FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0037028

Facility Name: Villa Health Care East

Address: 100 Marian Pkwy B109 (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:

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

IRS Exemption Code 501C3

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** (309)8237135
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 1/1/2020 to 12/31/2020 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: 1/1/2020 Ending: 12/31/2020

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	39,894	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	39,894	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	8,894	11,113	4,065	24,072	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,894	11,113	4,065	24,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.34%

D. How many bed reserve days during this year were paid by the Department?
None (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 [xx]

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

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 [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 109 and days of care provided 4,065

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] 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: 1/1/2020 Ending: 12/31/2020

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	285,125	30,401	6,482	322,008		322,008		322,008			1
2	Food Purchase		210,178		210,178		210,178		210,178			2
3	Housekeeping	147,109	28,641		175,750		175,750		175,750			3
4	Laundry	67,717	9,420		77,137		77,137		77,137			4
5	Heat and Other Utilities			169,615	169,615		169,615		169,615			5
6	Maintenance	105,794	55,772	123,716	285,282		285,282	(42,662)	242,620			6
7	Other (specify):*											7
8	TOTAL General Services	605,745	334,412	299,813	1,239,970		1,239,970	(42,662)	1,197,308			8
	B. Health Care and Programs											
9	Medical Director			9,632	9,632		9,632		9,632			9
10	Nursing and Medical Records	2,462,082	162,345	49,502	2,673,929	(6,326)	2,667,603		2,667,603			10
10a	Therapy		212,258	67,240	279,498	(273,172)	6,326		6,326			10a
11	Activities	58,407	9,655		68,062		68,062		68,062			11
12	Social Services	90,424		2,198	92,622		92,622		92,622			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,610,913	384,258	128,572	3,123,743	(279,498)	2,844,245		2,844,245			16
	C. General Administration											
17	Administrative	122,139			122,139		122,139		122,139			17
18	Directors Fees											18
19	Professional Services			432,913	432,913		432,913	(20,896)	412,017			19
20	Dues, Fees, Subscriptions & Promotions			348,463	348,463	(193,557)	154,906	(140,856)	14,050			20
21	Clerical & General Office Expenses	246,344	36,414	19,346	302,104		302,104		302,104			21
22	Employee Benefits & Payroll Taxes			716,763	716,763		716,763		716,763			22
23	Inservice Training & Education			585	585		585		585			23
24	Travel and Seminar			1,970	1,970		1,970		1,970			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			155,681	155,681		155,681		155,681			26
27	Other (specify):* Lost resident items			12,913	12,913		12,913	(12,638)	275			27
28	TOTAL General Administration	368,483	36,414	1,688,634	2,093,531	(193,557)	1,899,974	(174,390)	1,725,584			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,585,141	755,084	2,117,019	6,457,244	(473,055)	5,984,189	(217,052)	5,767,137			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: 1/1/2020 Ending: 12/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			422,259	422,259		422,259		422,259			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			577,162	577,162		577,162	(3,710)	573,452			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			45,094	45,094		45,094		45,094			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,044,515	1,044,515		1,044,515	(3,710)	1,040,805			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			627,169	627,169	273,172	900,341		900,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					193,557	193,557		193,557			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			627,169	627,169	466,729	1,093,898		1,093,898			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,585,141	755,084	3,788,703	8,128,928	(6,326)	8,122,602	(220,762)	7,901,840			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: 1/1/2020 Ending: 12/31/2020

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	(42,662)			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	(3,710)			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	(6,122)			17
18	Fines and Penalties	(6,250)			18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(20,896)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,388)			24
25	Fund Raising, Advertising and Promotional	(134,734)			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)**	$ (220,762)		$	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))**	$ (220,762)		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 Health Care East

