

Facility Name & ID Number Champaign County Nrsg Home

0046664 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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 4/18/13

	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	204	Skilled (SNF)	243	83,313	1
2		Skilled Pediatric (SNF/PED)			2
3	39	Intermediate (ICF)	0	5,382	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,695	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	717	272	5,993	6,982	8
9	SNF/PED					9
10	ICF	36,709	22,769	2,117	61,595	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,426	23,041	8,110	68,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.32%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Adult Day Care

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 2007

J. Was the facility purchased or leased after January 1, 1978?
 YES Date N/A NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 243 and days of care provided 5,053

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2013 Fiscal Year: 11/30/2013

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

Champaign County Nursing Home
 Provider #: 0001636
 FYE: November 30, 2013

Schedule 2A

Census Calculation

Dates	Days
12/1/2012-4/17/2013	138
4/18/2013-11/30/2013	227
	<u>365</u>

	Beds From 12/1/2012-4/17/2013	Bed Days Avail 12/1/2012-4/17/2013	Beds From 4/18/2013-11/30/2013	Bed Days Avail 4/18/2013-11/30/2013	Total Beds Available
Skilled	204	28,152	243	55,161	83,313
Intermediate	39	5,382	-	-	5,382
					<u>88,695</u>

Facility Name & ID Number

Champaign County Nrsg Home

0046664

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	462,278	106,884	94,438	663,600		663,600	(5,682)	657,918		1
2	Food Purchase		478,151		478,151		478,151	(17,882)	460,269		2
3	Housekeeping	364,551	63,621		428,172		428,172	(273)	427,899		3
4	Laundry	115,231	27,780		143,011		143,011		143,011		4
5	Heat and Other Utilities			433,870	433,870		433,870	(2,026)	431,844		5
6	Maintenance	48,333	41,033	179,532	268,898		268,898	(787)	268,111		6
7	Other (specify):*										7
8	TOTAL General Services	990,393	717,469	707,840	2,415,702		2,415,702	(26,650)	2,389,052		8
	B. Health Care and Programs										
9	Medical Director			40,800	40,800		40,800		40,800		9
10	Nursing and Medical Records	4,498,071	382,994	889,313	5,770,378		5,770,378		5,770,378		10
10a	Therapy	79,955			79,955		79,955		79,955		10a
11	Activities	169,301	4,879	1,946	176,126		176,126		176,126		11
12	Social Services	122,642	54	45,020	167,716		167,716		167,716		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Adult Day Care	140,988	15,054	61,805	217,847		217,847	(217,847)			15
16	TOTAL Health Care and Programs	5,010,957	402,981	1,038,884	6,452,822		6,452,822	(217,847)	6,234,975		16
	C. General Administration										
17	Administrative	173,999		330,027	504,026		504,026		504,026		17
18	Directors Fees										18
19	Professional Services			220,262	220,262		220,262	(5,390)	214,872		19
20	Dues, Fees, Subscriptions & Promotions			65,997	65,997		65,997	(17,660)	48,338		20
21	Clerical & General Office Expenses	266,944	14,801	43,629	325,374		325,374	(77)	325,297		21
22	Employee Benefits & Payroll Taxes			2,189,854	2,189,854		2,189,854		2,189,854		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,014	18,014		18,014		18,014		24
25	Other Admin. Staff Transportation			3,787	3,787		3,787	(20)	3,767		25
26	Insurance-Prop.Liab.Malpractice			273,704	273,704		273,704	(8,776)	264,928		26
27	Other (specify):*										27
28	TOTAL General Administration	440,943	14,801	3,145,274	3,601,018		3,601,018	(31,922)	3,569,096		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,442,293	1,135,251	4,891,998	12,469,542		12,469,542	(276,419)	12,193,123		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 County Nrsg Home

#0046664

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			743,935	743,935	743,935	(13,358)	730,577				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,342	134,342	134,342	(563)	133,779				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68,448	68,448	68,448		68,448				35
36	Other (specify):*											36
37	TOTAL Ownership			946,725	946,725	946,725	(13,921)	932,804				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,189	938,975	1,175,164	1,175,164		1,175,164				39
40	Barber and Beauty Shops	52,359	1,810		54,169	54,169		54,169				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			519,143	519,143	519,143		519,143				42
43	Other (specify):* Non-Allowable Co			463,622	463,622	463,622	(463,622)					43
44	TOTAL Special Cost Centers	52,359	237,999	1,921,740	2,212,098	2,212,098	(463,622)	1,748,476				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,494,652	1,373,250	7,760,463	15,628,365	15,628,365	(753,962)	14,874,403				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 County Nrsng Home

