
Roy & Pape	Tax Audit	3,580	
Total (agrees to Sch V, line 19, column 3)		128,146	
Non-Allowable Legal Fees		(85,121)	
Non-Allowable Consultant		(225)	
Total (agrees to Sch V, line 19, column 8)		<u>42,800</u>	

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

