

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Nsg & Rehab Address: 302 Burwash Avenue Savoy 61874 County: Champaign Telephone Number: (217) 402-9700 Fax #: (217) 402-9750 HFS ID Number: Date of Initial License for Current Owners: 41275 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Larry Templin Telephone Number: (630) 361-2868 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 1/1/16 to 12/31/16 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) (Type or Print Name) (Title) Paid Preparer (Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Print Name and Title) Larry Templin Partner (Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525 (Telephone) (630) 361-2868 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
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nsg & Rehab

0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	<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>8,993</u>	<u>8,993</u>	8
9	SNF/PED					9
10	ICF	<u>28,109</u>	<u>5,465</u>	<u>1,117</u>	<u>34,691</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,109</u>	<u>5,465</u>	<u>10,110</u>	<u>43,684</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.04%

D. How many bed-hold days during this year were paid by the Department? None (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) 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 6,420

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nsg & Rehab # 0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16
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	307,181	19,980	30,744	357,905		357,905		357,905			1
2	Food Purchase		297,793		297,793		297,793	(2,618)	295,175			2
3	Housekeeping		24,999	283,580	308,579		308,579		308,579			3
4	Laundry		6,255	110,988	117,243		117,243		117,243			4
5	Heat and Other Utilities			202,605	202,605		202,605	467	203,072			5
6	Maintenance	81,198		90,351	171,549		171,549	14,676	186,225			6
7	Other (specify):* Waste Removal			21,193	21,193		21,193		21,193			7
8	TOTAL General Services	388,379	349,027	739,461	1,476,867		1,476,867	12,525	1,489,392			8
	B. Health Care and Programs											
9	Medical Director			66,307	66,307		66,307		66,307			9
10	Nursing and Medical Records	2,784,799	305,127	62,879	3,152,805		3,152,805	63,892	3,216,697			10
10a	Therapy	131,978	6,613	40,854	179,445		179,445		179,445			10a
11	Activities	77,238		8,417	85,655		85,655		85,655			11
12	Social Services	128,570		5,833	134,403		134,403		134,403			12
13	CNA Training											13
14	Program Transportation			29,789	29,789		29,789		29,789			14
15	Other (specify):*							12,126	12,126			15
16	TOTAL Health Care and Programs	3,122,585	311,740	214,079	3,648,404		3,648,404	76,018	3,724,422			16
	C. General Administration											
17	Administrative	127,818			127,818		127,818	85,977	213,795			17
18	Directors Fees											18
19	Professional Services			352,124	352,124		352,124	1,733	353,857			19
20	Dues, Fees, Subscriptions & Promotions			46,631	46,631		46,631	(4,512)	42,119			20
21	Clerical & General Office Expenses	266,790	33,352	60,490	360,632		360,632	104,955	465,587			21
22	Employee Benefits & Payroll Taxes			667,684	667,684		667,684		667,684			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,022	12,022		12,022	547	12,569			24
25	Other Admin. Staff Transportation			39,652	39,652		39,652	796	40,448			25
26	Insurance-Prop.Liab.Malpractice			188,592	188,592		188,592		188,592			26
27	Other (specify):*							30,176	30,176			27
28	TOTAL General Administration	394,608	33,352	1,367,195	1,795,155		1,795,155	219,672	2,014,827			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,905,572	694,119	2,320,735	6,920,426		6,920,426	308,215	7,228,641			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.

