

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

0052217 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 _____

	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	213	Skilled (SNF)	213	77,745	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	213	TOTALS	213	77,745	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,688	10,688	8
9	SNF/PED					9
10	ICF	27,311	5,181	1,379	33,871	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,311	5,181	12,067	44,559	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.31%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/1/2013 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 6,852

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	311,150	24,123	34,388	369,661		369,661		369,661		1
2	Food Purchase		290,909		290,909		290,909	(3,111)	287,798		2
3	Housekeeping	8,621	26,206	232,650	267,477		267,477		267,477		3
4	Laundry		19,331	89,100	108,431		108,431		108,431		4
5	Heat and Other Utilities			241,948	241,948		241,948	672	242,620		5
6	Maintenance	87,980		102,984	190,964		190,964	8,148	199,112		6
7	Other (specify):* Waste Removal			30,578	30,578		30,578		30,578		7
8	TOTAL General Services	407,751	360,569	731,648	1,499,968		1,499,968	5,709	1,505,677		8
	B. Health Care and Programs										
9	Medical Director			56,100	56,100		56,100	(56,100)			9
10	Nursing and Medical Records	3,125,010	249,883	51,391	3,426,284		3,426,284	76,618	3,502,902		10
10a	Therapy	157,000	11,160	45,291	213,451		213,451		213,451		10a
11	Activities	87,817		6,499	94,316		94,316		94,316		11
12	Social Services	133,115		8,717	141,832		141,832		141,832		12
13	CNA Training										13
14	Program Transportation			12,418	12,418		12,418		12,418		14
15	Other (specify):* Mgmt Co Benefits Alloc							14,364	14,364		15
16	TOTAL Health Care and Programs	3,502,942	261,043	180,416	3,944,401		3,944,401	34,882	3,979,283		16
	C. General Administration										
17	Administrative	117,589			117,589		117,589	108,709	226,298		17
18	Directors Fees										18
19	Professional Services			263,132	263,132		263,132	(8,026)	255,106		19
20	Dues, Fees, Subscriptions & Promotions			20,924	20,924		20,924	504	21,428		20
21	Clerical & General Office Expenses	289,828	31,526	71,709	393,063		393,063	119,493	512,556		21
22	Employee Benefits & Payroll Taxes			661,440	661,440		661,440		661,440		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,332	12,332		12,332	187	12,519		24
25	Other Admin. Staff Transportation			37,761	37,761		37,761	747	38,508		25
26	Insurance-Prop.Liab.Malpractice			218,893	218,893		218,893		218,893		26
27	Other (specify):* Mgmt Co Benefits Alloc							37,066	37,066		27
28	TOTAL General Administration	407,417	31,526	1,286,191	1,725,134		1,725,134	258,680	1,983,814		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,318,110	653,138	2,198,255	7,169,503		7,169,503	299,271	7,468,774		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

#0052217

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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							471,703	471,703			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,639	84,639		84,639	817,756	902,395			32
33	Real Estate Taxes			84,303	84,303		84,303		84,303			33
34	Rent-Facility & Grounds			1,261,925	1,261,925		1,261,925	(1,248,610)	13,315			34
35	Rent-Equipment & Vehicles			52,736	52,736		52,736	1,511	54,247			35
36	Other (specify):*											36
37	TOTAL Ownership			1,483,603	1,483,603		1,483,603	42,360	1,525,963			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		541,872	1,266,362	1,808,234		1,808,234		1,808,234			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,257	345,257		345,257		345,257			42
43	Other (specify):* Disallowed Costs	88,981	16,973	247,414	353,368		353,368	(353,368)				43
44	TOTAL Special Cost Centers	88,981	558,845	1,859,033	2,506,859		2,506,859	(353,368)	2,153,491			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,407,091	1,211,983	5,540,891	11,159,965		11,159,965	(11,737)	11,148,228			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(34,398)	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	471,703	30		9
10	Interest and Other Investment Income	(1,465)	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	(57,800)	43		18
19	Entertainment				19
20	Contributions	(18,400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,162)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,772)	43		24
25	Fund Raising, Advertising and Promotional	(25,267)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(141,852)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 14,587		\$	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)	(26,324)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (26,324)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (11,737)		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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Champaign Urbana Nursing and Rehab, LP