0046664

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

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	\$ (217,847)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(29,019)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,160)	30		9
10	Interest and Other Investment Income	(563)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(935)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,660)	43		28
29	Other-Attach Schedule	(477,778)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (753,962)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (753,962)		37

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

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

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

Champaign County Nrsg Home

ID# 0046664

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset meal revenue against food cost	\$ (4,388)	2	1
2	Laboratory fees	(39,490)	43	2
3	Medicare ancillary expense	(33,645)	43	3
4	Non-allowable transfers to General Corporate Fund	(2,733)	43	4
5	Public relations expense	(6,667)	19	5
6	Dietary	(5,682)	1	6
7	Food	(13,494)	2	7
8	Housekeeping	(273)	3	8
9	Utilities	(2,026)	5	9
10	Maintenance	(787)	6	10
11	Professional Fees	(1,139)	19	11
12	Office	(77)	21	12
13	Staff Transportation	(20)	25	13
14	Insurance - Auto	(7,360)	26	14
15	Insurance - Other	(1,416)	26	15
16	Depreciation - Other	(3,198)	30	16
17	Financial Charges	(11,856)	43	17
18	Out-of-Period Legal Exp	2,416	19	18
19	Bad Debt Expense	(345,943)	43	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(477,778)	49

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
Champaign County	100	N/A	N/A	Champaign County	Urbana	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Champaign County Nrsg Home # 0046664 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	See Attached List	Board of Directors	Administrative	0.00	None	<1	<1%		\$ None	N/A	1
2											2
3	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										3
4	transactions with the nursing home during the reporting period.										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 County Nrsg Home

0046664 Report Period Beginning: 12/01/2012

Ending: 11/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Champaign County Day Care Cost
 Street Address 5600 South Are Bartell Rd.
 City / State / Zip Code Urbana, IL 61802
 Phone Number (217) 384-3776
 Fax Number (217) 337-0120

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	212,138	\$ 201,322	\$	5,987	\$ 5,682	1
2	2	Food	Meals	212,138	478,151		5,987	13,494	2
3	3	Housekeeping	Square Feet	67,925	63,621		292	273	3
4	5	Utilities	Square Feet	67,925	471,332		292	2,026	4
5	6	Maintenance	Square Feet	67,925	183,103		292	787	5
6	19	Professional Fees	Revenue	14,940,682	220,262		77,286	1,139	6
7	21	Office Expense	Revenue	14,940,682	14,801		77,286	77	7
8	25	Staff Transportation	Revenue	14,940,682	3,787		77,286	20	8
9	26	Insurance - Auto	Direct	1	7,360		1	7,360	9
10	26	Insurance - Other	Revenue	14,940,682	273,704		77,286	1,416	10
11	30	Depreciation - Other	Square Feet	67,925	743,935		292	3,198	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,661,378	\$		\$ 35,472	25

Facility Name & ID Number

Champaign County Nrsg Home

0046664

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Interest - Bonds Payable		X	Construction	Varies	06/30/06	\$ 4,000,000	\$ 2,885,000	6/30/2026	Varies	\$ 130,090						
2																	
3																	
4																	
5																	
Working Capital																	
6	Champaign County		X	Interfund Loan - working capital							4,252						
7																	
8																	
9	TOTAL Facility Related						\$ 4,000,000	\$ 2,885,000			\$ 134,342						
B. Non-Facility Related*																	
10																	
11									Offset interest income		(563)						
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (563)						
15	TOTALS (line 9+line14)						\$ 4,000,000	\$ 2,885,000			\$ 133,779						

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.)

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 N/A 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 135,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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).

Adults Day Care Services
4,680 Square Feet

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>670,000</u>	<u>2007</u>	<u>\$ 253,543</u>	1
2					2
3	TOTALS	670,000		\$ 253,543	3

