

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

<p>I. IDPH License ID Number: <u>0037028</u></p> <p>Facility Name: <u>Villa Healthcare East</u></p> <p>Address: <u>100 Marian Parkway, PO BOX 109</u> <u>Sherman</u> <u>62684</u> <small>Number City Zip Code</small></p> <p>County: <u>Sangamon</u></p> <p>Telephone Number: <u>2177442299</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Freeman</u> Telephone Number: <u>225 301 2510</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) _____ (Title) _____ </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Michael Freeman</u> <u>Managing Director</u> (Firm Name & Address) <u>TFG Consulting, LLC</u> <u>3620 Church Street, Zachary, LA 70791</u> (Telephone) <u>225 301 2510</u> Fax # () </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Michael Freeman</u> <u>Managing Director</u> (Firm Name & Address) <u>TFG Consulting, LLC</u> <u>3620 Church Street, Zachary, LA 70791</u> (Telephone) <u>225 301 2510</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Michael Freeman</u> <u>Managing Director</u> (Firm Name & Address) <u>TFG Consulting, LLC</u> <u>3620 Church Street, Zachary, LA 70791</u> (Telephone) <u>225 301 2510</u> Fax # ()							

Facility Name & ID Number Villa Healthcare East

0037028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	15,139	10,375	7,118	32,632	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,139	10,375	7,118	32,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.31%

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

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

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 10/21/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/21/1991 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 6,882

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	228,574	18,787	10,399	257,760		257,760	(3,537)	254,223		1
2	Food Purchase		215,959		215,959		215,959		215,959		2
3	Housekeeping	48,449	21,806	76,551	146,806		146,806		146,806		3
4	Laundry	23,445	21,262	50,848	95,555		95,555		95,555		4
5	Heat and Other Utilities			194,899	194,899		194,899		194,899		5
6	Maintenance	157,182	23,153	130,702	311,037		311,037		311,037		6
7	Other (specify):*										7
8	TOTAL General Services	457,650	300,967	463,399	1,222,016		1,222,016	(3,537)	1,218,479		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,084,394	89,363	67,899	2,241,656		2,241,656		2,241,656		10
10a	Therapy		637	1,105,015	1,105,652		1,105,652		1,105,652		10a
11	Activities	66,571	2,828	7,835	77,234		77,234		77,234		11
12	Social Services	125,595	196	22,256	148,047		148,047		148,047		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,276,560	93,024	1,203,005	3,572,589		3,572,589		3,572,589		16
	C. General Administration										
17	Administrative	95,925		151,249	247,174		247,174		247,174		17
18	Directors Fees							(25,304)	(25,304)		18
19	Professional Services			449,435	449,435		449,435		449,435		19
20	Dues, Fees, Subscriptions & Promotions			20,139	20,139		20,139		20,139		20
21	Clerical & General Office Expenses	103,144	42,928	133	146,205		146,205	(5,371)	140,834		21
22	Employee Benefits & Payroll Taxes			485,568	485,568		485,568		485,568		22
23	Inservice Training & Education			290	290		290		290		23
24	Travel and Seminar			6,849	6,849		6,849	(93,028)	(86,179)		24
25	Other Admin. Staff Transportation			8,112	8,112		8,112		8,112		25
26	Insurance-Prop.Liab.Malpractice			223,235	223,235		223,235		223,235		26
27	Other (specify):*										27
28	TOTAL General Administration	199,069	42,928	1,345,010	1,587,007		1,587,007	(123,703)	1,463,304		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,933,279	436,919	3,011,414	6,381,612		6,381,612	(127,240)	6,254,372		29