ID# 0052217

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Comissions	\$ (3,111)	2	1
2	Rental Income	(800)	6	2
3	Miscellaneous Income	(898)	21	3
4	Marketing Salary	(88,981)	43	4
5	Expense Repairs under \$2,500	8,861	6	5
6	Offset Vendor Credits	(56,100)	9	6
7	Disallow Marketing Travel costs	(823)	25	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
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26				26
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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	(141,852)		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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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	32 Interest		Champaign Urbana Realty	100.00%	\$ 819,221	\$ 819,221	1
2	V	34 Rent-Facility & Grounds	1,261,925	Champaign Urbana Realty	100.00%		(1,261,925)	2
3	V	43 Late Fees		Champaign Urbana Realty	100.00%	36,250	36,250	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		\$ 1,261,925			\$ 855,471	\$ * (406,454)	14

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

VII. RELATED PARTIES (continued)

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)		
15	V	5 Heat and Other Utilities	\$	Premier Healthcare Management, LLC	100.00%	\$ 672	\$	672	15
16	V	6 Maintenance		Premier Healthcare Management, LLC	100.00%	87		87	16
17	V	10 Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	85,914		85,914	17
18	V	10 Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0			18
19	V	15 Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	14,364		14,364	19
20	V	15 Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0			20
21	V	17 Administrative		Premier Healthcare Management, LLC	100.00%	87,316		87,316	21
22	V	17 Administrative		Premier Healthcare Management, LLC	100.00%	21,393		21,393	22
23	V	17 Administrative		Premier Healthcare Management, LLC	100.00%	0			23
24	V	19 Professional Services		Premier Healthcare Management, LLC	100.00%	5,136		5,136	24
25	V	20 Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	504		504	25
26	V	21 Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	120,391		120,391	26
27	V	24 Travel and Seminar		Premier Healthcare Management, LLC	100.00%	187		187	27
28	V	25 Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	1,570		1,570	28
29	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	33,489		33,489	29
30	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	3,577		3,577	30
31	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	0			31
32	V	34 Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	13,315		13,315	32
33	V	35 Equipment Rental		Premier Healthcare Management, LLC	100.00%	1,511		1,511	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 389,426	\$ *	389,426	39

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

VII. RELATED PARTIES (continued)

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)
15	V	10 Nursing and Medical Records	\$ 17,000	Premier Healthcare Supplies, LLC	100.00%	\$ 7,704	\$ (9,296)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,000			\$ 7,704	\$ * (9,296)

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Knopf	2.80%	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	Ayelet Knopf	2.80%	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Naomi Lopin	2.80%	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Yisroel Lopin	2.80%	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Michael & Carol Knopf	0.90%	Gardenview Manor	Danville	Champaign Urbana	Savoy	Lessor	5
6	Isaac & Rachel Knopf	0.50%	Norridge Gardens	Norridge	Realty			6
7	BDS Whampo LLC	0.90%	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN	REX Therapeutics	Skokie	Therapy	7
8	Orsheve Enterprises	3.30%	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	Razie Indich	0.50%	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10	Jerry & Deena Cheplowitz	0.50%	Premier Healthcare of Connerville, LLC	Connerville, IN				10
11	Leonard & Felice Frand	0.50%						11
12	Waxcap, Inc.	12.20%						12
13	Barak Baver	34.70%						13
14	David Cheplowitz	34.80%						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP # 0052217 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	David Cheplowitz	Shareholder	Administrative	34.80%	See Att Sch 7A	4.16	10%	Alloc Salary	\$ 18,291	17-7	1	
2	Barak Bayer	Shareholder	Administrative	34.70%	See Att Sch 7A	4.16	10%	Alloc Salary	18,291	17-7	2	
3	Sara Bayer	Relative	Clerical	0.00	See Att Sch 7A	4.16	10%	Alloc Salary	4,592	21-7	3	
4	Yocheved Bayer	Relative	Consulting	0.00	See Att Sch 7A			Consulting	9,000	19-3	4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 50,174		13	

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

0052217

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Premier Healthcare Management, LLC
 Street Address 8170 N. McCormick Blvd. Suite 137
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 674-2800
 Fax Number (847) 674-4133