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	243	2007	2007	\$ 23,227,193	\$ 577,728	40	\$ 580,680	\$ 2,952	\$ 3,968,072	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	New NH parking lot		2007	189,924	36,333	8	22,173	(14,160)	163,434	9
10	Masonry sign		2008	16,741	670	25	670		3,685	10
11	Smoke Barriers		2010	89,879	2,429	37	2,429		8,502	11
12	Smoke Barriers		2011	3,900	110	35.5	110		256	12
13	Boiler Repair		2011	4,990	2,495	2	2,495		6,238	13
14										14
15	Boiler Upgrades-Basement		2012	21,339	1,067	20	1,067		1,600	15
16	Fulton Boiler Controller-Basement		2012	7,309	1,462	5	1,462		1,949	16
17	External Storage Unit		2012	6,217	1,244	5	1,244		1,659	17
18	Basement Water Leak Repair		2012	4,441		10	444	444	666	18
19	Basement Heat Trace Repair		2012	2,992		10	300	300	450	19
20	Emergency Generator Repair		2012	3,040		10	304	304	456	20
21										21
22	Additional Fulton Boiler Work		2013	10,700	1,783	5	1,783		1,783	22
23	Water Heater Replacement		2013	28,445	1,896	10	1,896		1,896	23
24	Chiller Phase Sequencers and installation		2013	9,968	457	10	457		457	24
25	Water Mixing Valves		2013	8,761	73	10	73		73	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

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	TOTAL (lines 4 thru 69)	\$ 23,635,839	\$ 627,747		\$ 617,587	\$ (10,160)	\$ 4,161,176	70

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

Facility Name & ID Number Champaign County Nrsg Home

0046664

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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	\$ 880,518	\$ 87,659	\$ 87,659	\$		\$ 500,039	71
72	Current Year Purchases	43,170	6,377	6,377		2-5	6,377	72
73	Fully Depreciated Assets	171,532					171,532	73
74	Disallowed Day Care Depreciation			(3,198)	(3,198)			74
75	TOTALS	\$ 1,095,220	\$ 94,036	\$ 90,838	\$ (3,198)		\$ 677,948	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	See Sch 13A	See Sch 13A	See Sch 13A	\$ 209,013	\$ 22,152	\$ 22,152	\$	5-10	\$ 156,057	76
77										77
78										78
79										79
80	TOTALS			\$ 209,013	\$ 22,152	\$ 22,152	\$		\$ 156,057	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)	\$ 25,193,615	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 743,935	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 730,577	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,358)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,995,181	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	N/A	\$	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.

XI. OWNERSHIP COSTS (continued)

D. Vehicle Depreciation (See instructions.)*

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Life in Years	Accumulated Depreciation
Resident Use	96 Ford Bus	1996	36,532			-	10	36,532
Resident Use	98 Dodge Van	1998	33,746			-	10	33,746
Resident Use	Lift for Van	2001	537			-	5	537
Resident Use	97 Ford	2002	1,358				10	1,358
Resident Use	Mini Van Paratransit w/ ramp	2009	33,104	6,621	6,621	-	5	30,897
Resident Use	09 Ford Eldorado Van	2009	51,576	10,315	10,315	-	5	42,120
Resident Use	2011 Ford Van	2011	52,160	5,216	5,216	-	10	10,867
			209,013	22,152	22,152	-		156,057

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 68,448 Description: See Schedule 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>N/A</u>	\$	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.

Champaign County Nursing Home
Provider #: 0001636
FYE: November 30, 2013

Schedule 14A

XII. RENTAL COSTS

B(16). Rental Amount & Descriptions

<u>Description</u>	<u>Amount</u>
Trash Compactor	3,096
Construction vehicles	119
Dishwasher	4,549
Wound Vac	6,153
Therapy Equipment	#####
Mattresses & Bed Rentals	#####
Mattresses	8,260
Medical Supply	5,570
Oxygen Concentrators	2,713
Respiratory Equipment	1,979
Total Line B (16)	<u>68,448</u>

Facility Name & ID Number Champaign County Nrsng Home # 0046664 Report Period Beginning: 12/01/2012 Ending: 11/30/2013
 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? 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>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	L39, C3	hrs	\$	4,878	\$	365,873	\$	4,878	\$	365,873	1	
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,575		118,136		1,575		118,136	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	L39, C3	hrs		4,879		365,893		4,879		365,893	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation	L39, C3	hrs		1,188		89,073		1,188		89,073	8	
9	Pharmacy	L39, C2	# of prescrpts					236,189			236,189	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			\$	12,520	\$	938,975	\$	236,189	12,520	\$	1,175,164	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 County Nrsng Home

0046664

Report Period Beginning: 12/01/2012

Ending:

