FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0037028

Facility Name: Villa Health Care East

Address: 100 Marian Pky Bx109 (Number) Sherman (City) 62684 (Zip Code)

County: Sangamon

Telephone Number: (217)744-2299 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** 309 823-7135
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 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,124	13,366	4,083	31,573	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,124	13,366	4,083	31,573	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.38%

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 [x]

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

I. On what date did you start providing long term care at this location?
Date started 1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 99 and days of care provided 4,083

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	260,199	22,489		282,688		282,688		282,688			1
2	Food Purchase		235,825		235,825		235,825		235,825			2
3	Housekeeping		170,755		170,755		170,755		170,755			3
4	Laundry		112,639		112,639		112,639		112,639			4
5	Heat and Other Utilities			177,983	177,983		177,983		177,983			5
6	Maintenance	127,068	90,132	56,877	274,077		274,077		274,077			6
7	Other (specify):*											7
8	TOTAL General Services	387,267	631,840	234,860	1,253,967		1,253,967		1,253,967			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,978,924	211,160	8,238	2,198,322		2,198,322		2,198,322			10
10a	Therapy		195,439	749,122	944,561	(268,726)	675,835		675,835			10a
11	Activities	67,667	20,972		88,639		88,639		88,639			11
12	Social Services	76,057	700	3,567	80,324		80,324		80,324			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,122,648	428,271	770,527	3,321,446	(268,726)	3,052,720		3,052,720			16
	C. General Administration											
17	Administrative	99,059			99,059		99,059		99,059			17
18	Directors Fees											18
19	Professional Services			505,521	505,521		505,521	(21,412)	484,109			19
20	Dues, Fees, Subscriptions & Promotions			116,900	116,900	(54,203)	62,697	(44,518)	18,179			20
21	Clerical & General Office Expenses	257,667	35,566	9,851	303,084		303,084		303,084			21
22	Employee Benefits & Payroll Taxes			458,555	458,555		458,555	(8,000)	450,555			22
23	Inservice Training & Education			7,992	7,992		7,992		7,992			23
24	Travel and Seminar			6,777	6,777		6,777	(1,778)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			129,974	129,974		129,974		129,974			26
27	Other (specify):* Lost resident items			62,666	62,666		62,666	(62,400)	266			27
28	TOTAL General Administration	356,726	35,566	1,298,236	1,690,528	(54,203)	1,636,325	(138,108)	1,498,217			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,866,641	1,095,677	2,303,623	6,265,941	(322,929)	5,943,012	(138,108)	5,804,904			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 Health Care East #0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			259,936	259,936		259,936		259,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			312,536	312,536		312,536	(8,428)	304,108			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,729	23,729		23,729		23,729			35
36	Other (specify):*											36
37	**TOTAL Ownership**			596,201	596,201		596,201	(8,428)	587,773			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					268,726	268,726		268,726			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,203	54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					322,929	322,929		322,929			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,866,641	1,095,677	2,899,824	6,862,142		6,862,142	(146,536)	6,715,606			45

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,428)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,000)			18
19	Entertainment	(1,778)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,412)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,400)			24
25	Fund Raising, Advertising and Promotional	(44,518)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (146,536)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (146,536)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Villa Health Care East

ID# 0037028

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(21,412)	19	22
23				23
24		(62,400)	27	24
25		(44,518)	20	25
26				26
27		(8,000)	22	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**	(136,330)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Health Care East **#** 0037028 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,412)	0	0	0	0	0	0	0	0	0	0	(21,412)	19
20	Fees, Subscriptions & Promotions	(44,518)	0	0	0	0	0	0	0	0	0	0	(44,518)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(8,000)	0	0	0	0	0	0	0	0	0	0	(8,000)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,778)	0	0	0	0	0	0	0	0	0	0	(1,778)	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):*	(62,400)	0	0	0	0	0	0	0	0	0	0	(62,400)	27
28	**TOTAL General Administration**	(138,108)	0	0	0	0	0	0	0	0	0	0	(138,108)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(138,108)	0	0	0	0	0	0	0	0	0	0	(138,108)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Health Care East **#** 0037028 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,428)	0	0	0	0	0	0	0	0	0	0	(8,428)	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**	(8,428)	0	0	0	0	0	0	0	0	0	0	(8,428)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(146,536)	0	0	0	0	0	0	0	0	0	0	(146,536)	45

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
				Villa West	Sherman	ALF
NFP				Vila Vianney	Sherman	Apts.