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							465,569	465,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,388	56,388		56,388	767,171	823,559			32
33	Real Estate Taxes			83,753	83,753		83,753		83,753			33
34	Rent-Facility & Grounds			1,129,558	1,129,558		1,129,558	(1,113,198)	16,360			34
35	Rent-Equipment & Vehicles			23,086	23,086		23,086		23,086			35
36	Other (specify):*											36
37	TOTAL Ownership			1,292,785	1,292,785		1,292,785	119,542	1,412,327			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		544,765	1,150,466	1,695,231		1,695,231		1,695,231			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,444	342,444		342,444		342,444			42
43	Other (specify):* Nonallowable exp	71,594	12,277	151,663	235,534		235,534	(235,534)				43
44	TOTAL Special Cost Centers	71,594	557,042	1,644,573	2,273,209		2,273,209	(235,534)	2,037,675			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,977,166	1,251,161	5,258,093	10,486,420		10,486,420	192,223	10,678,643			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(33,905)	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	465,569	30		9
10	Interest and Other Investment Income	(565)	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	(118)	20		17
18	Fines and Penalties	(21,142)	43		18
19	Entertainment				19
20	Contributions	(7,400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,387)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,193)	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	(107,857)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 226,002		\$	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 Amount	2 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)	(33,779)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (33,779)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 192,223		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Comissions	\$ (2,618)	2	1
2	Rental Income	(900)	6	2
3	Miscellaneous Income	(2,325)	21	3
4	Marketing Salary	(71,594)	43	4
5	Marketing Expense	(40,300)	43	5
6	Additional R&M	15,408	6	6
7	PAC Dues	(5,528)	20	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				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	(107,857)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Champaign Urbana Nsg & Rehab # 0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,618)	0	0	0	0	0	0	0	0	0	0	(2,618)	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	0	0	467	0	0	0	0	0	0	0	0	467	5
6	Maintenance	14,508	0	168	0	0	0	0	0	0	0	0	14,676	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	11,890	0	635	0	0	0	0	0	0	0	0	12,525	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	74,151	(10,259)	0	0	0	0	0	0	0	63,892	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	12,126	0	0	0	0	0	0	0	0	12,126	15
16	TOTAL Health Care and Programs	0	0	86,277	(10,259)	0	0	0	0	0	0	0	76,018	16
	C. General Administration													
17	Administrative	0	0	85,977	0	0	0	0	0	0	0	0	85,977	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,387)	0	9,120	0	0	0	0	0	0	0	0	1,733	19
20	Fees, Subscriptions & Promotions	(5,646)	0	1,134	0	0	0	0	0	0	0	0	(4,512)	20
21	Clerical & General Office Expenses	(2,325)	0	107,280	0	0	0	0	0	0	0	0	104,955	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	547	0	0	0	0	0	0	0	0	547	24
25	Other Admin. Staff Transportation	0	0	796	0	0	0	0	0	0	0	0	796	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	30,176	0	0	0	0	0	0	0	0	30,176	27
28	TOTAL General Administration	(15,358)	0	235,030	0	0	0	0	0	0	0	0	219,672	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(3,468)	0	321,942	(10,259)	0	0	0	0	0	0	0	308,215	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign Urbana Nsg & Rehab # 0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	465,569	0	0	0	0	0	0	0	0	0	0	465,569	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(565)	767,736	0	0	0	0	0	0	0	0	0	767,171	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,129,558)	16,360	0	0	0	0	0	0	0	0	(1,113,198)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	465,004	(361,822)	16,360	0	0	0	0	0	0	0	0	119,542	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(235,534)	0	0	0	0	0	0	0	0	0	0	(235,534)	43
44	TOTAL Special Cost Centers	(235,534)	0	0	0	0	0	0	0	0	0	0	(235,534)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	226,002	(361,822)	338,302	(10,259)	0	0	0	0	0	0	0	192,223	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
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:	
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	32	Interest		Champaign Urbana Realty	100.00%	\$ 767,736	\$ 767,736	1
2	V	34	Rent-Facility & Grounds	1,129,558	Champaign Urbana Realty	100.00%		(1,129,558)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,129,558			\$ 767,736	\$ * (361,822)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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%	\$ 467	\$ 467	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	168	168	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	74,151	74,151	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	12,126	12,126	18
19	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	85,977	85,977	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	9,120	9,120	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	1,134	1,134	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	107,280	107,280	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	547	547	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	796	796	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	30,176	30,176	25
26	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	16,360	16,360	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 338,302	\$ * 338,302	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 16,173	Premier Healthcare Supplies, LLC	100.00%	\$ 5,914	\$ (10,259)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 16,173			\$ 5,914	\$ * (10,259)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Whampoa 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 Connersville, LLC	Connersville, IN				10
11	Leonard & Felice Frand	0.50%						11
12	Waxcap, Inc.	12.20%						12
13	Barak Bayer	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nsg & Rehab # 0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	5.01	13%	Alloc Salary	\$ 19,529	17-7	1
2	Barak Bayer	Shareholder	Administrative	34.70%	See Att Sch 7A	5.01	13%	Alloc Salary	19,529	17-7	2
3	Sara Bayer	Relative	Clerical	0	See Att Sch 7A	5.01	13%	Alloc Salary	5,533	21-7	3
4	Yocheved Bayer	Relative	Consulting	0.00	9,000			Consulting	9,750	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	\$ 54,341		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 Nsg & Rehab # 0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Heat and Other Utilities	Census Days	348,950	11	\$ 3,732	\$	43,684	\$ 467	1
2	6	Maintenance	Census Days	348,950	11	1,338		43,684	168	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	592,321	43,684	74,151	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859		43,684	12,126	4
5	17	Administrative	Census Days	348,950	11	686,791	686,791	43,684	85,977	5
6	19	Professional Services	Census Days	348,950	11	72,849		43,684	9,120	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057		43,684	1,134	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	787,295	43,684	107,280	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369		43,684	547	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355		43,684	796	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050		43,684	30,176	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681		43,684	16,360	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,702,363	\$ 2,066,407		\$ 338,302	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nsg & Rehab # 0052217 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 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

	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	111,222	11	\$ 40,679	\$	16,173	\$ 5,914	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					\$ 40,679	\$		\$ 5,914	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	First Midwest Bank		X	Mortgage		7/25/2014	\$ 16,100,000	\$ 16,100,000	8/5/2017		\$ 767,736	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	First Midwest Bank		X	Line of Credit		12/31/14		1,521,100	3/31/17		56,388	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 16,100,000	\$ 17,621,100			\$ 824,124	9	
	B. Non-Facility Related*												
10	Allocated from Management Co.											10	
11												11	
12								Offset Interest Income			(565)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (565)	14	
15	TOTALS (line 9+line14)						\$ 16,100,000	\$ 17,621,100			\$ 823,559	15	

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

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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	121,897	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.)		See Below	\$	141,990	2
3. Under or (over) accrual (line 2 minus line 1).			\$	20,093	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	63,660	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.			\$	83,753	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012	79,589	9	
		2013	82,903	10	
		2014	84,303	11	
		2015	84,687	12	
Accrual based on prior year tax bill.					
		Taxes pd	2014	57303	
Adjusted Beg accrual to actual			2015	84687	
		Total		141990	
			13	FROM R. E. TAX STATEMENT FOR 2015	13
			14	PLUS APPEAL COST FROM LINE 5	14
			15	LESS REFUND FROM LINE 6	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign Urbana Nsg & Rehab COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0052217

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 03-20-25-300-004	Long Term Care Property	\$ 84,686.68	\$ 84,686.68
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 84,686.68	\$ 84,686.68

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 69,118

B. General Construction Type: Exterior BrickFrame WoodNumber 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

If so, please complete the following:

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.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2015	\$ 945,720	1
2					2
3	TOTALS			\$ 945,720	3

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	\$ 522,398	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	2,144	9
10	New Floor, Wall Tiles, Paint In 2 Shower Rooms			2014	12,750		20	638	638	1,807	10
11	Paint 15 Units, Including Bathrooms			2014	4,500		20	225	225	638	11
12	Gym Flooring & Cove Base			2014	23,343		20	1,167	1,167	3,307	12
13	Dialysis Room Carpet			2014	9,271		20	464	464	1,237	13
14	Plumbing			2014	3,282		20	164	164	424	14
15	Install Generator Controller			2014	23,115		20	1,156	1,156	2,890	15
16	Water Supply Line & Piping			2014	3,690		20	185	185	539	16
17	Replace Compressor			2014	4,630		20	232	232	541	17
18	Install Dome Lights & Pull Cords In Rehab Area Bathrooms			2014	3,815		20	191	191	429	18
19	Change Two 85 Gallon/500,000 Btu Water Heaters			2015	30,687		20	1,534	1,534	3,068	19
20	Install 2' Gas Main To 4 Water Heaters/Fix Gas Leak In Basement			2015	5,300		20	150	150	300	20
21	Addition Of 4 Circuits For New Dialysis Machines/Gfci Breaker			2015	5,015		20	251	251	502	21
22	Remove/Install High & Low Slow Mixing Valve			2015	3,248		20	162	162	324	22
23	Install Epdm Rubber Roof At East/Center Of Building			2015	5,635		20	282	282	564	23
24	Security System			2015	10,195		20	510	510	1,020	24
25	Dialysis Room - Electrical, Wall boxes, paint, cabinets and faucets			2016	2,680		20	67	67	67	25
26	Flooring in Rehab Nurses station, Rms 105-113, Lobby, Hallway,			2016	51,174		20	1,279	1,279	1,279	26
27	South Corridor and Dialysis Den Room										27
28	Install Two 85 Gallon BTU Water Heating Units			2016	29,497		20	737	737	737	28
29	Boiler Repair			2016	3,239		20	81	81	81	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nsg & Rehab

0052217

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	Allocated from Premier Healthcare Management, LLC	2013	3,116		20	156	156	498	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)		\$ 9,394,839	\$		\$ 271,565	\$ 271,565	\$ 544,794	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	\$1,920,644	\$	\$192,064	\$192,064	10	\$475,875	71
72	Current Year Purchases	38,800		1,940	1,940	10	1,940	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,959,444	\$	\$194,004	\$194,004		\$477,815	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	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)	\$12,300,003	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)	\$465,569	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$465,569	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,022,609	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Management Co.				16,360			5
6								6
7	TOTAL				\$ 16,360			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?
16. Rental Amount for movable equipment: \$ 22,297 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	Facility	2014 Ford Elkhart	788.81	789	18
19					19
20					20
21	TOTAL		\$ 788.81	\$ 789	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 Nsg & Rehab

IDPH License ID Number:0052217

Fiscal Year End:12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	11,746
Dietary Equipment	6,483
Office Equipment	4,068
Total - Line 16	22,297

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

ALLOCATION OF COSTS (d)

		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)	\$			

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.)

12345678												
	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	\$		\$	405,087	\$		\$	405,087	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs				114,940				114,940	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39(2), 39(3)	hrs				593,861				593,861	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				538,110				538,110	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)											
10			hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Attached Scheule 16A						36,578	6,655			43,233	13
14	TOTAL			\$		\$	1,150,466	\$	544,765	\$	1,695,231	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 Nsg & Rehab

IDPH License ID Number:

0052217

Fiscal Year End:

12/31/16

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V	
	Line & Column	
	Reference	Amount
Lab & Xray	39(3)	9,307
Dialysis	39(3)	8,672
Outside MD Service-MCA	39(3)	18,399
Dental	39(3)	200
Medical Supplies - MCA	39(2)	6,655
Total - Line 13		43,233

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	\$ 18,478	\$ 18,939	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,846,573)	3,601,627	3,601,627	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,995	6,995	6
7	Other Prepaid Expenses	17,429	17,429	7
8	Accounts Receivable (owners or related parties)	1,338,135	970,219	8
9	Other(specify): See Attached Schedule 17A	29,878	29,878	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,012,542	\$ 4,645,087	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	288,915	252,879	15
16	Equipment, at Historical Cost	595,637	1,959,444	16
17	Accumulated Depreciation (book methods)	(200,091)	(1,022,609)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	72,867	72,867	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(57,867)	(57,867)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	22,915	5,559,362	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 722,376	\$ 16,851,756	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,734,918	\$ 21,496,843	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,466,841	\$ 2,466,841	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,521,100	1,521,100	29
30	Accrued Salaries Payable	137,015	137,015	30
31	Accrued Taxes Payable (excluding real estate taxes)	727,230	727,230	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,660	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	622,109	622,109	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,474,295	\$ 5,537,955	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)	\$ 5,474,295	\$ 21,637,955	46
47	TOTAL EQUITY (page 18, line 24)	\$ 260,623	\$ (141,112)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,734,918	\$ 21,496,843	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,945,658	1
2	Restatements (describe): Bad Debt Expense		2
3	Post closing adjustments - bad debts	(1,356,855)	3
4	Post closing adjustments - other	(581,142)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,661	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	284,812	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)	\$ 252,962	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)	\$ 260,623	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nsg & Rehab