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

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

Facility Name & ID Number

Villa Healthcare East

#0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			223,769	223,769		223,769	(5,068)	218,701			30
31	Amortization of Pre-Op. & Org.			3,772	3,772		3,772		3,772			31
32	Interest			302,754	302,754		302,754	(11,416)	291,338			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,958	3,958		3,958		3,958			35
36	Other (specify):*											36
37	TOTAL Ownership			534,253	534,253		534,253	(16,484)	517,769			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			53,065	53,065		53,065		53,065			38
39	Ancillary Service Centers		358,939	7,242	366,181		366,181		366,181			39
40	Barber and Beauty Shops			585	585		585		585			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,318	54,318		54,318		54,318			42
43	Other (specify):*		3,796	128,607	132,403		132,403	(13,877)	118,526			43
44	TOTAL Special Cost Centers		362,735	243,817	606,552		606,552	(13,877)	592,675			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,933,279	799,654	3,789,484	7,522,417		7,522,417	(157,601)	7,364,816			45

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

Villa Healthcare East

ID# 0037028

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Home Office Allocation	\$	1
2	Misc Expense		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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Healthcare East# 0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	(3,537)	0	0	0	0	0	0	0	0	0	0	(3,537)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,537)	0	0	0	0	0	0	0	0	0	0	(3,537)	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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	(25,304)	0	0	0	0	0	0	0	0	0	0	(25,304)	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(5,371)	0	0	0	0	0	0	0	0	0	0	(5,371)	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	(93,028)	0	0	0	0	0	0	0	0	0	0	(93,028)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(123,703)	0	0	0	0	0	0	0	0	0	0	(123,703)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(127,240)	0	0	0	0	0	0	0	0	0	0	(127,240)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Healthcare East# 0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,068)	0	0	0	0	0	0	0	0	0	0	(5,068)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,416)	0	0	0	0	0	0	0	0	0	0	(11,416)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	(16,484)	0	0	0	0	0	0	0	0	0	0	(16,484)	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):*	(13,877)	0	0	0	0	0	0	0	0	0	0	(13,877)	43
44	TOTAL Special Cost Centers	(13,877)	0	0	0	0	0	0	0	0	0	0	(13,877)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(157,601)	0	0	0	0	0	0	0	0	0	0	(157,601)	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

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

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

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

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

Facility Name & ID Number

Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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									\$		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 Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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				\$	\$		\$	25

Facility Name & ID Number

Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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										
										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	GE Capital	X	Mortgage	Various	2010	\$ 6,467,415	\$ 6,199,658	2040	0.0658	\$ 302,754	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 6,467,415	\$ 6,199,658			\$ 302,754	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 6,467,415	\$ 6,199,658			\$ 302,754	15								

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

* 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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2010 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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2011 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.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	_____	8
	2007	_____	9
	2008	_____	10
	2009	_____	11
	2010	_____	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Healthcare East COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0037028

CONTACT PERSON REGARDING THIS REPORT Michael Freeman

TELEPHONE 2253012510 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

Facility Name & ID Number Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,368 B. General Construction Type: Exterior Brick Frame Block Number of Stories _____

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).

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: 275,845 2. Number of Years Over Which it is Being Amortized: Various

3. Current Period Amortization: 5,380 4. Dates Incurred: Various

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>383,686</u>	<u>1991</u>	<u>\$ 465,019</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	383,686		\$ 465,019	3