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 [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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								1
2	Board of Directors List Attached							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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	None								$		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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [x]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Cambridge Capital Realty		x	Mortgage			$	$ 5,844,705			$ 312,536	1
2	T & C Bank		x	Refinancing - Loan Fees				129,000				2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,973,705			$ 312,536	9
	B. Non-Facility Related*											
10	Interest Income										(8,428)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,428)	14
15	TOTALS (line 9+line14)						$	$ 5,973,705			$ 304,108	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 29,494 **Line #** 32

*** 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.)**

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 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:		
2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Health Care East COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0037028

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,368 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [x] (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? [x] (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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 465,000	1
2					2
3	TOTALS			$ 465,000	3

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99				$ 2,146,102	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1991 Additions			1991	691,048						9
10	1992 Additions			1992	30,954						10
11	1993 Additions			1993	14,489						11
12	1994 Additions			1994	10,567						12
13	1995 Additions			1995	56,538						13
14	1996 Additions			1996	17,082						14
15	1997 Additions			1997	35,201						15
16	1998 Additions			1998	68,233						16
17	1999 Additions			1999	77,766						17
18	2000 Additions			2000	89,975						18
19	2001 Additions			2001	54,322						19
20	2004 Additions			2004	16,868						20
21	2005 Additions			2005	74,461						21
22	2006 Additions			2006	31,729						22
23	2002 Additions			2002	110,177						23
24	2003 Additions			2003	8,545						24
25	2007 Additions			2007	18,646						25
26	Carpet			2008	65,083						26
27	Roof Repair			2008	912						27
28	Refinish drywall			2008	912						28
29	paint, trim, blinds, valances to remodel courtyard			2008	2,617						29
30	Parking lot repair			2009	1,400						30
31	exterior doors			2009	7,772						31
32	down spout drains			2009	29,000						32
33	Roof			2009	98,896						33
34	floor, lighting, carpentry labor			2009	10,541						34
35	lighting			2009	23,644						35
36						213,912		213,912			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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Wallcovering, flooring, carpentry, furnishing, beds, labor	2009	$ 57,062	$		$	$	$	37
38	fixtures, flooring, lighting, wallcovering	2009	23,149						38
39	labor, cabinets, counters, drywall, plumbing	2010	18,896						39
40	therapy room expansion	2010	3,778						40
41	remodel therapy room	2010	2,065						41
42	courtyard drainage	2010	2,636						42
43	living room, bird room phase 1 remodel	2010	45,118						43
44	dumpster enclosure	2010	5,043						44
45	main family room renovation	2011	65,483						45
46	rehab resident rooms	2011	13,948						46
47	garage	2011	51,806						47
48	wall guard, chair rail	2011	7,835						48
49	kitchen water heater	2011	6,704						49
50	paving	2011	105,774						50
51	exterior doors	2011	1,651						51
52	concrete sidewalks	2011	6,345						52
53	Headwall, door protection, hand rails	2011	20,663						53
54									54
55	Window Blinds	2013	9,749						55
56	Gazebo	2013	17,599						56
57	HVAC 10 Ton	2013	11,013						57
58	Purchase and installation of new flooring-7 pt rooms	2013	15,680						58
59	Installation of new cabinetry, light fixtures, flooring	2013	76,219						59
60	and upgraded plumbing for three nurse stations-L&M								60
61									61
62	Completion of Window Blinds and Valances Installation	2014	11,900						62
63	HVAC Installation - East and Southwest Wings	2014	20,085						63
64	Walk In Cooler and Freezer Replacement	2014	19,103						64
65	Interior Window Replacement	2014	10,449						65
66	Proposed Addition-Engineering and Architectural Work	2014	23,121						66
67	Therapy Remodeling - Wallcovering, Flooring Carpentry	2014	69,264						67
68	Lighting and Plumbing								68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,515,618	$ 213,912		$ 213,912	$	$	70