11/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 368,498	\$ 368,498	1
2	Cash-Patient Deposits	8,964	8,964	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>174,008</u>)	1,445,309	1,445,309	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	24,490	24,490	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due to/from Other Funds</u>	1,668,972	1,668,972	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,516,233	\$ 3,516,233	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		253,543	13
14	Buildings, at Historical Cost	23,281,504	23,227,194	14
15	Leasehold Improvements, at Historical Cost	469,744	408,645	15
16	Equipment, at Historical Cost	1,356,362	1,304,233	16
17	Accumulated Depreciation (book methods)	(5,105,307)	(4,995,181)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,002,303	\$ 20,198,434	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 23,518,536	\$ 23,714,667	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,932,106	\$ 1,932,106	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,964	8,964	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	474,312	474,312	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,415,382	\$ 2,415,382	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,885,000	2,885,000	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,885,000	\$ 2,885,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,300,382	\$ 5,300,382	46
47	TOTAL EQUITY(page 18, line 24)	\$ 18,218,154	\$ 18,414,285	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 23,518,536	\$ 23,714,667	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,662,015	1
2	Restatements (describe):		2
3	Prior Period Adjustment	243,822	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,905,837	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(687,683)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (687,683)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 18,218,154	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,672,613	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,672,613	3
B. Ancillary Revenue			
4	Day Care	77,286	4
5	Other Care for Outpatients	496,034	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 573,320	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	139,553	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	38,941	13
14	Non-Patient Meals	4,388	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	71,186	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 254,068	23
D. Non-Operating Revenue			
24	Contributions	342,590	24
25	Interest and Other Investment Income***	563	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 343,153	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	1,097,528	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,097,528	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,940,682	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,415,702	31
32	Health Care	6,452,822	32
33	General Administration	3,601,018	33
B. Capital Expense			
34	Ownership	946,725	34
C. Ancillary Expense			
35	Special Cost Centers	1,692,955	35
36	Provider Participation Fee	519,143	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,628,365	40
41	Income before Income Taxes (line 30 minus line 40)**	(687,683)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (687,683)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,863,229	44
45	Private Pay - Net Inpatient Revenue	4,221,450	45
46	Medicare - Net Inpatient Revenue	2,627,187	46
47	Other-(specify) <u>VA - Veterans Care</u>	212,959	47
48	Other-(specify) <u>Hospice and HMO</u>	747,788	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,672,613	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.

*** 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.

^ - Government Entity (Part of County)

Champaign County Nursing Home
Provider #: 0001636
FYE: November 30, 2013

Schedule 19A

XVII. Income Statement

Line 28 Other Income(specify):

<u>Description</u>	<u>Amount</u>
Taxes - Current Operating	1,049,644
Other Operating Taxes	562
Mobile Home Tax	1,128
Payment in Lieu of Taxes	835
Resident Transportation	19,556
Late charges	22,711
Misc Income	3,092
Total - Line 28	<u>1,097,528</u>
	0

Facility Name & ID Number Champaign County Nrsng Home

0046664

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				1
2	Assistant Director of Nursing	1,821	2,077	65,626	31.60
3	Registered Nurses	34,195	36,959	1,035,327	28.01
4	Licensed Practical Nurses	37,021	39,679	939,713	23.68
5	CNAs & Orderlies	163,527	168,686	2,306,569	13.67
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	5,342	6,270	79,955	12.75
9	Activity Director				9
10	Activity Assistants	12,634	13,857	169,301	12.22
11	Social Service Workers	7,169	7,655	122,642	16.02
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	36,174	40,345	462,278	11.46
16	Dishwashers				16
17	Maintenance Workers	4,246	4,634	48,333	10.43
18	Housekeepers	28,211	31,796	364,551	11.47
19	Laundry	8,188	9,710	115,231	11.87
20	Administrator	3,892	4,160	173,999	41.83
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	18,099	19,986	266,944	13.36
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	1,613	1,729	17,574	10.16
32	Other Health Care(specify)	7,879	9,574	140,988	14.73
33	Other(specify) <u>See Sch 20A</u>	10,273	11,546	185,621	16.08
34	TOTAL (lines 1 - 33)	380,284	408,663	\$ 6,494,652 *	\$ 15.89