Facility Name & ID Number Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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		1991	1991	\$ 2,146,102	\$ 71,537	30	\$ 71,537	\$	\$ 1,448,619	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1991 Additions		1991	691,048	23,035	Various	23,035		466,458	9
10	1992 Additions		1992	30,954	1,032	Various	1,032		20,362	10
11	1993 Additions		1993	14,489	483	Various	483		9,031	11
12	1994 Additions		1994	10,567	352	Various	352		6,096	12
13	1995 Additions		1995	56,538	758	Various	758		42,986	13
14	1996 Additions		1996	17,082	453	Various	453		15,059	14
15	1997 Additions		1997	35,201	100	Various	100		34,911	15
16	1998 Additions		1998	68,233	2,192	Various	2,192		58,773	16
17	1999 Additions		1999	77,766	3,819	Various	3,819		63,210	17
18	2000 Additions		2000	89,975	4,650	Various	4,650		55,220	18
19	2001 Additions		2001	54,322	3,086	Various	3,086		43,832	19
20	2004 Additions		2004	16,868		Various			16,868	20
21	2005 Additions		2005	74,461	5,227	Various	5,227		32,570	21
22	2006 Additions		2006	31,729	2,076	Various	2,076		23,130	22
23	2002 Additions		2002	110,177	5,175	Various	5,175		68,774	23
24	2003 Additions		2003	8,545	854	10	854		6,978	24
25	2007 Additions		2007	18,646	1,865	10	1,865		8,054	25
26	CARPET		2008	65,083	13,017	05	13,017		49,813	26
27	Roof repair		2008	912	91	10	91		319	27
28	Refinish drywall		2008	912	182	05	182		639	28
29	PAINT, TRIM, BLINDS, VALANCES TO REMODEL COURTYARD W		2008	2,617	262	10	262		894	29
30	PARKING LOT REPAIR & STRIPING		2009	1,400	292	02	292		1,400	30
31	EXTERIOR DOORS		2009	7,772	389	20	389		907	31
32	DOWN SPOUTS DRAINS		2009	29,000	2,900	10	2,900		6,767	32
33	ROOF		2009	98,896	4,945	20	4,945		11,126	33
34	FLOORING, LIGHTING, CARPENTRY LABOR TO REMODEL INTE		2009	10,541	1,054	10	1,054		2,284	34
35	LIGHTING		2009	23,644	2,364	10	2,364		4,926	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

Facility Name & ID Number Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wallcovering, flooring, carpentry, furnishing, beds, labor to remod	2009	\$ 57,062	\$ 2,853	20	\$ 2,853	\$	\$ 5,706	37
38	FIXTURES, FLOORING, LIGHTING, WALLCOVERING, LAB	2009	23,149	1,157	20	1,157		2,315	38
39	LABOR, CABINETS, COUNTERS, DRYWALL, PLUMBING, FI	2010	18,896	1,260	15	1,260		2,414	39
40	THERAPY ROOM EXPANSION	2010	3,778	189	20	189		283	40
41	Remodel Therapy Room	2010	2,065	138	15	138		207	41
42	COURTYARD DRAINAGE	2010	2,636	132	20	132		176	42
43	LIVING ROOM, BIRD ROOM, PHASE 1 REMODEL	2010	45,118	2,256	20	2,256		2,632	43
44	Dumpster enclosure	2010	5,043	202	25	202		219	44
45	Main Family Room Renovation	2011	65,483	4,366	15	4,366		4,366	45
46	Rehab Resident Rooms	2011	13,948	930	15	930		930	46
47	Garage	2011	51,806	1,209	25	1,209		1,209	47
48	Wall guard, chair rail throughout building	2011	7,835	196	20	196		196	48
49	Kitchen Water Heater	2011	6,704	335	10	335		335	49
50	Paving	2011	105,774	6,611	08	6,611		6,611	50
51	Exterior Doors	2011	1,651	69	10	69		69	51
52	Concrete Sidewalks	2011	6,345	141	15	141		141	52
53	Headwall, door protection, hand rail throughout	2011	20,663	459	15	459		459	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)		\$ 4,231,436	\$ 174,693		\$ 174,693	\$	\$ 2,528,274	70

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

Facility Name & ID Number Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	\$ 980,712	\$ 40,519	\$ 40,519	\$	10, 20, 05	\$ 811,989	71
72	Current Year Purchases	70,304	3,489	3,489		10, 20, 05	3,488	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,051,016	\$ 44,008	\$ 44,008	\$		\$ 815,477	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,747,471	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,701	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,701	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,343,751	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: NA

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								5
6								6
7	TOTAL				\$			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: \$ _____ Description: _____
(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.	<u>/2012</u>	\$ _____
13.	<u>/2013</u>	\$ _____
14.	<u>/2014</u>	\$ _____