ID# 0037028

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	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		(20,896)	19	11
12		(3,710)	32	12
13		(6,388)	27	13
14		(134,734)	20	14
15		(6,122)	20	15
16		(42,662)	6	16
17		(6,250)	27	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(220,762)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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	(42,662)	0	0	0	0	0	0	0	0	0	0	(42,662)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(42,662)	0	0	0	0	0	0	0	0	0	0	(42,662)	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	(20,896)	0	0	0	0	0	0	0	0	0	0	(20,896)	19
20	Fees, Subscriptions & Promotions	(140,856)	0	0	0	0	0	0	0	0	0	0	(140,856)	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):*	(12,638)	0	0	0	0	0	0	0	0	0	0	(12,638)	27
28	TOTAL General Administration	(174,390)	0	0	0	0	0	0	0	0	0	0	(174,390)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,052)	0	0	0	0	0	0	0	0	0	0	(217,052)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Health Care East **#** 0037028 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(3,710)	0	0	0	0	0	0	0	0	0	0	(3,710)	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**	(3,710)	0	0	0	0	0	0	0	0	0	0	(3,710)	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)**	(220,762)	0	0	0	0	0	0	0	0	0	0	(220,762)	45

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Sheltered Care
Board of Directors List Attached				Vila Vianney	Sherman	Apts.
(Not for profit Board-No individual						
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 [xx] 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: 1/1/2020 Ending: 12/31/2020

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				0	0			$ 0		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 Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 [xx]

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: 1/1/2020 Ending: 12/31/2020

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	T & C Bank		xx	Mortgage			$	$ 5,345,209			$ 577,162	1
2	T & C Bank		xx	Rehab Addition				3,717,797				2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 9,063,006			$ 577,162	9
	B. Non-Facility Related*											
10	Interest Income										(3,710)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,710)	14
15	TOTALS (line 9+line14)						$	$ 9,063,006			$ 573,452	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 Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

Not for profit - no real estate taxes due

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,233 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [xx] (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? [xx] (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 [xx] 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	Nursing Facility		1991	$ 465,019	1
2					2
3	TOTALS			$ 465,019	3

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			2017	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	2002 Additions			2002	110,177						20
21	2003 Additions			2003	8,545						21
22	2004 Additions			2004	16,868						22
23	2005 Additions			2005	74,461						23
24	2006 Additions			2006	31,729						24
25	2007 Additions			2007	18,646						25
26	2008 Additions			2008	69,524						26
27	2009 Additions			2009	251,464						27
28	2010 Additions			2010	77,536						28
29	2011 Additions			2011	280,209						29
30	2012 Additions			2012							30
31	2013 Additions			2013	130,260						31
32	2014 Additions			2014	153,922						32
33											33
34											34
35	Depreciation Expense					352,549		352,549			35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Completion of walk-in cooler, freezer and replacement of	2015	$ 79,684	$		$	$	$	37
38	refrigeration equipment project - started in 2014								38
39	Construction of equipment storage alcoves - east wing	2015	17,147						39
40	Installation of new interior signage for rooms and hallways	2015	8,999						40
41	Design services for bathroom remodeling scheduled for 2016	2015	13,873						41
42	Install new carpeting in (6) resident rooms	2015	13,440						42
43	Preparation for 10 room addition in 2016 - deisgn fees,	2015	219,371						43
44	soil testing and relocation of utilites								44
45	Installation of interior doors and windows	2015	11,443						45
46									46
47	Install AO Smith water heater	2016	9,321						47
48									48
49	Bathing rooms remodel - stripped all (4) rooms to bare wall	2017	236,310						49
50	and floor. Replaced all plumbing fixtures, created barrier free								50
51	showers and added new floor and wall tile.								51
52	lift capability added in two rooms.								52
53									53
54	No 2018 improvements	2018							54
55	No 2019 Improvements	2019							55
56									56
57	Replace condensing unit in Walk-In Cooler	2020	3,702						57
58	Replace siding and trim surrounding courtyard	2020	12,878						58
59	Converted 12 rooms in the wing adjacent to the Rehab Unit								59
60	from double rooms to private rooms. Work consisted of	2020	40,197						60
61	removal of all privacy drapes and associated ceiling metal,								61
62	moving lighting to meet private room needs, paint all rooms and								62
63	install new base board and chair rail moldings								63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,372,312	$ 352,549		$ 352,549	$	$	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: 1/1/2020 Ending: 12/31/2020

