

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0052217

Facility Name: Champaign Urbana Nrsg & Rehab

Address: 302 Burwash Avenue Savoy 61874
Number City Zip Code

County: Champaign

Telephone Number: (217)402-9700 Fax # (727)723-3076

HFS ID Number:

Date of Initial License for Current Owners: 11/4/2009

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Melissa Miller Telephone Number: (727)724-2403
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) (Date)

(Type or Print Name) Lynda Hebbeln

(Title) CFO

Paid
Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,958</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,958</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>29,817</u>	<u>19,907</u>	<u>10,486</u>	<u>60,210</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,817</u>	<u>19,907</u>	<u>10,486</u>	<u>60,210</u>	14

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

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

442 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)0

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☒

NO

☐

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

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 11/04/2009

J. Was the facility purchased or leased after January 1, 1978?

YES

☒Date 11/04/2009

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

213

and days of care provided

6,417Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			12,985	12,985		12,985	329,266	342,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			217,059	217,059		217,059	310,361	527,420			32
33	Real Estate Taxes			72,247	72,247		72,247	77,000	149,247			33
34	Rent-Facility & Grounds			870,910	870,910		870,910	(870,910)				34
35	Rent-Equipment & Vehicles			64,960	64,960		64,960		64,960			35
36	Other (specify):*							47,810	47,810			36
37	TOTAL Ownership			1,238,161	1,238,161		1,238,161	(106,473)	1,131,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		413,045	35,548	448,593		448,593	(35,548)	413,045			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			472,834	472,834		472,834		472,834			42
43	Other (specify):*			718,418	718,418		718,418	(648,830)	69,588			43
44	TOTAL Special Cost Centers		413,045	1,226,800	1,639,845		1,639,845	(684,378)	955,467			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,907,000	925,798	7,177,944	13,010,742		13,010,742	(1,090,338)	11,920,404			45

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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab # 0052217 Report Period Beginning: 1/1/2012 Ending: 12/31/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,196)	1		4
5	Telephone, TV & Radio in Resident Rooms	(21,314)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	128	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,128)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(315,732)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (342,242)		\$	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)	(191,566)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (191,566)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (533,808)		37

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

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

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

STATE OF ILLINOIS
Champaign Urbana Nrsg & Rehab

Page 5A

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Nonallowable Marketing Expenses	\$ (87,709)	43	1
2	Lab Fees - Part A	(47,781)	43	2
3	X-Rays - Part A	(55,226)	43	3
4	Collection/Late Fees	(109,189)	43	4
5	State Income Taxes	(1,795)	43	5
6	Nonreimbursable expense	(30,000)	43	6
7	Offset Vending Machine Revenue	(8,026)	21	7
8	Offset Interest Income	(5,390)	32	8
9	Non-Care Related Rent Expense	(20,400)	34	9
10	Non-Allowable Consultant	(225)	19	10
11	Non-Allowable Legal Fees	(85,121)	19	11
12	Offset Loss from Foreign Exchange Rate	135,377	27	12
13	Offset Loss on Sale of Fixed Assets	70,945	27	13
14	Remove Physician services	(35,548)	39	14
15	Remove Reimbursement lost/stolen items	(11,800)	26	15
16	Offset Miscellaneous Income	(264,642)	27	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(556,530)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(3,196)	0	0	0	0	0	0	0	0	0	0	(3,196)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(21,314)	0	0	0	0	0	0	0	0	0	0	(21,314)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(24,510)	0	0	0	0	0	0	0	0	0	0	(24,510)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(586,915)	0	0	0	0	0	0	0	0	0	(586,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(85,346)	12,018	0	0	0	0	0	0	0	0	0	(73,328)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(8,026)	227	0	0	0	0	0	0	0	0	0	(7,799)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(11,800)	2,719	0	0	0	0	0	0	0	0	0	(9,081)	26
27	Other (specify):*	(58,320)	460,466	0	0	0	0	0	0	0	0	0	402,146	27
28	TOTAL General Administration	(163,492)	(111,485)	0	0	0	0	0	0	0	0	0	(274,977)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(188,002)	(111,485)	0	0	0	0	0	0	0	0	0	(299,487)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	128	329,138	0	0	0	0	0	0	0	0	0	329,266	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,390)	315,751	0	0	0	0	0	0	0	0	0	310,361	32
33	Real Estate Taxes	0	77,000	0	0	0	0	0	0	0	0	0	77,000	33
34	Rent-Facility & Grounds	(20,400)	(850,510)	0	0	0	0	0	0	0	0	0	(870,910)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	47,810	0	0	0	0	0	0	0	0	0	47,810	36
37	TOTAL Ownership	(25,662)	(80,811)	0	0	0	0	0	0	0	0	0	(106,473)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(35,548)	0	0	0	0	0	0	0	0	0	0	(35,548)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(649,560)	730	0	0	0	0	0	0	0	0	0	(648,830)	43
44	TOTAL Special Cost Centers	(685,108)	730	0	0	0	0	0	0	0	0	0	(684,378)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(898,772)	(191,566)	0	0	0	0	0	0	0	0	0	(1,090,338)	45