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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 column 3	hrs	\$	15,082	\$ 433,768	\$	15,082	\$ 433,768	1
2	Licensed Speech and Language Development Therapist	10a column 3	hrs		26,776	244,332		26,776	244,332	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a column 3	hrs		26,353	426,915	637	26,353	427,552	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$	68,211	\$ 1,105,015	\$ 637	68,211	\$ 1,105,652	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 **Villa Healthcare East**# **0037028**Report Period Beginning: **1/1/2011**Ending: **12/31/2011****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2011**

(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	\$ 1,064,194	\$	1
2	Cash-Patient Deposits	16,096		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,126,743		3
4	Supply Inventory (priced at)	10,185		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	116,130		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,333,348	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	886,303		13
14	Buildings, at Historical Cost	4,147,670		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,051,016		16
17	Accumulated Depreciation (book methods)	(3,349,403)		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):	312,504		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,048,090	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,381,438	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 475,415	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,659		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	234,287		30
31	Accrued Taxes Payable (excluding real estate taxes)	91,317		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	24,956		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 833,634	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	6,307,192		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)	\$ 6,307,192	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,140,826	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,759,388)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,381,438	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,801,392)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,801,392)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,004	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 42,004	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)	\$ (1,759,388)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Villa Healthcare East

0037028

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,656,979	1
2	Discounts and Allowances for all Levels	(1,019,248)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,637,731	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,332,312	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,332,312	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	1,061	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,537	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	499,798	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,982	19
20	Radiology and X-Ray		20
21	Other Medical Services	52,309	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 580,687	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,416	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,416	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	2,275	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,275	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,564,421	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,222,016	31
32	Health Care	3,572,589	32
33	General Administration	1,587,007	33
B. Capital Expense			
34	Ownership	534,253	34
C. Ancillary Expense			
35	Special Cost Centers	606,552	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,522,417	40
41	Income before Income Taxes (line 30 minus line 40)**	42,004	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 42,004	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number **Villa Healthcare East**

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	8,160	8,546	\$ 262,280	\$ 30.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,314	4,314	101,487	23.53	3
4	Licensed Practical Nurses	33,590	33,590	646,087	19.23	4
5	CNAs & Orderlies	83,157	89,263	1,047,141	11.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,759	6,154	66,571	10.82	9
10	Activity Assistants					10
11	Social Service Workers	6,000	6,427	125,595	19.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,539	19,913	228,574	11.48	15
16	Dishwashers					16
17	Maintenance Workers	10,887	11,674	157,182	13.46	17
18	Housekeepers					18
19	Laundry	8,634	9,515	71,895	7.56	19
20	Administrator	2,056	2,056	95,925	46.66	20
21	Assistant Administrator					21
22	Other Administrative	1,045	1,045	14,554	13.93	22
23	Office Manager					23
24	Clerical	5,943	5,943	92,418	15.55	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	968	1,483	23,570	15.89	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,052	199,923	\$ 2,933,279 *	\$ 14.67	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shannon Cassidy	Administrator	0	\$ 95,925	Workers' Compensation Insurance	\$ 114,467	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	8,001	
				FICA Taxes	275,458	Health Care Worker Background Check		
				Employee Health Insurance	93,902	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Deus and Subscriptions	3,390	
				Other Benefits	1,741	Licenses	3,170	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 95,925					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 485,568	Less: Public Relations Expense	()	
None			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
IL Healthcare Mgt II	Management Fees		\$				Out-of-State Travel	\$
See Attached	Legal Fees							
BKD, LLP	Accounting Fees						In-State Travel	
Galazy/E Health Services	Data Processing Fees							
Pinnacle Consulting	Professional Services						Seminar Expense	
Yellow Pages/Various	Advertising & Pr Other						Admin/Gen Travel and Seminar	6,849
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$				TOTAL	
							\$ 6,849	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Villa Healthcare East

0037028

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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? Yes
If YES, give association name and amount. 2,277 IL Healthcare Assoc
- (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? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 98
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,480 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 54,318
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. \$ 3,537
- (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. \$ NA
c. What percent of all travel expense relates to transportation of nurses and patients? NA
d. Have vehicle usage logs been maintained? NA
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: NA
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.