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	$ 65,044	$ 65,044	$		$	71
72	Current Year Purchases	4,121						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,615,811	$ 65,044	$ 65,044	$		$	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)	$ 11,499,799	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 422,259	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 422,259	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: 1/1/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 45,094 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 Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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: 1/1/2020 Ending: 12/31/2020

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	$		$ 256,527	$		$ 256,527	1
2	Licensed Speech and Language Development Therapist		hrs			87,475			87,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			283,167	0		283,167	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				212,258		212,258	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					67,240			67,240	13
14	TOTAL			$		$ 694,409	$ 212,258		$ 906,667	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 Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 1,019,548	$	1
2	Cash-Patient Deposits	4,951		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	118,092		3
4	Supply Inventory (priced at FIFO)	32,421		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,989		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(275,346)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 914,655	$	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	8,926,984		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,662,468		16
17	Accumulated Depreciation (book methods)	(6,333,283)		17
18	Deferred Charges	189,736		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): Investment in Risk Retention	15,716		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,873,623	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,788,278	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 655,048	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,951		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	288,258		30
31	Accrued Taxes Payable (excluding real estate taxes)	(827)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,545		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	8,710		36
37	Deferred Stimulus	299,485		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,271,170	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,063,006		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)**	$ 9,063,006	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,334,176	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,545,898)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,788,278	$	48

*(See instructions.)

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,757,996)	1
2	Restatements (describe):		2
3	Year end closing adjustments	12,420	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,745,576)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(800,322)	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)**	$ (800,322)	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)**	$ (3,545,898)	24 *

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 6,591,614	1
2	Discounts and Allowances for all Levels	(2,418,496)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,173,118	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,178,880	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,178,880	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	498,863	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	42,662	16
17	Sale of Drugs	404,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	54	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 946,550	23
	D. Non-Operating Revenue		
24	Contributions	26,348	24
25	Interest and Other Investment Income***	3,710	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,058	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)**	$ 7,328,606	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,239,970	31
32	Health Care	3,123,743	32
33	General Administration	2,093,531	33
	B. Capital Expense		
34	Ownership	1,044,515	34
	C. Ancillary Expense		
35	Special Cost Centers	627,169	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)***	$ 8,128,928	40
41	**Income before Income Taxes (line 30 minus line 40)****	(800,322)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (800,322)	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 Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	1,812	1,888	$ 82,460	$ 43.68	1
2	Assistant Director of Nursing	1,850	1,927	67,305	34.93	2
3	Registered Nurses	9,918	10,331	338,268	32.74	3
4	Licensed Practical Nurses	25,299	26,353	681,135	25.85	4
5	CNAs & Orderlies	68,529	71,384	1,203,977	16.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,911	4,074	88,937	21.83	8
9	Activity Director					9
10	Activity Assistants	4,178	4,352	58,407	13.42	10
11	Social Service Workers	4,137	4,309	90,424	20.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,340	18,062	285,125	15.79	15
16	Dishwashers					16
17	Maintenance Workers	3,934	4,098	105,794	25.82	17
18	Housekeepers	11,398	11,873	147,109	12.39	18
19	Laundry	4,770	4,969	67,717	13.63	19
20	Administrator	1,997	2,080	122,139	58.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,046	11,506	246,344	21.41	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)	170,119	177,206	$ 3,585,141 *	$ 20.23	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		$ 6,482	L1 C3	35
36	Medical Director		9,632	L9 C3	36
37	Medical Records Consultant		473	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,326	L10a C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,913		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		25,014	L10 C3	51
52	Certified Nurse Assistants/Aides		17,183	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 42,197		53

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sharon Herpstreith	Administrator		$ 122,139
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,139

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	Management	$ 334,239
KEB	Audit & Tax	11,182
VRI, Inc.	Facility consulting	66,596
Legal adj to Zero		20,896
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 432,913

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,929
Unemployment Compensation Insurance	29,915
FICA Taxes	274,263
Employee Health Insurance	252,957
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	94,699
TOTAL (agree to Schedule V, line 22, col.8)	$ 716,763

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,831
Health Care Worker Background Check	
(Indicate # of checks performed)	2,835
Patient Background Checks	
	19,053
	11,612
	3,894
Less: Public Relations Expense	(19,053)
Non-allowable advertising	(6,122)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,050

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,251
	0
Seminar Expense	719
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,970

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI; $6,542**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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 **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** 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. $ **193,557**
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. $ **598**

(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? **NA**
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 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	1,019,548						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	118,092						
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	14,989						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	32,421						
1310			SUPPLIES INVENTORY							
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	1,662,468						
1460			ACCUM DEPR-FURN & EQUIP	-1,340,233						
1475			BUILDING & IMPROVEMENTS	8,926,984						
1490			ACCUM DEPR-BUILDING	-4,993,050						
1530			RESIDENT FUNDS	4,951						
1550			LOAN FEES	189,736						
1560			REAL ESTATE TAX ESCROW							
1535			INVESTMENT IN TRINITY RISK	15,716						
1850			INTRACOMPANY	-275,346						
2010			ACCOUNTS PAYABLE	-655,048						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-184,026						
2110			ACCRUED VACATION PAY	-104,232						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	827	827					
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 - IBNR	0						
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	-15,545						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-8,710						
2350			REAL ESTATE TAX PAYABLE	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS							
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	-4,951						
2600			PPP LOAN	-8,729,986						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT	-333,020						
2696			DEFERRED STIMULUS	-299,485						
2710			COMMON STOCK							
2720			RETAINED EARNINGS	2,745,576						
2970			PROFIT/LOSS FOR PERIOD	800,322						
3007.1			PATIENT DAYS-PRIVATE	11,113						
3007.2			PATIENT DAYS-IPA	8,894						
3007.3			PATIENT DAYS-MEDICARE	4,065						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-6,578,200		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	-5,027		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	-404,971		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-2,178,880		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	133,716						
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	2,418,496		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3452		10	HHS STIMULUS REVENUE	-498,863		42	3	0	0	
3520		16	RENT INCOME	-42,662		6	0	6	-42,662	
3530		13	BEAUTY SHOP	0		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	-25		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-8,387		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0	
3600		21	MISC INCOME	-54		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	238,368	246,344	21	1	17	0	
4111			ADMINISTRATOR WAGES	122,139	122,139	17	1	0	0	
4115			VACATION & SICK - G&A	7,976		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	88,394	716,763	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	0	133,716	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	6,305		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	36,414	36,414	21	2	0	0	
4260			TELEPHONE	19,346	19,346	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	585	585	23	3	16	0 **	
4280			GENERAL TRAVEL	1,251	1,970	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285			EDUCATION & SEMINAR	719		24	3	19	0 ***	
4290			HELP WANTED ADVERTISING	1,831	214,747	20	3	0	0	-59,841
4291			PROMOTIONAL ADVERTISING	115,681		20	3	25	-115,681	
4292			PUBLIC RELATIONS	19,053		20	3	25	-19,053	
4300			LICENSES & FEES	63,735		20	3	17	-1,675	
4310			DUES & SUBSCRIPTIONS	11,612		20	3	17	-4,447	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	33,338	432,913	19	3	22	-20,896	
4355			MEDICAL DIRECTOR	9,632	9,632	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	473		10	3	0	0	
4363			PHARMACIST FEES	6,326		10	3	0	0	
4364			SOC SERV/ACT CONSULT	0	0	12	3	0	0	
4370			TV RENTAL	11,772		35	3	5	0	
4380			INCOME TAXES		12,913	27	3	26	0	
4383			BACKGROUND CHECKS	2,835		20	3	26	0	
4400			PAYROLL TAXES	290,594		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	13,584		22	3	0	0	
4410			GROUP INSURANCE	252,957		22	3	0	0	
4420			LIABILITY INSURANCE	155,681	155,681	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	64,929		22	3	0	0	
4450			CENTRAL OFFICE FEES	399,575		19	3	34	0 **	
4460			BAD DEBTS	6,388		27	3	24	-6,388	
4470			LOST ITEMS-RESIDENTS	275		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	33,322	45,094	35	3	16	0	
5110			MAINTENANCE SALARIES	99,991	105,794	6	1	0	0	
5120			MAINTENANCE SICK & VAC	5,803		6	1	0	0	
5130			ELECTRIC	56,540	169,615	5	3	0	0	
5131			NATURAL GAS	14,284		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	98,791		5	3	0	0	
5134			TRASH COLLECTION	9,274	123,716	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	7,843	55,772	6	2	0	0	
5160			GENERAL REPAIR & MAINT	47,929		6	2	0	0	
5165			MAINTENANCE CONTRACTS	114,442		6	3	0	0	
5210			DIETARY WAGES	274,349	285,125	1	1	0	0	
5220			DIETARY SICK & VAC	10,776		1	1	0	0	
5240			DIETARY CONSULTANT	6,482	6,482	2	3	13	0	
5248			FOOD PURCHASES	210,776	210,178	2	2	0	0	
5250			SUPPLIES-DISHWASHING	6,095	30,401	1	2	0	0	
5260			DIETARY REPLACEMENT	4,862		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	19,444		1	2	0	0	
5295			MEAL CREDIT	-598		2	2	0	0	
5310			LAUNDRY WAGES	66,587	67,717	4	1	0	0	
5340			LAUNDRY SICK & VAC	1,130		4	1	0	0	
5370			LAUNDRY REPLACEMENT	3,822	9,420	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	5,598		4	2	0	0	
5410			HOUSEKEEPING WAGES	142,370	147,109	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	4,739		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	28,641	28,641	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010			RN WAGES-MEDICARE		2,462,082	10	1	0	0	
6020			RN WAGES-NON MEDICARE	318,886		10	1	0	0	
6030			DON WAGES	82,460		10	1	0	0	
6035			ADON	67,305		10	1	0	0	
6040			RN SICK & VACATION	19,382		10	1	0	0	
6110			LPN WAGES-MEDICARE	662,588		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	18,547		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	1,170,969		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	33,008		10	1	0	0	
6245			CONTRACT NURSES-RN	0		10	3	0	0	
6246			CONTRACT NURSES-LPN	25,014		10	3	0	0	
6247			CONTRACT NURSES-AIDES	17,183		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	85,400		10	1	0	0	
6275			REHAB SICK & VAC	3,537		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	18,844	162,345	10	2	0	0	
6295			NURSING SUPPLIES	137,913		10	2	0	0	
6390			REPLACEMENT-NURSING	5,588		10	2	0	0	
6490			NURSING OTHER	506	49,502	10	3	0	0	
7280			DRUG PURCHASES	212,258	212,258	39	2	0	0 ***	
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	67,240	67,240	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	56,091	58,407	11	1	0	0	
7540			ACTIVITIES SICK & VAC	2,316		11	1	0	0	
7590			ACTIVITIES SUPPLIES	9,655	9,655	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	283,167	627,169	39	3	0	0 ***	
7660			PT SUPPLIES	0		39	2	0	0	
7710			SOCIAL SERVICE WAGES	85,251	90,424	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	5,173		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	2,198	2,198	12	2	0	0	
7740			OT FEE	256,527		39	3	0	0 ***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	87,475		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	562,437	577,162	32	3	14	0	
8130			DEPRECIATION	422,259	422,259	30	3	9	0	
8150			LOAN FEE AMORTIZATION	14,725		32	3	0	0	0
9510			INTEREST INCOME	-3,710		32	0	10	-3,710	
9520			MISC NON-OPERATING INCOM	-26,348		0	0	0	0	
9700			INCOME TAXES	6,250		0	0	0	-6,250	
				7,965,154	8,128,928					
					163,774					
GRAND TOTALS				800,297					-220,762	
				(NET INCOME)						
				0						
			FACILITY NAME:							
			FACILITY ID:	0						
			FACILITY UNITS:	162						
			BALANCE SHEET TOTAL	-1,412,002						