* 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	\$ 94,318	1(7) 35
36	Medical Director	Monthly	40,800	9(3) 36
37	Medical Records Consultant	Monthly	1,961	10(3) 37
38	Nurse Consultant	Monthly	136,898	10(3) 38
39	Pharmacist Consultant	Monthly	9,579	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	1,946	11(3) 44
45	Social Service Consultant	Monthly	45,020	12(3) 45
46	Other(specify) <u>MDS Consultant</u>	Monthly	81,563	10(3) 46
47	<u>Care Plan Coordinator</u>	Monthly	172,653	10(3) 47
48	<u>Transport Services</u>	Monthly	13,698	10(3) 48
49	TOTAL (lines 35 - 48)		\$ 598,436	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,045	\$ 50,907	10(3) 50
51	Licensed Practical Nurses	2,102	74,061	10(3) 51
52	Certified Nurse Assistants/Aides	13,959	320,295	10(3) 52
53	TOTAL (lines 50 - 52)	17,106	\$ 445,263	53

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

Ln 30 Other

	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salaries</u>	AHW
Barber& Beauty	3,466	4,106	52,359	12.75
Unit Secretary	3,426	3,806	39,324	10.33
Dental Hygentist	1,326	1,557	38,454	24.70
Care Plan Coordinator	2,055	2,077	55,484	26.71
Total to page 20	<u>10,273</u>	<u>11,546</u>	<u>185,621</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Noffke	Administrator	0	\$ 100,000	Workers' Compensation Insurance	\$ 267,794	IDPH License Fee	\$	
Traci Harris	Assistant Administrator	0	73,999	Unemployment Compensation Insurance	165,187	Advertising: Employee Recruitment	17,700	
				FICA Taxes	468,253	Health Care Worker Background Check		
				Employee Health Insurance	607,694	(Indicate # of checks performed <u>31</u>)	955	
				Employee Meals	0	Patient Background Checks	665	
				Illinois Municipal Retirement Fund (IMRF)*	654,625	Life Services Network	19,549	
				Employee Morale	391	Yellow Page Advertising	17,660	
				Employee Labs & Physicals	25,910	Miscellaneous Dues	640	
						Miscellaneous Publications	2,844	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 173,999			Non-allowable advertising	()	
B. Administrative - Other						Yellow page advertising	(17,660)	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
Management Performance (Management Fees)			\$ 330,027			\$ 48,338		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 330,027	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,189,854		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
See SCH 21A	See SCH 21A		\$ 220,262	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	18,014
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 220,262				TOTAL	\$ 18,014

* Attach copy of IMRF notifications

**See instructions.

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor	Type	Amount
Champaign County Treasurer	Accounting	49,061
McGladrey & Pullen, LLP	Accounting	18,178
Stricklin & Associates	Public Relations - Disallow	6,667
Pinnacle Consulting	IT Consulting	4,550
Lifecycle Systems	Aviary Delivery	890
Oliver Group, The	Predictive Index	7,900
Triad Shredding Corp	Paper Shredding Services	477
Apex Solutions	IT Staffing and recruiting services	1,510
Greensberg & Associates, Inc	Health Information Management services	829
Providertrust, Inc	Healthcare software solutions	2,040
Harmony Healthcare International	Compliance Consulting	6,583
GHR Engineers & Associates	Consulting Engineering Service	1,554
Trillium	Software	8,762
Champaign County Treasurer- Gen	Accounting	1,686
Heyl, Royster, Voelker & Allen	Legal Fees	5,368
Polsinelli Shughart Pc	Legal Fees	9,351
Evans, Froehlich, Beth & Chamley	Legal Fees	2,750
Elvidge Kelley	Legal Fees	650
Meyer Capel	Legal Fees	6,523
Champaign County Treasurer- Gen	Legal Fees	2,000
E-health Data Solutions	Computer Services	4,140
Allscripts Healthcare, Llc	Computer Services	3,900
MDI Achieve Inc	Computer Services	38,610
Comcast Cable	Computer Services	666
Ivans, Inc	Computer Services	2,361
AT & T	Computer Services	815
Champaign County Treasurer- Gen	Computer Services	31,726
Uvanta Pharmacy of Central IL	Computer Services	63
Visa Cardmember Services-Nursing	Computer Services	143

Ability Network, Inc	Computer Services	509
Total agreeing to Schedule V, Line 19, Col 3		<u>220,262</u>
	To Disallow Adult Day Care Expenses	(1,139)
	To Disallow OOP Legal Expenses	2,416
	To Disallow Public Relations	(6,667)
Total (agree to Schedule V, line 20, column 8)		<u><u>214,872</u></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										N/A		
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Champaign County Nrsg Home

0046664

Report Period Beginning: 12/01/2012 Ending: 11/30/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$19,549
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 106,143 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 519,143
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes-See Pg 8 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,388
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Bray, Drake, Liles & Richardson LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.