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	5	Heat and Other Utilities	Census Days	428,856	12	\$ 6,472	\$ 44,559	\$ 672	1
2	6	Maintenance	Census Days	428,856	12	843	44,559	87	2
3	10	Nursing and Medical Records	Illinois Census Days	307,749	7	593,374	44,559	85,914	3
4	10	Nursing and Medical Records	Indiana Census Days	121,107	5	239,535	44,559	0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	307,749	7	99,203	44,559	14,364	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	121,107	5	40,047	44,559	0	6
7	17	Administrative	Census Days	428,856	12	840,373	44,559	87,316	7
8	17	Administrative	Illinois Census Days	307,749	7	147,750	44,559	21,393	8
9	17	Administrative	Indiana Census Days	121,107	5	133,577	44,559	0	9
10	19	Professional Services	Census Days	428,856	12	49,430	44,559	5,136	10
11	20	Dues, Fees, Subs & Promo	Census Days	428,856	12	4,850	44,559	504	11
12	21	Clerical & Gen Office Expenses	Census Days	428,856	12	1,158,702	44,559	120,391	12
13	24	Travel and Seminar	Census Days	428,856	12	1,803	44,559	187	13
14	25	Other Admin. Staff Trans	Census Days	428,856	12	15,107	44,559	1,570	14
15	27	Emp Benefit Alloc-Gen Admin	Census Days	428,856	12	322,307	44,559	33,489	15
16	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	307,749	7	24,702	44,559	3,577	16
17	27	Emp Benefit Alloc-Gen Admin	Indiana Census Days	121,107	5	22,332	44,559	0	17
18	34	Rent-Facility & Grounds	Census Days	428,856	12	128,146	44,559	13,315	18
19	35	Equipment Rental	Census Days	428,856	12	14,538	44,559	1,511	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,843,091	\$ 3,042,080	\$ 389,426	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

0052217

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Premier Healthcare Supplies, LLC

Street Address

8170 N. McCormick Blvd. Suite 137

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 674-2800

Fax Number

(847) 674-4133

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

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

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	10	Nursing and Medical Records	Revenue	12	\$ 65,860	\$	18,880	\$ 7,704	1
2									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				\$ 65,860	\$		\$ 7,704	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Champaign Urbana Nursing and Rehab, LP

0052217

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	First Midwest Bank		X	Mortgage		7/25/2014	\$ 16,100,000	\$ 16,100,000	8/5/2017		\$ 819,221	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	First Midwest Bank		X	Line of Credit		12/31/14		1,691,100	3/31/17		81,958	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 16,100,000	\$ 17,791,100			\$ 901,179	9						
B. Non-Facility Related*																		
10												10						
11								Other Interest			2,681	11						
12								Offset Interest Income			(1,465)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 1,216	14						
15	TOTALS (line 9+line14)						\$ 16,100,000	\$ 17,791,100			\$ 902,395	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	76,538	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.)	2016	\$	82,598	2
3. Under or (over) accrual (line 2 minus line 1).		\$	6,060	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	78,243	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	84,303	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	79,589	8
	2013	82,903	9
	2014	84,303	10
	2015	84,687	11
	2016	82,598	12

Accrual based on prior year tax bill.

Adjusted Beg accrual to actual

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

0052217 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 2015, \$945,720. Row 2: (blank). Row 3: TOTALS, \$945,720.