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
1	Totals from Page 12A, Carried Forward		$ 4,515,618	$ 213,912		$ 213,912	$	$	1
2									2
3	Completion of walk-in cooler, freezer and replacement of	2015	79,684						3
4	refrigeration equipment project - started in 2014								4
5	Construction of equipment storage alcoves - east wing	2015	17,147						5
6	Installation of new interior signage for rooms and hallways	2015	8,999						6
7	Design services for bathroom remodeling scheduled for 2016	2015	13,873						7
8	Install new carpeting in (6) resident rooms	2015	13,440						8
9	Preparation for 10 room addition in 2016 - deisgn fees,	2015	219,371						9
10	soil testing and relocation of utilites								10
11	Installation of interior doors and windows	2015	11,443						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	TOTAL (lines 1 thru 33)		$ 4,879,575	$ 213,912		$ 213,912	$	$	34

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$	$ 41,358	$ 41,358	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$ 41,358	$ 41,358	$		$	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		2013 Town & Country Van	2013	$ 22,405	$ 2,425	$ 2,425	$		$	76
77		2013 Town & Country Van	2013	24,252	2,241	2,241				77
78										78
79										79
80	TOTALS			$ 46,657	$ 4,666	$ 4,666	$		$	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)	$ 5,391,232	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 259,936	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 259,936	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)	$	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.

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None
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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 23,729 Description: Office equipment and televisions
    (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

* 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.

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.)

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.

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 257,297	$		$ 257,297	1
2	Licensed Speech and Language Development Therapist		hrs			78,360			78,360	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			340,178	0		340,178	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				195,439		195,439	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					73,287			73,287	13
14	TOTAL			$		$ 749,122	$ 195,439		$ 944,561	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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 1,459,190	$	1
2	Cash-Patient Deposits	13,581		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	815,346		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,155		6
7	Other Prepaid Expenses	266,009		7
8	Accounts Receivable (owners or related parties)	(83,001)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,573,280	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	924,122		13
14	Buildings, at Historical Cost	4,868,807		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,337,554		16
17	Accumulated Depreciation (book methods)	(4,353,235)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,777,248	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,350,528	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 198,389	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,581		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	199,827		30
31	Accrued Taxes Payable (excluding real estate taxes)	372		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	23,153		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	28,086		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 463,408	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,973,705		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)**	$ 5,973,705	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,437,113	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,086,585)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,350,528	$	48

***(See instructions.)**

Facility Name & ID Number Villa Health Care East **#** 0037028 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,075,779)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,075,779)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(10,806)	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)**	$ (10,806)	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)**	$ (1,086,585)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,556,083	1
2	Discounts and Allowances for all Levels	(2,671,526)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,884,557	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,582,754	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,582,754	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	343,902	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	932	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 344,834	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,448	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,448	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Contributions	30,743	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 30,743	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,851,336	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,253,967	31
32	Health Care	3,321,446	32
33	General Administration	1,690,528	33
	B. Capital Expense		
34	Ownership	596,201	34
	C. Ancillary Expense		
35	Special Cost Centers		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)***	$ 6,862,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	(10,806)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (10,806)	43

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

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Y 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 Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,839	1,936	$ 75,086	$ 38.78	1
2	Assistant Director of Nursing	1,520	1,600	50,625	31.64	2
3	Registered Nurses	8,863	9,330	264,241	28.32	3
4	Licensed Practical Nurses	23,890	25,147	587,919	23.38	4
5	CNAs & Orderlies	72,033	75,824	931,792	12.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,584	3,773	69,261	18.36	8
9	Activity Director					9
10	Activity Assistants	4,607	4,850	67,667	13.95	10
11	Social Service Workers	3,702	3,897	76,057	19.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,639	19,620	260,199	13.26	15
16	Dishwashers					16
17	Maintenance Workers	3,463	3,645	127,068	34.86	17
18	Housekeepers			0		18
19	Laundry			0		19
20	Administrator	1,976	2,080	99,059	47.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,539	14,252	257,667	18.08	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,655	165,954	$ 2,866,641 *	$ 17.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		9,600		36
37	Medical Records Consultant		1,656		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,826		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		3,567		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,649		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sharon Herpstreith			$ 99,059
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,059

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 337,487
KEB	Audit & Tax	10,620
ADP	Payroll Tax	1,007
Villa Retirement	Mgt	134,995
Legal adj to Zero		21,412
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 505,521

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,426
Unemployment Compensation Insurance	246
FICA Taxes	219,298
Employee Health Insurance	114,012
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	44,573
TOTAL (agree to Schedule V, line 22, col.8)	$ 450,555

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,735
Health Care Worker Background Check	
(Indicate # of checks performed)	2,319
Patient Background Checks	
PR	22,438
Dues & Subscriptions	1,181
License & Fees	2,262
Less: Public Relations Expense	(22,438)
Non-allowable advertising	(318)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,179

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,084
	812
Seminar Expense	1,881
	(1,778)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Villa Health Care East **#** 0037028 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** 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. $ **54,203**
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. $ **322**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Kerber Eck & Braeckel**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None claimed**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount
1009	PETTY CASH	1,459,190					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	815,346					
1110	MEDICARE RECEIVABLES						
1125	IPA INCOME RECEIVABLE						
1130	MEDICARE COST REPORT						
1135	ACCOUNTS RECEIVABLE-IC						
1140	UNAPPLIED CASH RECEIPTS						
1145	A/R SUSPENSE-REFUNDS						
1190	ACCRUED INTEREST REC						
1200	PREPAID INSURANCE	102,155					
1220	OTHER PREPAID EXPENSES						
1300	FOOD INVENTORY						
1310	SUPPLIES INVENTORY						
1409	LAND	924,122					
1450	FURNITURE & EQUIPMENT	1,337,554					
1460	ACCUM DEPR-FURN & EQU	-1,018,646					
1475	BUILDING & IMPROVEMEN	4,868,807					
1490	ACCUM DEPR-BUILDING	-3,334,589					
1530	RESIDENT FUNDS	13,581					
1550	LOAN FEES	266,009					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	-83,001					
2010	ACCOUNTS PAYABLE	-198,389					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	-102,392					
2110	ACCRUED VACATION PAY	-97,435					
1,009	1,009 CASH	1,459,190					
1,100	1,100 ACCTS R	1,087,137					
1,101	1,101 ALLOW.	(271,791)					
1,110	1,110 ACCTS RECEIV-M/C						
1,125	1,125 ACCTS RECEIV-IPA						
1,135	1,135 ACCTS RECEIV-IC						
1,140	1,140 UNAPPLIED CASH RECEIPTS						
1,145	1,145 A/R SUSPENSE-REFUNDS						
1,200	1,200 PREPAID	102,155					
1,220	1,220 OTHER PREPAID EXPENSES						
1,300	1,300 DIETARY INVENTORY						
1,310	1,310 SUPPLIES INVENTORY						
1,320	1,320 LINEN INVENTORY						
1,409	1,409 LAND	924,122					
1,450	1,450 FURNITU	1,337,554					
1,460		(1,018,646)					
1,475	1,475 BUILDIN	4,868,807					
1,490	1,490 ACCUM I	(3,334,589)					
1,530	1,530 RESIDEN	13,581					
1,550	1,550 LOAN FE	266,009					
1,551	1,551 LOAN FEES ADDED						
1,850	1,850 INTERCC	(83,001)					
2,010	2,010 ACCOUN	(198,389)					
2,100	2,095 BONUSES PAYABLE						
2,100	2,100 ACCRUE	(102,392)					
2,100	2,100 PR CLEARING-BENEFITS						
2,100	2,100 PR CLEARING-LABOR						
2,110	2,110 ACCRUE	(97,435)					
2,120	2,120 U.C. TAX	0					

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-372	-372
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYA	-23,153	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-28,086	
2350	REAL ESTATE TAX PAYAB	0	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-13,581	
2600	MORTGAGE PAYABLE	-5,973,705	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	1,075,779	
2970	PROFIT/LOSS FOR PERIOD	10,806	
3007.1	PATIENT DAYS-PRIVATE	13,366	

2,125	2,125	FICA TA	(372)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REF	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETE	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE G.	
2,300	2,300	ACCRUE	(23,153)
2,320	2,320	IPA PAYI	(28,086)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURREN	0
2,512	2,512	DUE TO I	(13,581)
2,600	2,600	LASALLI	(5,973,705)
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DE	
2,720	2,720	RETAINE	1,075,779
		net incom	10,806
		balance	0
			3,007

3007.2		PATIENT DAYS-IPA	14,124					3,007
3007.3		PATIENT DAYS-MEDICARE	4,083					3,007
3007.4		PATIENT DAYS-CONVERSION						3,007
3007.5		PATIENT DAYS-LICENSED						3,007
3007.6		PATIENT DAYS-TOTAL						3,007
3010	1	BASIC CHARGE-PRIVATE &	-6,555,643	0	0	0	0	3,007
3015	1	PRIVATE ASSESSMENT TAX INCOME		0	0	0	0	3,010
3020	1	BASIC CHARGE-IPA	0	0	0	0	0	3,020
3030	1	BASIC CHARGE-MEDICARI	0	0	0	0	0	3,030
3035	4	DAY CARE/HOME CARE		0	0	0	0	3,040
3040	1	LIGHT NURSING CARE	0	0	0	0	0	3,050
3050	1	MEDIUM NURSING CARE		0	0	0	0	3,060
3060	1	HEAVY NURSING CARE		0	0	0	0	3,061
3061	1	SKILLED NURSING CARE						3,080
3080	1	NURSING SUPPLIES-PRIVA	-440	0	0	0	0	3,081
3081	1	NURSING SUPPLIES-IPA		0	0	0	0	3,082
3082	1	NURSING SUPPLIES MED PT A		0	0	0	0	3,083
3083	1	NURSING SUPPLIES MED PT B						3,100
3100	17	DRUGS	-343,902	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-2,582,754	0	0	0	0	3,111
3111	6	PT-IPA		0	0	0	0	3,112
3112	6	PT-MEDICARE PART A		0	0	0	0	3,113
3113	6	PT-MEDICARE PART B		0	0	0	0	3,140
3130	1	PUBLIC AID ASSESSMENT INC						3,150
3140	19	LABORATORY INCOME		0	0	0	0	3,151
3150	6	SPEECH/OT-PRIVATE		0	0	0	0	3,152
3151	6	SPEECH/OT-IPA		0	0	0	0	3,153
3152	6	SPEECH/OT-MED PART A		0	0	0	0	3,160
3153	6	SPEECH/OT MED PART B						3,410
3410	2	IPA DISCOUNTS	2,671,526	0	0	0	0	3,411
3411	2	MEDICAID PART B DISCOUNT		0	0	0	0	3,420
3420	2	MEDICARE DISCOUNTS		0	0	0	0	3,500

3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0			3,520
3520		16	RENT INCOME	0		6	0	6	0			3,530
3530		13	BEAUTY SHOP	0		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	-932		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	0		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	0		0	0	0	0			4,110
3600		21	MISC INCOME	0		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	246,488	257,667	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	99,059	99,059	17	1	0	0			4,120
4115			VACATION & SICK - G&A	11,179		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	41,681	458,555	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP	2,892		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	35,566	35,566	21	2	0	0			4,275
4260			TELEPHONE	9,851	9,851	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	7,992	7,992	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	4,084	6,777	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	812		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	1,881		24	3	19	-1,778	***		4,289
4290			HELP WANTED ADVERTISI	12,735	116,900	20	3	0	0	-54,203		4,290
4291			PROMOTIONAL ADVERTIS	21,762		20	3	25	-21,762			4,291
4292			PUBLIC RELATIONS	22,438		20	3	25	-22,438			4,292
4300			LICENSES & FEES	56,465		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	1,181		20	3	17	-318			4,310
4320			CONTRIBUTIONS	-195		27	3	20	0			4,320
4350			PROFESSIONAL FEES	33,039	505,521	19	3	22	-21,412			4,350
4355			MEDICAL DIRECTOR	9,600	9,600	9	3	0	0			4,355
4360			UTILIZATION REVIEW	0		10	3	0	0			4,362
4361			OTHER PHYSICIAN FEES			39	3	0	0			4,363