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
Ben Atkins	33.33	N/A		Traditions Sr Mgmt	Clearwater, FL	Mgmt Company
Morrison Family LTD Partnership, LLP	20			Savoy HCP I, LLC	Clearwater, FL	Real Estate
Careen, LLC	13.33					
Adam Garff	33.33					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)	
1	V	17	Management Fees	\$ 586,915	Traditions Management		\$	(586,915)	1
2	V	27	Home Office A&G		Traditions Management		460,466	460,466	2
3	V	36	Home Office Capital		Traditions Management		47,810	47,810	3
4	V								4
5	V	34	Rent Expense	850,510	Savoy HCP I, LLC			(850,510)	5
6	V	19	Accounting Fees		Savoy HCP I, LLC		12,018	12,018	6
7	V	43	Bank Service Charges		Savoy HCP I, LLC		580	580	7
8	V	21	Office Expense		Savoy HCP I, LLC		227	227	8
9	V	43	Loan Costs		Savoy HCP I, LLC		150	150	9
10	V	32	Interest Expense		Savoy HCP I, LLC		315,751	315,751	10
11	V	26	Mortgage Insurance		Savoy HCP I, LLC		2,719	2,719	11
12	V	33	Taxes		Savoy HCP I, LLC		77,000	77,000	12
13	V	30	Depreciation Expense		Savoy HCP I, LLC		329,138	329,138	13
14	Total			\$ 1,437,425			\$ 1,245,859	\$ * (191,566)	14

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	No compensation paid to owners								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab # 0052217 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Home Office A&G	Direct Cost	82,653,681	12	\$ 3,020,262	\$ 1,820,688	12,601,288	\$ 460,466	1
2	36	Home Office Capital	Direct Cost	82,653,681	12	313,593	1,820,688	12,601,288	47,810	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,333,855	\$ 3,641,376		\$ 508,276	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

	Name of Lender Working Capital	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	TM - Fifth Third bank		X	LOC	Interest Only	11/1/2009	150,000	0	LOC	5.700	10,476	
2	Mrs. Christiansen	X		LOC	Interest Only	11/2/2009	1,219,403	0	LOC	9.000	127,690	
3	Owner	X		Working Capital	Interest Only	7/1/2011	648,587	0	6/30/2012	10.000	50,067	
4	Ben Atkins	X		LOC	Interest Only	7/5/2011	300,000	0	LOC	9.000	27,470	
9	TOTAL Facility Related						2,317,990	0			215,703	

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$75,643	2
3. Under or (over) accrual (line 2 minus line 1).			\$75,643	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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.			\$75,643	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2007 8 2008 9 2009 10 2010 11 2011 12	FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2011 \$	13
			14 PLUS APPEAL COST FROM LINE 5 \$	14
			15 LESS REFUND FROM LINE 6 \$	15
			16 AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign Urbana Nrsg & Rehab COUNTY Champaign
FACILITY IDPH LICENSE NUMBER 0052217
CONTACT PERSON REGARDING THIS REPORT Melissa Miller
TELEPHONE (727)724-2403 FAX #: (727)723-3076

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>03-20-25-300-004</u>	<u>302 Burwash Ave</u>	\$ <u>75,643.00</u>	\$ <u>75,643.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>75,643.00</u></u>	\$ <u><u>75,643.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

A. Square Feet:

69,118

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A			\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	213		2009	1983	\$ 3,445,797	\$ 329,138	25	\$ 329,138	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Second Floor Utility Room Repair			2010	3,845		15	128	128		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											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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,449,642	\$ 329,138		\$ 329,266	\$ 128	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$88,795	\$22,532	\$22,532	\$	3-5	\$	71
72	Current Year Purchases	27,799	6,236	6,236		3-5		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$116,594	\$28,768	\$28,768	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Champion Bus 2010	2010	\$47,350	\$(15,783)	\$(15,783)	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$47,350	\$(15,783)	\$(15,783)	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,613,58681
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$342,12382
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$342,25183**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$12884
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Savoy HCP
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	231	11/4/09	\$870,910	10		3
4	Additions							4
5								5
6								6
7	TOTAL		231		\$870,910			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?☐ YES☐ NO
16. Rental Amount for movable equipment: \$64,960
- Description:See Sch 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,052	\$ 336,410	\$	5,052	\$ 336,410	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,672	124,298		4,672	124,298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)(3)	hrs		1,726	363,763	2,928	1,726	366,691	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				413,045		413,045	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,450	\$ 824,471	\$ 415,973	11,450	\$ 1,240,444	14

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

Facility Name & ID Number Champaign Urbana Nrsg & Rehab

#

0052217

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

12/31/2012

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,527,506	\$ 1,527,506	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 313,571)	2,674,404	2,674,404	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,236	24,236	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17	306,634	306,634	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,532,780	\$ 4,532,780	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,532,780	\$ 4,532,780	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,179,740	\$ 2,179,740	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	747,525	747,525	29
30	Accrued Salaries Payable	162,139	162,139	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,992	69,992	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17	8,091	8,091	36
37	See Sch 17	1,075,133	1,075,133	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,242,620	\$ 4,242,620	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	892,115	892,115	39
40	Mortgage Payable			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)	\$ 892,115	\$ 892,115	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,134,735	\$ 5,134,735	46
47	TOTAL EQUITY(page 18, line 24)	\$ (601,955)	\$ (601,955)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,532,780	\$ 4,532,780	48

***(See instructions.)**

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

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

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,123,532)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	837,918	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Retained Earnings	(316,341)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (601,955)	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)	\$ (601,955)	24 *

* This must agree with page 17, line 47.

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

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	\$ 12,486,598	1
2	Discounts and Allowances for all Levels	(5,179,988)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,306,610	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,143,460	6
7	Oxygen	1,930	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,145,390	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		12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals	3,196	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	426,924	16
17	Sale of Drugs	1,056,408	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	192,260	19
20	Radiology and X-Ray	129,049	20
21	Other Medical Services	515,397	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,324,434	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,390	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,390	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19</u>	105,386	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 105,386	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,887,210	30

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

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **LLC Members are cash basis tax payers.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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

Line 28

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,973	2,016	\$ 85,572	\$ 42.45	1
2	Assistant Director of Nursing	7,309	7,942	225,150	28.35	2
3	Registered Nurses	17,160	17,668	497,019	28.13	3
4	Licensed Practical Nurses	45,942	47,466	1,116,245	23.52	4
5	CNAs & Orderlies	147,924	151,298	1,992,404	13.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,260	3,585	74,332	20.73	9
10	Activity Assistants	8,392	8,795	93,615	10.64	10
11	Social Service Workers	4,360	4,683	96,067	20.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,698	8,252	112,022	13.58	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,012	2,188	123,278	56.34	20
21	Assistant Administrator					21
22	Other Administrative	1,932	2,051	35,188	17.16	22
23	Office Manager	4,782	5,274	96,098	18.22	23
24	Clerical	4,150	4,690	34,268	7.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,923	2,128	39,960	18.78	31
32	Other Health C: See Sch 20	10,253	11,142	254,931	22.88	32
33	Other(specify) <u>Transportation</u>	2,371	2,555	30,851	12.07	33
34	TOTAL (lines 1 - 33)	271,441	281,733	\$ 4,907,000 *	\$ 17.42	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 999,861	1(3)	35
36	Medical Director	Monthly	44,743	9(3)	36
37	Medical Records Consultant	Monthly	2,540	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,506	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,357	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Managed Care Consultant</u>	per patient day	1,616	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,065,623		49

C. CONTRACT NURSES

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

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

** See instructions.

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	
Lorraine Bellinger	Administrator		\$ 26,114	Workers' Compensation Insurance		\$ 213,740	IDPH License Fee	\$ 11,163	
Lisa Niehaus	Administrator		23,311	Unemployment Compensation Insurance		198,546	Advertising: Employee Recruitment		
Jamie Patton	Administrator		14,383	FICA Taxes		371,434	Health Care Worker Background Check		
Kay Ross	Administrator		51,291	Employee Health Insurance		93,826	(Indicate # of checks performed <u>481</u>)	6,196	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	19,577	
				Employee Benefits/Expenses		30,462	Miscellaneous Dues & Subscriptions	4,316	
				Employee Life Insurance		4,417	Pre-Employment Physicals	1,329	
				Employee Dental Insurance		1,798			
				Employee Vision Insurance		1,693			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,099				Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	()	
							Yellow page advertising	()	
Description			Amount						
Management Fees "Eliminated in Col 7"			\$ 586,915						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 586,915	TOTAL (agree to Schedule V, line 22, col.8)			\$ 915,916	TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Sch 21A			\$ 116,128			\$	Out-of-State Travel	\$	
							In-State Travel	4,244	
							Seminar Expense	4,289	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 116,128	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 8,533	

*** Attach copy of IMRF notifications**

****See instructions.**

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

C.

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

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? 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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 70,330 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 472,834
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,196
- (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
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? Yes
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) 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.