SEE ACCOUNTANTS' PREPARATION REPORT

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	2015	1975	\$ 9,141,960	\$	35	\$ 261,199	\$ 261,199	\$ 783,597	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	New Skilled Unit: Reroute Power In Therapy, Dialysis Room Outlets		2014	14,697		20	735	735	2,879	9
10	New Floor, Wall Tiles, Paint In 2 Shower Rooms		2014	12,750		20	638	638	2,445	10
11	Paint 15 Units, Including Bathrooms		2014	4,500		20	225	225	863	11
12	Gym Flooring & Cove Base		2014	23,343		20	1,167	1,167	4,474	12
13	Dialysis Room Carpet		2014	9,271		20	464	464	1,701	13
14	Plumbing		2014	3,282		20	164	164	588	14
15	Install Generator Controller		2014	23,115		20	1,156	1,156	4,046	15
16	Water Supply Line & Piping		2014	3,690		20	185	185	724	16
17	Replace Compressor		2014	4,630		20	232	232	773	17
18	Install Dome Lights & Pull Cords In Rehab Area Bathrooms		2014	3,815		20	191	191	620	18
19	Change Two 85 Gallon/500,000 Btu Water Heaters		2015	30,687		20	1,534	1,534	4,602	19
20	Install 2' Gas Main To 4 Water Heaters/Fix Gas Leak In Basement		2015	5,300		20	265	265	565	20
21	Addition Of 4 Circuits For New Dialysis Machines/Gfci Breaker		2015	5,015		20	251	251	753	21
22	Remove/Install High & Low Slow Mixing Valve		2015	3,248		20	162	162	486	22
23	Install Epdm Rubber Roof At East/Center Of Building		2015	5,635		20	282	282	846	23
24	Security System		2015	10,195		20	510	510	1,530	24
25	Dialysis Room - Electrical, Wall boxes, paint, cabinets and faucets		2016	2,680		20	134	134	201	25
26	Flooring in Rehab Nurses station, Rms I05-113, Lobby, Hallway, South Corridor and Dialysis Den Room		2016	51,174		20	2,559	2,559	3,838	26
27										27
28	Install Two 85 Gallon BTU Water Heating Units		2016	29,497		20	1,475	1,475	2,212	28
29	Boiler Repair		2016	3,239		20	162	162	243	29
30	Reapirs on 3 Boilers - Replace Pumps, Motors, Blades & Contactors		2017	5,084		20	127	127	127	30
31	Install 2 new ASI Controls with Sensors,AAON RTUs, Pumps and Exhuas		2017	15,800		20	395	395	395	31
32	Replaced Blower Motors and Circuit Boards on 3 PTAC units		2017	2,862		20	72	72	72	32
33	Repair Water Damaged Fire Alarm System		2017	2,769		20	69	69	69	33
34	Electrical Wiring and Circuts for new Dialysis Room		2017	7,097		20	177	177	177	34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

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	Allocated from Premier Healthcare Management, LLC	2013	2,586	20	129	129	542	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)		\$ 9,427,921	\$	\$ 274,659	\$ 274,659	\$ 819,368	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 1,959,444	\$	\$ 195,944	\$ 195,944	10	\$ 673,759	71
72	Current Year Purchases	22,005		1,100	1,100	10	1,100	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,981,449	\$	\$ 197,044	\$ 197,044		\$ 674,859	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 12,355,090	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 471,703	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 471,703	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,494,227	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

0052217

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:				\$			3
4	Additions							4
5	<u>Allocated from Management Co.</u>				<u>13,315</u>			5
6								6
7	TOTAL				\$ 13,315			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 44,240 Description: See Attached 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>Facility</u>	<u>2014 Ford Elkhart</u>	\$ <u>772.39</u>	\$ <u>8,496</u>	17
18					18
19	<u>Allocated from Management Co</u>			<u>1,511</u>	19
20					20
21	TOTAL		\$ 772.39	\$ 10,007	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Champaign Urbana Nursing and Rehab, LP
IDPH License ID Number: 0052217
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	24,404
Dietary Equipment	6,873
Laundry Equipment	123
Office Equipment	12,840
Total - Line 16	44,240

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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 434,514	\$		\$ 434,514	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			144,673			144,673	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3),39(2), (3)	hrs			720,668	11,160		731,828	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				533,884		533,884	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Attached Sch 16A</u>					(12,202)	7,988		(4,214)	13
14	TOTAL			\$		\$ 1,287,653	\$ 553,032		\$ 1,840,685	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Champaign Urbana Nursing and Rehab, LP
IDPH License ID Number: 0052217
Fiscal Year End: 12/31/2017

Schedule 16A

**XIV. Special Services
Line 13 Other Services**

Description	Schedule V	
	Line & Column	Reference
Description	Reference	Amount
Lab & Xray	39(3)	19,298
Dialysis	39(3)	4,114
Outside MD Service-MCA	39(3)	(35,614)
Medical Supplies - MCA	39(2)	7,988
Total - Line 13		(4,214)