4362	MEDICAL RECORDS CONSI	1,656		10	3	0	0	4,364
4363	PHARMACIST FEES	5,826		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,567	3,567	12	3	0	0	4,383
4370	TV RENTAL	11,509		35	3	5	0	4,390
4380	INCOME TAXES		62,666	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,319		20	3	26	0	4,401
4400	PAYROLL TAXES	209,262		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	10,282		22	3	0	0	4,420
4410	GROUP INSURANCE	114,012		22	3	0	0	4,430
4420	LIABILITY INSURANCE	129,974	129,974	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	72,426		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	472,482		19	3	34	0 **	4,460
4460	BAD DEBTS	62,400		27	3	24	-62,400	4,461
4470	LOST ITEMS-RESIDENTS	461		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	12,220	23,729	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	118,937	127,068	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	8,131		6	1	0	0	4,510
5130	ELECTRIC	58,321	177,983	5	3	0	0	4,600
5131	NATURAL GAS	11,372		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	108,290		5	3	0	0	5,130
5134	TRASH COLLECTION	12,426	56,877	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	39,157	90,132	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	50,975		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	44,451		6	3	0	0	5,140
5210	DIETARY WAGES	251,668	260,199	1	1	0	0	5,160
5220	DIETARY SICK & VAC	8,531		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	235,503	235,825	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	39	22,489	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	10,512		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	11,938		1	2	0	0	5,260
5295	MEAL CREDIT	322		2	2	0	0	5,270
5310	LAUNDRY WAGES	0	0	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	0		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	111,632	112,639	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	1,007		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	0	0	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	0		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	31,760	170,755	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	138,995		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,978,924	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	247,721		10	1	0	0	6,020
6030	DON WAGES	75,086		10	1	0	0	6,030
6035	ADON	50,625		10	1	0	0	6,035
6040	RN SICK & VACATION	16,520		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	567,990		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	19,929		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICA	906,459		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	25,333		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WA	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	-20		0	0	0	0	6,295
6270	REHAB WAGES	66,528		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,733		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	12,414	211,160	10	2	0	0	7,281
6295	NURSING SUPPLIES	198,746		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	0		10	2	0	0	7,391
6490	NURSING OTHER	756	8,238	10	3	0	0	7,393
7280	DRUG PURCHASES	195,439	195,439	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	0		39	2			7,540
7380	LABORATORY SERVICES	73,287	749,122	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	64,898	67,667	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	2,769		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	20,972	20,972	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	340,178		39	3	0	0 ***	7,890
7660	PT SUPPLIES	0		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	71,149	76,057	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	4,908		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	700	700	12	2	0	0	8,130
7740	OT FEE	257,297		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	78,360		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	309,749	312,536	32	3	14	-8,428	
8130	DEPRECIATION	259,936	259,936	30	3	9	0	
8150	LOAN FEE AMORTIZATION	2,787		32	3	0	0	0
9510	INTEREST INCOME	-8,428		32	0	10	0	
9520	MISC NON-OPERATING INC	-30,743		0	0	0	0	
9700	INCOME TAXES	8,000		0	0	0	-8,000	
		6,822,951	6,862,142					
			39,191					
GRAND TOTALS		10,806					-146,536	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	13,366	13,366
IPA	14,124	14,124
medicare	4,083	4,083
		31,573

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RIA

BT

3,007 PATIENT 13,366

3,007	PATIENT	14,124
3,007	PATIENT	4,083
		0
3,010	BASIC CI	(6,555,643)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSINC	(440)
3,081	NURSINC	0
3,082	NURSINC	0
3,083	NURSINC	0
3,100	DRUGS-N	(343,902)
		0
3,110	PHYSICA	(2,582,754)
		0
3,112	PHYSICA	0
3,113	PHYSICA	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTH	0
3,411	MEDICA	0
3,420	MEDICA	2,658,159