0052217

Report Period Beginning: 1/1/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,359,859	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,359,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	324,630	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 324,630	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	2,618	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	900	16
17	Sale of Drugs	13,805	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	50,490	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 67,813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	565	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 565	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	2,325	28
28a	<u>Credit from PY Accounts Payable</u>	16,040	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,365	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,771,232	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,476,867	31
32	Health Care	3,648,404	32
33	General Administration	1,795,155	33
	B. Capital Expense		
34	Ownership	1,292,785	34
	C. Ancillary Expense		
35	Special Cost Centers	1,930,765	35
36	Provider Participation Fee	342,444	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,486,420	40
41	Income before Income Taxes (line 30 minus line 40)**	284,812	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 284,812	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,165,034	44
45	Private Pay - Net Inpatient Revenue	1,112,909	45
46	Medicare - Net Inpatient Revenue	3,437,874	46
47	Other-(specify) <u>Insurance</u>	1,375,111	47
48	Other-(specify) <u>Veterans</u>	268,931	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,359,859	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,153	2,217	\$ 101,718	\$ 45.88	1
2	Assistant Director of Nursing	1,799	1,903	69,680	36.62	2
3	Registered Nurses	21,535	22,136	667,072	30.14	3
4	Licensed Practical Nurses	27,852	29,075	789,093	27.14	4
5	CNAs & Orderlies	72,522	74,507	1,004,334	13.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,690	5,802	131,978	22.75	8
9	Activity Director	1,848	1,888	38,477	20.38	9
10	Activity Assistants	3,739	3,819	38,761	10.15	10
11	Social Service Workers	2,902	3,022	67,634	22.38	11
12	Dietician					12
13	Food Service Supervisor	1,443	1,475	22,751	15.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,057	24,745	284,430	11.49	15
16	Dishwashers					16
17	Maintenance Workers	4,269	4,405	81,198	18.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,116	2,172	127,818	58.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,474	13,974	266,790	19.09	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	1,639	1,671	24,190	14.48	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	10,353	10,761	261,242	24.28	33
34	TOTAL (lines 1 - 33)	197,391	203,572	\$ 3,977,166 *	\$ 19.54	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	\$ 30,629	L1, C3	35
36	Medical Director	Monthly	66,307	L9, C3	36
37	Medical Records Consultant	Monthly	1,890	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	18,823	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	15	1,055	L11, C3	44
45	Social Service Consultant	83	5,833	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	26,000	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	98	\$ 150,537		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 736	L10, C3	50
51	Licensed Practical Nurses	963	41,430	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	979	\$ 42,166		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

Champaign Urbana Nsg & Rehab

Period Beginning 1/1/16
Period End 12/31/16

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	3,891	3,979	128,712	32.35
Transportation	4,249	4,465	60,936	13.65
Marketing	2,213	2,317	71,594	30.90
TOTAL	10,353	10,761	261,242	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Steven Territo	Administrator	0	\$ 116,600	Workers' Compensation Insurance	\$ 91,069	IDPH License Fee	\$ 3,980		
Valerie Tischler	Asst. Admin	0	11,218	Unemployment Compensation Insurance	134,955	Advertising: Employee Recruitment	16,307		
				FICA Taxes	300,153	Health Care Worker Background Check			
				Employee Health Insurance	129,378	(Indicate # of checks performed 350)	2,966		
				Employee Meals	92	Patient Background Checks	611		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	100		
				Other Employee Benefits	10,521	Licenses & Permits	218		
				Physical Exams	1,516	IL Council on LTC	11,224		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)				\$ 127,818		Allocated from Management Co.	1,134		
B. Administrative - Other						Less: Public Relations Expense	()		
Description			Amount			Non-allowable advertising	()		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$			Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)									
(Attach a copy of any management service agreement)									
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 Attached	Legal		\$ 21,462				Out-of-State Travel	\$	
Richard Peelo & Associates, Inc	Accounting		4,200	N/A					
FR&R/Marcum LLP	Accounting		9,071						
Plante & Moran, PLLC	Accounting		60,000				In-State Travel		
LTC Consulting Services	Consulting Fees		124,752						
Personnel Planners	Unemployment Consultants		1,875						
Ability Network Inc.	Data Processing		8,276						
ADP	Payroll Service		15,361				Seminar Expense	12,022	
HDSI	Data Processing		6,491				Allocated from Management Co.	547	
MatrixCare	Data Processing		47,246						
Singer Networks, LLC	Data Processing		16,284						
See Attached Schedule 21A			37,106				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)							(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)				\$ 352,124			TOTAL	\$ 12,569	

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name:

Champaign Urbana Nsg & Rehab

IDPH License ID Number:

0052217

Fiscal Year End:

12/31/16

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
M & M Financial	Financial Consultant	5,000
Terrill Consulting Services, Inc.	Billing Consultant	19,181
Yocheved Baver	Website Services	9,750
Change Healthcare	Data Processing	631
eSolutions, Inc	Data Processing	2,879
IIT/Sourcetech	Computer Service	(335)
Total		37,106

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