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,089	\$ 14,089	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,244,340</u>)	3,717,997	3,717,997	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,639	17,639	6
7	Other Prepaid Expenses	58,379	58,379	7
8	Accounts Receivable (owners or related parties)	1,064,787	381,426	8
9	Other(specify): <u>See Attached Schedule 17A</u>	26,455	26,455	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,899,346	\$ 4,215,985	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		945,720	13
14	Buildings, at Historical Cost		9,141,960	14
15	Leasehold Improvements, at Historical Cost	286,138	285,961	15
16	Equipment, at Historical Cost	656,064	1,981,449	16
17	Accumulated Depreciation (book methods)	(293,881)	(1,494,227)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	72,867	72,867	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(110,782)	(110,782)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule 17A</u>	118,865	2,007,376	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 729,271	\$ 12,830,324	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,628,617	\$ 17,046,309	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,640,962	\$ 2,640,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(87)	(87)	28
29	Short-Term Notes Payable	1,691,100	1,691,100	29
30	Accrued Salaries Payable	151,245	151,245	30
31	Accrued Taxes Payable (excluding real estate taxes)	380,320	380,320	31
32	Accrued Real Estate Taxes(Sch.IX-B)		78,243	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	638,340	638,340	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,501,880	\$ 5,580,123	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,100,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,100,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,501,880	\$ 21,680,123	46
47	TOTAL EQUITY(page 18, line 24)	\$ 126,737	\$ (4,633,814)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,628,617	\$ 17,046,309	48

Facility Name: Champaign Urbana Nursing and Rehab, LP
IDPH License ID Number: 0052217
Fiscal Year End: 12/31/2017

Schedule 17A

XV. Balance Sheet

Line 9 Other Current Assets (specify):

Description	Operating	After Consolidation
Employee Advances	3,099	3,099
Due From Prior Owner	9,229	9,229
Security Deposit	1,200	1,200
Due From Others	12,927	12,927
Total - Line 9	26,455	26,455

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs	118,865	118,865
Loan Origination Fees - CUR		292,317
CIP		
Goodwill & CON - CUR		
Amortization - CUR		(237,325)
Capital Impr Reserve - CUR		132,805
Pledge Accts Fund - CUR		500,000
RE Tax Escrow - CUR		22,266
Sinking Fund - CUR		1,178,448
Total - Line 23	118,865	2,007,376

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	113,916	113,916
Accrued Expenses	159,702	159,702
Accrued Bed Tax	65,492	65,492
Payroll Withholdings	299,230	299,230
Total - Line 36	638,340	638,340

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 260,623	1
2	Restatements (describe):		2
3	Post closing adjustments -Addl Bad Debt Expense	(225,030)	3
4	Post closing adjustments -Addl Depreciation Expense	(131,705)	4
5	Post closing adjustments -Misc Invoice Reversals	(35,619)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (131,731)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	290,318	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	(31,850)	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)	\$ 258,468	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)	\$ 126,737	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,273,788	1
2	Discounts and Allowances for all Levels	705,873	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,979,661	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	360,964	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 360,964	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,111	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	800	16
17	Sale of Drugs	27,888	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	16,786	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,585	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,465	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,465	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	898	28
28a	<u>Vendor Credits</u>	58,710	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 59,608	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,450,283	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,499,968	31
32	Health Care	3,944,401	32
33	General Administration	1,725,134	33
B. Capital Expense			
34	Ownership	1,483,603	34
C. Ancillary Expense			
35	Special Cost Centers	2,161,602	35
36	Provider Participation Fee	345,257	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,159,965	40
41	Income before Income Taxes (line 30 minus line 40)**	290,318	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 290,318	43

3		4	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,289,618	44
45	Private Pay - Net Inpatient Revenue	1,151,124	45
46	Medicare - Net Inpatient Revenue	4,659,818	46
47	Other-(specify) <u>Insurance</u>	537,865	47
48	Other-(specify) <u>Veterans</u>	341,236	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,979,661	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP

0052217

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,162	2,523	\$ 94,641	\$ 37.51	1
2	Assistant Director of Nursing	3,704	3,930	119,852	30.50	2
3	Registered Nurses	35,100	36,203	1,112,143	30.72	3
4	Licensed Practical Nurses	21,386	22,564	628,979	27.88	4
5	CNAs & Orderlies	74,155	76,881	987,979	12.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,134	8,919	157,000	17.60	8
9	Activity Director					9
10	Activity Assistants	6,675	7,134	87,817	12.31	10
11	Social Service Workers	5,229	5,605	86,305	15.40	11
12	Dietician					12
13	Food Service Supervisor	2,256	2,312	34,755	15.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,737	21,866	276,395	12.64	15
16	Dishwashers					16
17	Maintenance Workers	4,774	4,999	87,980	17.60	17
18	Housekeepers	809	809	8,621	10.66	18
19	Laundry					19
20	Administrator	1,968	2,080	117,589	56.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,276	14,237	289,828	20.36	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	1,535	1,583	28,205	17.82	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	9,464	10,058	289,002	28.73	33
34	TOTAL (lines 1 - 33)	211,364	221,703	\$ 4,407,091 *	\$ 19.88	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	\$ 34,388	L1, C3	35
36	Medical Director	Monthly	56,100	L9, C3	36
37	Medical Records Consultant	Monthly	5,520	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	22,808	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	8,717	L12, C3	45
46	Other(specify) <u>Rehab Mgmt</u>	Monthly	24,000	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 151,533		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	536	23,063	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	536	\$ 23,063		53

SEE ACCOUNTANTS' PREPARATION REPORT

Champaign Urbana Nursing and Rehab, LP

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,762	4,956	153,211	30.91
Transportation	2,431	2,631	46,810	17.79
Marketing	2,271	2,471	88,981	36.01
TOTAL	<u>9,464</u>	<u>10,058</u>	<u>289,002</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			
Steven Territo	Administrator	0	\$ 117,589	Workers' Compensation Insurance	\$ 112,999	IDPH License Fee	\$ 3,980			
				Unemployment Compensation Insurance	80,614	Advertising: Employee Recruitment	8,059			
				FICA Taxes	328,567	Health Care Worker Background Check (Indicate # of checks performed <u>36</u>)	3,184			
				Employee Health Insurance	129,657	Patient Background Checks	3,961			
				Employee Meals		Dues & Subscriptions	1,008			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	732			
				Other Employee Benefits	9,246					
				Physical Exams	357					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,589	TOTAL (agree to Schedule V, line 22, col.8)		\$ 661,440	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,428	
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
N/A			\$				\$	Out-of-State Travel		\$
								In-State Travel		
								Seminar Expense		12,332
								Allocated from Management Co.		187
								Entertainment Expense		()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 12,519
C. Professional Services										
Vendor/Payee		Type	Amount							
See Attached		Legal	\$ 28,378							
Richard Peelo & Associates, Inc		Accounting	2,100							
CohnReznick LLP		Accounting	33,946							
LTC Consulting Services		Consulting Fees	82,312							
Personnel Planners		Unemployment Consultants	1,350							
Ability Network Inc.		Data Processing	6,426							
ADP		Payroll Service	1,405							
HDSI		Data Processing	5,648							
MatrixCare		Data Processing	45,840							
Singer Networks, LLC		Data Processing	11,199							
See Attached Schedule 21A			44,528							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 263,132							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Champaign Urbana Nursing and Rehab, LP
IDPH License ID Number: 0052217
Fiscal Year End: 12/31/2017

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
M & M Financial	Financial Consultant	5,423
Terrill Consulting Services, Inc.	Billing Consultant	14,386
Yocheved Baver	Website Services	9,000
Change Healthcare	Data Processing	878
eSolutions, Inc	Data Processing	4,743
IIT/Sourcetechn	Computer Service	115
National Datacare Corporation	Resident Fund Mgmt	232
Paycor/Propay	Payroll Processing	22,751
Prior Year Accrual Reversals	Data Processing	(8,000)
Prior Year Accrual Reversals	Professional Fees	(5,000)
Total		44,528

Facility Name & ID Number Champaign Urbana Nursing and Rehab, LP# 0052217

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,537 Line 10
- (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. \$ 345,257
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT