		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0037028

Facility Name: Villa Healthcare East

Address: 100 Marian Parkway (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:** 309823-7135
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 1/1/2018 to 12/31/2018 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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	13,037	15,065	3,837	31,939	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,037	15,065	3,837	31,939	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.28%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 109 and days of care provided 3,837

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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	283,481	23,369	7,885	314,735		314,735		314,735			1
2	Food Purchase		241,306		241,306		241,306		241,306			2
3	Housekeeping	133,927	27,876		161,803		161,803		161,803			3
4	Laundry	95,799	16,140		111,939		111,939		111,939			4
5	Heat and Other Utilities			172,747	172,747		172,747		172,747			5
6	Maintenance	108,208	58,285	74,393	240,886		240,886	(44,631)	196,255			6
7	Other (specify):*											7
8	TOTAL General Services	621,415	366,976	255,025	1,243,416		1,243,416	(44,631)	1,198,785			8
	B. Health Care and Programs											
9	Medical Director			45,600	45,600		45,600		45,600			9
10	Nursing and Medical Records	2,383,105	156,213	19,448	2,558,766		2,558,766		2,558,766			10
10a	Therapy		287,785	69,494	357,279	(357,279)						10a
11	Activities	65,248	20,267		85,515		85,515		85,515			11
12	Social Services	85,088		1,541	86,629		86,629		86,629			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,533,441	464,265	136,083	3,133,789	(357,279)	2,776,510		2,776,510			16
	C. General Administration											
17	Administrative	104,643			104,643		104,643		104,643			17
18	Directors Fees											18
19	Professional Services			485,196	485,196		485,196	(18,510)	466,686			19
20	Dues, Fees, Subscriptions & Promotions			300,823	300,823	(230,263)	70,560	(53,466)	17,094			20
21	Clerical & General Office Expenses	256,619	24,646	19,291	300,556		300,556		300,556			21
22	Employee Benefits & Payroll Taxes			590,644	590,644		590,644		590,644			22
23	Inservice Training & Education			4,917	4,917		4,917		4,917			23
24	Travel and Seminar			3,746	3,746		3,746		3,746			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,919	110,919		110,919		110,919			26
27	Other (specify):* Lost resident items			58,532	58,532		58,532	(58,500)	32			27
28	TOTAL General Administration	361,262	24,646	1,574,068	1,959,976	(230,263)	1,729,713	(130,476)	1,599,237			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,516,118	855,887	1,965,176	6,337,181	(587,542)	5,749,639	(175,107)	5,574,532			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: 1/1/2018 Ending: 12/31/2018

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			450,163	450,163		450,163		450,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			300,281	300,281		300,281	(16,761)	283,520			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			42,711	42,711		42,711		42,711			35
36	Other (specify):*											36
37	**TOTAL Ownership**			793,155	793,155		793,155	(16,761)	776,394			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			846,941	846,941	357,279	1,204,220		1,204,220			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					230,263	230,263		230,263			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			846,941	846,941	587,542	1,434,483		1,434,483			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,516,118	855,887	3,605,272	7,977,277		7,977,277	(191,868)	7,785,409			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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(44,631)			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	(16,761)			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	(6,500)			18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,510)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,000)			24
25	Fund Raising, Advertising and Promotional	(53,466)			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)**	$ (191,868)		$	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))**	$ (191,868)		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

Villa Healthcare East

ID# 0037028

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	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				15
16				16
17				17
18				18
19				19
20				20
21				21
22		0	30	22
23		(18,510)	19	23
24		(52,000)	27	24
25		(53,466)	20	25
26		0	24	26
27		(44,631)	6	27
28		(6,500)	27	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	(175,107)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(44,631)	0	0	0	0	0	0	0	0	0	0	(44,631)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(44,631)	0	0	0	0	0	0	0	0	0	0	(44,631)	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	(18,510)	0	0	0	0	0	0	0	0	0	0	(18,510)	19
20	Fees, Subscriptions & Promotions	(53,466)	0	0	0	0	0	0	0	0	0	0	(53,466)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(58,500)	0	0	0	0	0	0	0	0	0	0	(58,500)	27
28	**TOTAL General Administration**	(130,476)	0	0	0	0	0	0	0	0	0	0	(130,476)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(175,107)	0	0	0	0	0	0	0	0	0	0	(175,107)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	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	(16,761)	0	0	0	0	0	0	0	0	0	0	(16,761)	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**	(16,761)	0	0	0	0	0	0	0	0	0	0	(16,761)	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)**	(191,868)	0	0	0	0	0	0	0	0	0	0	(191,868)	45

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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
Board of Directors List Attached				Villa West	Sherman	ALF
(Not for profit Board-No individual				Vila Vianney	Sherman	Apts.
ownership)						

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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Board Members are not compensated								$		1
2	for their services										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: 1/1/2018 Ending: 2/31/2018

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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	T & C Bank		X	Mortgage			$	$ 5,552,951			$ 300,281	1
2	T & C Bank		X	Construction				3,717,797				2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 9,270,748			$ 300,281	9
	B. Non-Facility Related*											
10	Interest Income										(16,761)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,761)	14
15	TOTALS (line 9+line14)						$	$ 9,270,748			$ 283,520	15

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

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

None - Exempt

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Healthcare 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,616 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 - Related organizations are located across a 4 lane highway.

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			1991	$ 465,000	1
2					2
3	TOTALS			$ 465,000	3

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			1991	$ 2,146,102	$		$	$	$	4
5	10			2007	4,190,329						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	Depreciation expense					377,836		377,836			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: 1/1/2018 Ending: 12/31/2018

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									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,705,947	$ 377,836		$ 377,836	$	$	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: 1/1/2018 Ending: 12/31/2018

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		$ 8,705,947	$ 377,836		$ 377,836	$	$	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	Install AO Smith water heater	2016	9,321						13
14									14
15	Bathing rooms remodel - stripped all (4) rooms to bare wall	2017	236,310						15
16	and floor. Replaced all plumbing fixtures, created barrier free								16
17	showers and added new floor and wall tile.								17
18	lift capability added in two rooms.								18
19									19
20	No 2018 improvements	2018							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)		$ 9,315,535	$ 377,836		$ 377,836	$	$	34

**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: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,611,690	$ 67,662	$ 67,662	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,611,690	$ 67,662	$ 67,662	$		$	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	2,240	2,240				77
78										78
79										79
80	TOTALS			$ 46,657	$ 4,665	$ 4,665	$		$	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)	$ 11,438,882	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 450,163	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 450,163	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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 42,711 Description: Office equipment
(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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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? [x] 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 [x]
- 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 Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$		$ 350,621	$		$ 350,621	1
2	Licensed Speech and Language Development Therapist		hrs			82,565			82,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			413,755	0		413,755	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				287,785		287,785	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					69,494			69,494	13
14	TOTAL			$		$ 916,435	$ 287,785		$ 1,204,220	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.

STATE OF ILLINOIS

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 771,192	$	1
2	Cash-Patient Deposits	9,223		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,268,949		3
4	Supply Inventory (priced at FIFO)	19,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,000		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(3,062)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,090,802	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,412,002		13
14	Buildings, at Historical Cost	8,869,157		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,658,347		16
17	Accumulated Depreciation (book methods)	(5,474,148)		17
18	Deferred Charges	219,186		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)**	$ 6,684,544	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,775,346	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 919,066	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,223		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	275,352		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,642		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,888		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	14,210		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,269,381	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,270,748		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)**	$ 9,270,748	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,540,129	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,764,783)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,775,346	$	48

*(See instructions.)

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,712,588)	1
2	Restatements (describe):		2
3	**Audit Adjustment - Interest Rate Swap**	(24,375)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,736,963)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(27,820)	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)**	$ (27,820)	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)**	$ (1,764,783)	24 *

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

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 6,987,078	1
2	Discounts and Allowances for all Levels	(3,136,954)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,850,124	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,235,375	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,235,375	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	44,631	16
17	Sale of Drugs	545,735	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,831	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 597,197	23
	D. Non-Operating Revenue		
24	Contributions	250,000	24
25	Interest and Other Investment Income***	16,761	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 266,761	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,949,457	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,243,416	31
32	Health Care	3,133,789	32
33	General Administration	1,959,976	33
	B. Capital Expense		
34	Ownership	793,155	34
	C. Ancillary Expense		
35	Special Cost Centers	846,941	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)***	$ 7,977,277	40
41	**Income before Income Taxes (line 30 minus line 40)****	(27,820)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (27,820)	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? _____ 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: 1/1/2018 Ending: 12/31/2018

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	1,822	1,939	$ 77,237	$ 39.83	1
2	Assistant Director of Nursing	1,737	1,848	60,414	32.69	2
3	Registered Nurses	13,961	14,852	464,263	31.26	3
4	Licensed Practical Nurses	21,487	22,858	547,462	23.95	4
5	CNAs & Orderlies	74,605	79,367	1,156,619	14.57	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,576	3,804	77,110	20.27	8
9	Activity Director					9
10	Activity Assistants	4,318	4,594	65,248	14.20	10
11	Social Service Workers	3,838	4,084	85,088	20.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,455	20,697	283,481	13.70	15
16	Dishwashers					16
17	Maintenance Workers	3,461	3,682	108,208	29.39	17
18	Housekeepers	11,468	12,200	133,927	10.98	18
19	Laundry	7,998	8,508	95,799	11.26	19
20	Administrator	1,955	2,080	104,643	50.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,789	12,542	256,619	20.46	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)	181,470	193,055	$ 3,516,118 *	$ 18.21	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		$ 7,885		35
36	Medical Director		45,600		36
37	Medical Records Consultant		1,507		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,824		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		1,343		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 62,159		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		11,673		52
53	TOTAL (lines 50 - 52)		$ 11,673		53

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sharon Herpstreith			$ 104,643
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 104,643

B. Administrative - Other

Description	Amount
	$ 0
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	Mgmt	$ 376,083
KEB	Audit & Tax	15,602
VRI, Inc.	Facility Consulting	75,001
Legal adj to Zero		18,510
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 485,196

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,932
Unemployment Compensation Insurance	9,857
FICA Taxes	268,983
Employee Health Insurance	231,026
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	17,846
TOTAL (agree to Schedule V, line 22, col.8)	$ 590,644

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	5,320
Health Care Worker Background Check (Indicate # of checks performed)	2,334
Patient Background Checks	
PR	17,519
Dues & Subscriptions	8,901
License & Fees	2,475
Less: Public Relations Expense	(17,519)
Non-allowable advertising	(1,936)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,094

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,451
	0
Seminar Expense	295
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,746

**See instructions.

Facility Name & ID Number Villa Healthcare East # 0037028 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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?

(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 Yrs**

(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. $ **230,263**
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. $ **74**

(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? **Y**
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 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount	
1009	PETTY CASH	771,192						
1010	CASH IN BANK							
1040	CASH IN BANK-PAYROLL							
1100	ACCOUNTS RECEIVABLE	1,268,949						
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	25,000						
1220	OTHER PREPAID EXPENSES							
1300	FOOD INVENTORY	19,500						
1310	SUPPLIES INVENTORY							
1409	LAND	0						
1450	FURNITURE & EQUIPMENT	1,658,347						
1460	ACCUM DEPR-FURN & EQUIP	-1,201,324						
1475	BUILDING & IMPROVEMENTS	8,869,157						
1490	ACCUM DEPR-BUILDING	-4,272,824						
1530	RESIDENT FUNDS	9,223						
1550	LOAN FEES	219,186						
1560	REAL ESTATE TAX ESCROW							
1575	REIMBURSABLE PURCHASES							
1850	INTRACOMPANY	-3,062						
2010	ACCOUNTS PAYABLE	-919,066						
2095	BONUSES PAYABLE							
2100	ACCRUED PAYROLL	-158,099						
2110	ACCRUED VACATION PAY	-117,253						
2120	UC TAXES PAYABLE							
2125	FICA TAX PAYABLE	-35,642	-35,642					
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 PAYABLE	-15,888						
2310	SALES TAX PAYABLE							
2320	IPA PAYMENTS PAYABLE	-14,210						
2350	REAL ESTATE TAX PAYABLE	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	-9,223						
2600	MORTGAGE PAYABLE	-9,270,748						
2650	EQUIPMENT LOAN PAYABLE							
2695	CURRENT PORTION LT DEBT							
2696	DEFERRED INCOME TAXES							
2710	COMMON STOCK							
2720	RETAINED EARNINGS	1,736,963						
2970	PROFIT/LOSS FOR PERIOD	27,820						
3007.1	PATIENT DAYS-PRIVATE	15,065						
3007.2	PATIENT DAYS-IPA	13,037						
3007.3	PATIENT DAYS-MEDICARE	3,837						
3007.4	PATIENT DAYS-CONVERSION							
3007.5	PATIENT DAYS-LICENSED							
3007.6	PATIENT DAYS-TOTAL							
3010	1 BASIC CHARGE-PRIVATE & VA	-6,977,488		0	0	0	0	
3015	1 PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020	1 BASIC CHARGE-IPA	0		0	0	0	0	
3030	1 BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035	4 DAY CARE/HOME CARE			0	0	0	0	
3040	1 LIGHT NURSING CARE	0		0	0	0	0	
3050	1 MEDIUM NURSING CARE			0	0	0	0	
3060	1 HEAVY NURSING CARE			0	0	0	0	
3061	1 SKILLED NURSING CARE							
3080	1 NURSING SUPPLIES-PRIVATE	-4,785		0	0	0	0	
3081	1 NURSING SUPPLIES-IPA			0	0	0	0	
3082	1 NURSING SUPPLIES MED PT A			0	0	0	0	
3083	1 NURSING SUPPLIES MED PT B							
3100	17 DRUGS	-545,735		0	0	0	0	
3101	17 DRUGS-OTHER							
3110	6 PT-PRIVATE	-3,235,375		0	0	0	0	
3111	6 PT-IPA			0	0	0	0	
3112	6 PT-MEDICARE PART A			0	0	0	0	
3113	6 PT-MEDICARE PART B			0	0	0	0	
3130	1 PUBLIC AID ASSESSMENT INC	170,585						
3140	19 LABORATORY INCOME			0	0	0	0	
3150	6 SPEECH/OT-PRIVATE			0	0	0	0	
3151	6 SPEECH/OT-IPA			0	0	0	0	
3152	6 SPEECH/OT-MED PART A			0	0	0	0	
3153	6 SPEECH/OT MED PART B							
3410	2 IPA DISCOUNTS	3,136,954		0	0	0	0	
3411	2 MEDICAID PART B DISCOUNT			0	0	0	0	
3420	2 MEDICARE DISCOUNTS			0	0	0	0	
3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	
3520	16 RENT INCOME	-44,631		6	0	6	-44,631	
3530	13 BEAUTY SHOP	0		0	0	0	0	
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	
3570	12 VENDING INCOME/EXPENSE	-563		0	0	0	0	
3580	12 MANAGEMENT FEES			0	0	0	0	
3590	1 EQUIPMENT RENTAL	-4,805		0	0	0	0	
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0	
3600	21 MISC INCOME	-6,268		0	0	0	0	
4110	GENERAL & ADMINIST WAGES	244,818	256,619	21	1	17	0	
4111	ADMINISTRATOR WAGES	104,643	104,643	17	1	0	0	
4115	VACATION & SICK - G&A	11,801		21	1	0	0	
4120 4475	EMPLOYEE BENEFITS	16,409	590,644	22	3	0	0	
4125	EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130	EMPLOYEE SCHOLORSHIP WA	1,437	170,585	21	1	0	0	
4135	EMPLOYEE SCHOLORSHIP CO:	0		23	3	0	0	
4220	DIRECTORS FEES	0	0	18	3	0	0	
4250 4255	OFFICE SUPPLIES	24,646	24,646	21	2	0	0	
4260	TELEPHONE	19,291	19,291	21	3	0	0	
4275	TRAINING & EMPLOYEE DEVL	4,917	4,917	23	3	16	0	**
4280	GENERAL TRAVEL	3,451	3,746	24	3	16	0	
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285	EDUCATION & SEMINAR	295		24	3	19	0	***
4290	HELP WANTED ADVERTISING	5,320	130,238	20	3	0	0	-59,678
4291	PROMOTIONAL ADVERTISING	34,011		20	3	25	-34,011	
4292	PUBLIC RELATIONS	17,519		20	3	25	-17,519	
4300	LICENSES & FEES	62,153		20	3	17	0	
4310	DUES & SUBSCRIPTIONS	8,901		20	3	17	-1,936	
4320	CONTRIBUTIONS	0		27	3	20	0	
4350	PROFESSIONAL FEES	35,189	485,196	19	3	22	-18,510	
4355	MEDICAL DIRECTOR	45,600	45,600	9	3	0	0	
4360	UTILIZATION REVIEW	0		10	3	0	0	
4361	OTHER PHYSICIAN FEES			39	3	0	0	
4362	MEDICAL RECORDS CONSULT	1,507		10	3	0	0	
4363	PHARMACIST FEES	5,824		10	3	0	0	
4364	SOC SERV/ACT CONSULT	1,343	1,343	12	3	0	0	
4370	TV RENTAL	8,940		35	3	5	0	
4380	INCOME TAXES		58,532	27	3	26	0	
4383	BACKGROUND CHECKS	2,334		20	3	26	0	
4400	PAYROLL TAXES	267,978		22	3	0	0	
4401	PAYROLL TAXES ADMINIST	10,862		22	3	0	0	
4410	GROUP INSURANCE	231,026		22	3	0	0	
4420	LIABILITY INSURANCE	110,919	110,919	26	3	0	0	
4425	INSURANCE-OWNERS			22	3	21	0	
4430	WORKMENS COMP INSURANCE	62,932		22	3	0	0	
4450	CENTRAL OFFICE FEES	450,007		19	3	34	0	**
4460	BAD DEBTS	52,000		27	3	24	-52,000	
4470	LOST ITEMS-RESIDENTS	32		27	3	0		
4490	MISCELLANEOUS	0		27	3	0	0	
4510	REAL ESTATE TAXES	0	0	33	3	0	0	
4600	LEASED EQUIPMENT	33,771	42,711	35	3	16	0	
5110	MAINTENANCE SALARIES	101,090	108,208	6	1	0	0	
5120	MAINTENANCE SICK & VAC	7,118		6	1	0	0	
5130	ELECTRIC	57,880	172,747	5	3	0	0	
5131	NATURAL GAS	17,229		5	3	0	0	
5132	HEATING & DIESEL OIL			5	3	0	0	
5133	WATER & SEWER	97,638		5	3	0	0	
5134	TRASH COLLECTION	8,084	74,393	6	3	0	0	
5140	PROPERTY PLANT REPLACEMI	13,226	58,285	6	2	0	0	
5160	GENERAL REPAIR & MAINT	45,059		6	2	0	0	
5165	MAINTENANCE CONTRACTS	66,309		6	3	0	0	
5210	DIETARY WAGES	273,355	283,481	1	1	0	0	
5220	DIETARY SICK & VAC	10,126		1	1	0	0	
5240	DIETARY CONSULTANT	7,885	7,885	2	3	13	0	
5248	FOOD PURCHASES	241,380	241,306	2	2	0	0	
5250	SUPPLIES-DISHWASHING	7,802	23,369	1	2	0	0	
5260	DIETARY REPLACEMENT	4,934		1	2	0	0	
5270	KITCHEN SUPPLIES-PAPER	10,633		1	2	0	0	
5295	MEAL CREDIT	-74		2	2	0	0	
5310	LAUNDRY WAGES	93,378	95,799	4	1	0	0	
5340	LAUNDRY SICK & VAC	2,421		4	1	0	0	
5370	LAUNDRY REPLACEMENT	8,115	16,140	4	2	0	0	
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	
5390	LAUNDRY SUPPLIES	8,025		4	2	0	0	
5410	HOUSEKEEPING WAGES	128,468	133,927	3	1	0	0	
5440	HOUSEKEEPING SICK & VAC	5,459		3	1	0	0	
5480	HOUSEKEEPING SUPPLIES	27,816	27,876	3	2	0	0	
5490	HOUSEKEEPING SUPPLIES-PPR	60		3	2	0	0	
6010	RN WAGES-MEDICARE		2,383,105	10	1	0	0	
6020	RN WAGES-NON MEDICARE	440,944		10	1	0	0	
6030	DON WAGES	77,237		10	1	0	0	
6035	ADON	60,414		10	1	0	0	
6040	RN SICK & VACATION	23,319		10	1	0	0	
6110	LPN WAGES-MEDICARE	528,319		10	1	0	0	
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	
6130	LPN WAGES OTHER			10	1	0	0	
6140	LPN SICK & VACATION	19,143		10	1	0	0	
6210	AIDE WAGES-MEDICARE			10	1	0	0	
6220	AIDE WAGES-NON MEDICARE	1,127,860		10	1	0	0	
6230	WARD CLERKS			10	1	0	0	
6240	AIDE VACATION & SICK	28,759		10	1	0	0	
6245	CONTRACT NURSES-RN	0		10	3	0	0	
6246	CONTRACT NURSES-LPN	0		10	3	0	0	
6247	CONTRACT NURSES-AIDES	11,673		10	3	0	0	
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270	REHAB WAGES	73,613		10	1	0	0	
6275	REHAB SICK & VAC	3,497		10	1	0	0	
6280	NURSING DEPT EDUCATION			23	3	0	0	
6290	NURSING SUPPLIES	17,673	156,213	10	2	0	0	
6295	NURSING SUPPLIES	133,440		10	2	0	0	
6390	REPLACEMENT-NURSING	5,100		10	2	0	0	
6490	NURSING OTHER	444	19,448	10	3	0	0	
7280	DRUG PURCHASES	287,753	287,785	39	2	0	0	***
7281	DRUG PURCHASES-OTHER	32		39	2			
7380	LABORATORY SERVICES	69,494	69,494	39	3	0	0	
7410	HOME HEALTH SALARY			39	1	0	0	
7440	HOME HEALTH SICK & VAC			39	1	0	0	
7450	HOME HEALTH EXPENSES			39	3	0	0	
7510	ACTIVITES WAGES	62,158	65,248	11	1	0	0	
7540	ACTIVITIES SICK & VAC	3,090		11	1	0	0	
7590	ACTIVITIES SUPPLIES	20,267	20,267	11	2	0	0	
7595	ACTIVITIES FEES	0	0	11	3	0	0	
7610	PT WAGES			39	1	0	0	
7611	PT SICK & VACATION			39	1	0	0	
7620	PT FEES	413,755	846,941	39	3	0	0	***
7660	PT SUPPLIES	0		39	2	0	0	
7710	SOCIAL SERVICE WAGES	79,915	85,088	12	1	0	0	
7720	SOCIAL SERVICE SICK & VAC	5,173		12	1	0	0	
7730	SOCIAL SERVICE EXPENSES	198	198	12	2	0	0	
7740	OT FEE	350,621		39	3	0	0	***
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770	SPEECH THERAPY FEE	82,565		39	3	0	0	***
7800	BEAUTICIAN WAGES		0	40	1	0	0	
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	285,556	300,281	32	3	14	-16,761	
8130	DEPRECIATION	450,163	450,163	30	3	9	0	
8150	LOAN FEE AMORTIZATION	14,725		32	3	0	0	0
9510	INTEREST INCOME	-16,761		32	0	10	0	
9520	MISC NON-OPERATING INCOME	-250,000		0	0	0	0	
9700	INCOME TAXES	6,500		0	0	0	-6,500	
		7,539,931	7,977,277					
			437,346					
GRAND TOTALS		27,820					-191,868	
		(NET INCOME)						
		0						
	FACILITY NAME:							
	FACILITY ID:	0						
	FACILITY UNITS:	162						
	BALANCE SHEET TOTAL	-1,412,002						

1,009	1,009	CASH	771,192
1,100	1,100	ACCTS RECEI	1,549,192
1,101	1,101	ALLOW. FOR U	(280,243)
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 INSU	25,000
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVE	0
1,310	1,310	SUPPLIES INV	10,216
1,320	1,320	LINEN INVENT	9,284
1,409	1,409	LAND	1,412,002
1,450	1,450	FURNITURE &	1,658,347
1,460			(1,201,324)
1,475	1,475	BUILDINGS	8,869,157
1,490	1,490	ACCUM DEPR	(4,272,824)
1,530	1,530	RESIDENT FU	9,223
1,550	1,550	LOAN FEES	219,186
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOMPA	(3,062)
2,010	2,010	ACCOUNTS PA	(919,066)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED PA'	(158,099)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED PT(	(117,253)
2,120	2,120	U.C. TAXES PA	0
2,125	2,125	FICA TAXES P	(35,642)
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 REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNIS	
2,300	2,300	ACCRUED INT	(15,888)
2,320	2,320	IPA PAYMENT	(14,210)
2,350	2,350	REAL ESTATE	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO RESID	(9,223)
2,600	2,600	LOC	0
2,600			
2,625	2,625	LASALLE CON	(9,270,748)
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINED EA	1,736,963
		net income	27,820
		balance	0

3,007	3,007	PATIENT DAYS-PI	15,065
3,007	3,007	PATIENT DAYS-IP	13,037
3,007	3,007	PATIENT DAYS-M	3,837
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHARGE-P	(6,977,488)
3,020	3,020	BASIC CHARGE-II	0
3,030	3,030	BASIC CHARGE-M	0
3,040		ASSESSMENT	170,585
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SUPPL-	(4,785)
3,081	3,081	NURSING SUPPLI	0
3,082	3,082	NURSING SUPPLI	0
3,083	3,083	NURSING SUPPLI	0
3,100	3,100	DRUGS-MEDICAR	(545,735)
3,101			0
3,110	3,110	PHYSICAL THERA	(3,235,375)
3,111			0
3,112	3,112	PHYSICAL THERA	0
3,113	3,113	PHYSICAL THERA	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THERAPY-I	0
3,153	3,153	ST/OT THERAPY-I	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER DISC	0
3,411	3,411	MEDICARE PT B-D	0
3,420	3,420	MEDICARE DISC	3,119,120
3,500			
3,520	3,520	RENT INCOME	(44,631)
3,530	3,530	BEAUTY SHOP	0
3,560			0
3,570	3,570	VENDING INCOME	(563)
3,590	3,590	EQUIPMENT REN	(4,805)
3,595	3,595	RESIDENT TRANS	0
3,600	3,600	MISC INCOME	(6,268)
4,110	4,110	G&A WAGES	244,818
4,111	4,111	ADMINISTRATOR	104,643
4,115	4,115	G&A PTO & RESE	11,801
4,120	4,120	EMPLOYEE BENE	19,398
4,121			0
4,130	4,130	EMPLOYEE SCHO	1,437
4,135	4,135	EMPLOYEE SCHO	0
4,250	4,250	OFFICE SUPPLIES	13,340
4,255	4,255	POSTAGE	6,138
4,260	4,260	TELEPHONE	19,291
4,275	4,275	TRAINING & EMPL	4,917
4,276			347
4,280	4,280	GENERAL TRAVE	3,451
4,281	4,281	MEAL EXPENSE F	0
4,285	4,285	EDUCATION/SEMI	295
4,289	4,289	MEETINGS EXPEN	0
4,290	4,290	HELP WANTED AI	5,320
4,291	4,291	PROMOTIONAL AI	34,011
4,292	4,292	PUBLIC RELATION	17,519
4,300	4,300	LICENSE & FEES	62,153
4,310	4,310	DUES & SUBSCRI	8,901
4,320	4,320	CONTRIBUTIONS	0
4,350	4,350	PROFESSIONAL F	35,189
4,355	4,355	MEDICAL DIRECT	45,600
4,362			1,507
4,363			5,824
4,364	4,364	SOCIAL SERV/AC	1,343
4,370	4,370	TV RENTAL	8,940
4,383	4,383	BACKGROUND CH	2,334
4,390	4,390	OTHER TAXES	6,500
4,400	4,400	PAYROLL TAXES	267,978
4,401	4,401	PAYROLL TAXES	10,862
4,410	4,410	GROUP INSURAN	231,026
4,420	4,420	LIABILITY INSURA	110,919
4,430	4,430	WORKMAN'S COM	61,319
4,435	4,435	W/C-FIRST AID CL	0
4,436	4,436	DRUG TESTING M	1,266
4,450	4,450	MANAGEMENT FE	450,007
4,460	4,460	BAD DEBTS	52,000
4,461	4,461	BAD DEBTS	17,834
4,470	4,470	LOST ITEMS-RESI	32
4,475	4,475	UNIFORM EXP/PE	(2,989)
4,486	4,486	SERVICE CONTR	42,269
4,490	4,490	MISC EXPENSE	492
4,496	4,496	MISC. M.I.S. EXPE	5,168
4,510	4,510	REAL ESTATE TA	0
4,600	4,600	LEASED EQUIPME	33,771
5,110	5,110	MAINTENANCE W	101,090
5,120	5,120	MAINTENANCE P	7,118
5,130	5,130	ELECTRIC	57,880
5,131	5,131	NATURAL GAS	17,229
5,133	5,133	WATER & SEWER	97,638
5,134	5,134	TRASH COLLECTI	8,084
5,140	5,140	PROP/PLANT REF	13,226
5,160	5,160	GENERAL REPAIR	45,059
5,165	5,165	MAINTENANCE C	24,040
5,210	5,210	DIETARY WAGES	273,355
5,220	5,220	DIETARY PTO & R	10,126
5,248	5,248	FOOD PURCHASE	240,888
5,250	5,250	SUPPLIES DISHW	7,802
5,260	5,260	REPLACEMENT-D	4,934
5,270	5,270	KITCHEN SUPPLIE	10,633
5,295	5,295	MEAL INCOME	(74)
5,310	5,310	LAUNDRY WAGES	93,378
5,340	5,340	LAUNDRY PTO & I	2,421
5,370	5,370	REPLACEMENT-L	8,115
5,380		DIETARY CONSUL	7,885
5,390	5,390	SUPPLIES	8,025
5,410	5,410	HOUSEKEEPING	128,468
5,440	5,440	HOUSEKEEPING I	5,459
5,480	5,480	SUPPLIES-CLEAN	27,816
5,490	5,490	SUPPLIES-HOUSE	60
6,020	6,020	RN WAGES	440,944
6,030	6,030	DON WAGES	77,237
6,035	6,035	ADON WAGES	60,414
6,040	6,040	RN PTO & RESER	23,319
6,120	6,120	LPN WAGES	528,319
6,140	6,140	LPN PTO & RESEI	19,143
6,220	6,220	AIDES WAGES	1,127,860
6,240	6,240	AIDES PTO & RES	28,759
6,245		RN CONTR	0
6,246		LPN CONTR	0
6,247		AIDES CONTR	11,673
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB WAGES	73,613
6,275	6,275	REHAB PTO & RE	3,497
6,290	6,290	NURSING SUPPLI	17,673
6,295	6,295	NURSING SUPPLI	133,440
6,390	6,390	REPLACEMENT-N	5,100
6,490	6,490	OTHER	444
7,280	7,280	DRUG PURCHASE	287,753
7,281	7,281	DRUG PURCHASE	32
7,380	7,380	LABORATORY SE	29,707
7,391	7,390	X-RAY SERVICES	5,766
7,393			34,021
7,510	7,510	ACTIVITIES WAGE	62,158
7,540	7,540	ACTIVITIES PTO &	3,090
7,590	7,590	ACTIVITIES SUPP	20,267
7,620	7,620	PHYSICAL THERA	413,755
7,660	7,660	P.T. SUPPLY - BIL	0
7,710	7,710	SOCIAL SERVICE	79,915
7,720	7,720	SOCIAL SERVICE	5,173
7,730	7,730	SOCIAL SERVICE-	198
7,740	7,740	OCCUPATIONAL T	350,621
7,750			
7,770	7,770	SPEECH THERAP	82,565
7,820	7,820	BEAUTICIAN FEE	0
7,890			0
7,960			0
8,120	8,120	INTEREST	362,881
8,125			(77,325)
8,130	8,130	DEPRECIATION	450,163
8,150			14,725
9,510	9,510	INTEREST INCOM	(16,761)
9,520	9,520	MISC NON-OPER/	(250,000)
9,530	4,220		0
	8,100		0
	9,702		0
	5,230		0
			27,820

Expenses Fixed Assets 0

G/L RECAP CENSUS

Villa Health Care East
2018 Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	287,785
Purchased Hospital Services		34,021
Purchased Laboratory Services		29,707
Purchased Radiology Services		5,766
Amount Reclassified to Line 39	$	357,279

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee - $1.50	$	(59,678)
Provider Assesment Fee - $6.07		(170,585)
		(230,263)
Provider Participation Fee		230,263