3,520	RENT IN(	0
3,530	BEAUTY	0
		0
3,570	VENDIN(	(932)
3,590	EQUIPMENT RENTAL	
3,595	RESIDENT TRANSPORTATION	
3,600	MISC INCOME	
4,110	G&A WA	246,488
4,111	ADMINIS	99,059
4,115	G&A PTC	11,179
4,120	EMPLOY	45,526
4,130	EMPLOY	0
4,135	EMPLOY	2,892
4,250	OFFICE S	16,146
4,255	POSTAGI	7,627
4,260	TELEPHC	9,851
4,275	TRAININ	7,992
		0
4,280	GENERA	4,084
4,281	MEAL EX	812
4,285	EDUCAT	1,881
4,289	MEETIN(	0
4,290	HELP WA	12,735
4,291	PROMOT	21,762
4,292	PUBLIC I	22,438
4,300	LICENSE	56,465
4,310	DUES & S	1,181
4,320	CONTRII	(195)
4,350	PROFESS	33,039
4,355	MEDICAI	9,600
		1,656
		5,826

4,364	SOCIAL S	3,567
4,370	TV RENT	11,509
4,383	BACKGR	2,319
4,390	OTHER T	8,000
4,400	PAYROL	209,262
4,401	PAYROL	10,282
4,410	GROUP I	114,012
4,420	LIABILIT	129,974
4,430	WORKM.	71,289
4,435	W/C-FIRST AID CLAIMS	
4,436	DRUG TE	1,137
4,450	MANAGI	472,482
4,460	BAD DEI	62,400
4,461	BAD DEI	13,367
4,470	LOST ITI	461
4,475	UNIFORM	(3,845)
4,486	SERVICE	20,505
4,490	MISC EX	(981)
4,496	MISC. M.	11,793
4,510	REAL ES	0
4,600	LEASED	12,220
5,110	MAINTEI	118,937
5,120	MAINTEI	8,131
5,130	ELECTRI	58,321
5,131	NATURA	11,372
5,133	WATER &	108,290
5,134	TRASH C	12,426
5,140	PROP/PL.	39,157
5,160	GENERA	50,975
5,165	MAINTEI	23,946
5,210	DIETARY	251,668
5,220	DIETARY	8,531
5,248	FOOD PU	236,484

5,250	SUPPLIE	39
5,260	REPLACI	10,512
5,270	KITCHEN	11,938
5,295	MEAL IN	322
5,310	LAUNDRY WAGES	
5,340	LAUNDRY PTO & RESERVE	
5,370	REPLACI	111,632
		0
5,390	SUPPLIE	1,007
5,410	HOUSEKEEPING WAGES	
5,440	HOUSEKEEPING PTO & RESERVE	
5,480	SUPPLIE	31,760
5,490	SUPPLIE	138,995
6,020	RN WAG	247,721
6,030	DON WA	75,086
6,035	ADON W	50,625
6,040	RN PTO &	16,520
6,120	LPN WAG	567,990
6,140	LPN PTO	19,929
6,220	AIDES W	906,459
6,240	AIDES PT	25,333
		0
		0
		(20)
6,270	REHAB V	66,528
6,275	REHAB P	2,733
6,290	NURSING	12,414
6,295	NURSING	198,746
6,390	REPLACEMENT-NURSING	
6,490	OTHER	756

7,280	DRUG PU	195,439
7,281	DRUG PURCHASES-OTHER	
7,380	LABORA	15,526
7,390	X-RAY S	57,761
		0
7,510	ACTIVIT	64,898
7,540	ACTIVIT	2,769
7,590	ACTIVIT	20,972
7,620	PHYSICA	340,178
7,660	P.T. SUPPLY - BILLABLE	
7,710	SOCIAL S	71,149
7,720	SOCIAL S	4,908
7,730	SOCIAL S	700
7,740	OCCUPA	257,297
7,770	SPEECH	78,360
7,820	BEAUTIC	0
		0
		0
8,120	INTERES	280,255
		29,494
8,130	DEPRECI	259,936
		2,787
9,510	INTERES	(8,428)
9,520	MISC NO	(30,743)
4,220		0
8,100		0
9,702		0
5,230		0
		10,806

Expenses Fixed Assets

0