1,009	1,009	CASH	1,019,548
1,100	1,100	ACCTS RE	418,092
1,101	1,101	ALLOW. F	(300,000)
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	12,150
1,220	1,220	OTHER PI	2,839
1,300	1,300	DIETARY I	32,421
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	1,412,002
1,450	1,450	FURNITUF	1,662,468
1,460			(1,340,233)
1,475	1,475	BUILDING	8,926,984
1,490	1,490	ACCUM DI	(4,993,050)
1,530	1,530	RESIDENT	4,951
1,550	1,550	LOAN FEE	189,736
1,535	1,535	INVESTME	15,716
1,850	1,850	INTERCO	(275,346)
2,010	2,010	ACCOUNT	(655,048)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED	(184,026)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED	(104,232)
2,120	2,120	U.C. TAXE	0
2,125	2,125	FICA TAXE	0
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 IN	0
2,246	2,250	401K W/H	(1,314)
2,250			
2,260	2,260	WAGE GA	2,141
2,300	2,300	ACCRUED	(15,545)
2,320	2,320	IPA PAYM	(8,710)
2,350	2,350	REAL EST	0
2,385		DEFERRE	(299,485)
2,400	2,400	CURRENT	(333,020)
2,512	2,512	DUE TO R	(4,951)
2,600	2,600	LOC	(8,729,986)
2,600		PPP LOAN	0
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINED	2,745,576
		net income	800,322
		balance	0

3,007	3,007	PATIENT D	11,113
3,007	3,007	PATIENT D	8,894
3,007	3,007	PATIENT D	4,065
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CH	(6,578,200)
3,020	3,020	BASIC CH	0
3,030	3,030	BASIC CH	0
3,040		ASSESSM	133,716
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING	(5,027)
3,081	3,081	NURSING	0
3,082	3,082	NURSING	0
3,083	3,083	NURSING	0
3,100	3,100	DRUGS-M	(404,971)
3,101			0
3,110	3,110	PHYSICAL	(2,178,880)
3,111			0
3,112	3,112	PHYSICAL	0
3,113	3,113	PHYSICAL	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT TH	0
3,153	3,153	ST/OT TH	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHE	0
3,411	3,411	MEDICARI	0
3,420	3,420	MEDICARI	2,399,153
3,452	3,452	HHS STIM	(498,863)
3,520	3,520	RENT INC	(42,662)
3,530	3,530	BEAUTY S	0
3,560			(25)
3,570	3,570	VENDING	0
3,590	3,590	EQUIPME	(8,387)
3,595	3,595	RESIDENT	0
3,600	3,600	MISC INC	(29)
4,110	4,110	G&A WAG	238,368
4,111	4,111	ADMINIST	122,139
4,115	4,115	G&A PTO	7,976
4,120	4,120	EMPLOYE	93,750
4,121			0
4,130	4,130	EMPLOYE	0
4,135	4,135	EMPLOYE	6,305
4,250	4,250	OFFICE S	14,551
4,255	4,255	POSTAGE	7,193
4,260	4,260	TELEPHO	19,346
4,275	4,275	TRAINING	585
4,276			0
4,280	4,280	GENERAL	1,251
4,281	4,281	MEAL EXF	0
4,285	4,285	EDUCATIC	539
4,289	4,289	MEETINGS	180
4,290	4,290	HELP WAI	1,831
4,291	4,291	PROMOTI	115,681
4,292	4,292	PUBLIC R	19,053
4,300	4,300	LICENSE	63,735
4,310	4,310	DUES & S	11,612
4,320	4,320	CONTRIBI	0
4,350	4,350	PROFESS	33,338
4,355	4,355	MEDICAL	9,632
4,362			473
4,363			6,326
4,364	4,364	SOCIAL S	0
4,370	4,370	TV RENTA	11,772
4,383	4,383	BACKGRC	2,835
4,390	4,390	OTHER TA	6,250
4,400	4,400	PAYROLL	290,594
4,401	4,401	PAYROLL	13,584
4,410	4,410	GROUP IN	252,957
4,420	4,420	LIABILITY	155,681
4,430	4,430	WORKMA	63,783
4,435	4,435	W/C-FIRS	156
4,436	4,436	DRUG TES	990
4,450	4,450	MANAGEM	399,575
4,460	4,460	BAD DEBT	6,388
4,461	4,461	BAD DEBT	19,343
4,470	4,470	LOST ITEI	275
4,475	4,475	UNIFORM	(5,356)
4,486	4,486	SERVICE	67,561
4,490	4,490	MISC EXP	87
4,496	4,496	MISC. M.I.S	14,670
4,510	4,510	REAL EST	0
4,600	4,600	LEASED E	33,322
5,110	5,110	MAINTENA	99,991
5,120	5,120	MAINTENA	5,803
5,130	5,130	ELECTRIC	56,540
5,131	5,131	NATURAL	14,284
5,133	5,133	WATER &	98,791
5,134	5,134	TRASH CO	9,274
5,140	5,140	PROP/PLA	7,843
5,160	5,160	GENERAL	47,929
5,165	5,165	MAINTENA	46,881
5,210	5,210	DIETARY	274,349
5,220	5,220	DIETARY	10,776
5,248	5,248	FOOD PU	210,689
5,250	5,250	SUPPLIES	6,095
5,260	5,260	REPLACE	4,862
5,270	5,270	KITCHEN	19,444
5,295	5,295	MEAL INC	(598)
5,310	5,310	LAUNDRY	66,587
5,340	5,340	LAUNDRY	1,130
5,370	5,370	REPLACE	3,822
5,230	5,230	DIETARY	6,482
5,390	5,390	LAUNDRY	5,598
5,410	5,410	HOUSEKE	142,370
5,440	5,440	HOUSEKE	4,739
5,480	5,480	SUPPLIES	28,641
5,490	5,490	SUPPLIES	0
6,020	6,020	RN WAGE	318,886
6,030	6,030	DON WAG	82,460
6,035	6,035	ADON WA	67,305
6,040	6,040	RN PTO &	19,382
6,120	6,120	LPN WAG	662,588
6,140	6,140	LPN PTO	18,547
6,220	6,220	AIDES WA	1,170,969
6,240	6,240	AIDES PT	33,008
6,245		RN CONT	0
6,246		LPN CONT	25,014
6,247		AIDES CO	17,183
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB W	85,400
6,275	6,275	REHAB PT	3,537
6,290	6,290	NURSING	18,844
6,295	6,295	NURSING	137,913
6,390	6,390	REPLACE	5,588
6,490	6,490	OTHER	506
7,280	7,280	DRUG PU	212,258
7,281	7,281	DRUG PU	0
7,380	7,380	LABORAT	13,752
7,391	7,390	X-RAY SE	53,470
7,393			18
7,510	7,510	ACTIVITIE	56,091
7,540	7,540	ACTIVITIE	2,316
7,590	7,590	ACTIVITIE	9,655
7,620	7,620	PHYSICAL	283,167
7,660	7,660	P.T. SUPF	0
7,710	7,710	SOCIAL S	85,251
7,720	7,720	SOCIAL S	5,173
7,730	7,730	SOCIAL S	2,198
7,740	7,740	OCCUPAT	256,527
7,750			
7,770	7,770	SPEECH	87,475
7,820	7,820	BEAUTICI	0
7,890			0
7,960			0
8,120	8,120	INTEREST	346,413
8,125			216,024
8,130	8,130	DEPRECI	422,259
8,150			14,725
9,510	9,510	INTEREST	(3,710)
9,520	9,520	MISC NON	(26,348)
9,530	4,220		0
	8,100		0
	9,702		0
	5,230		0
			800,322

Expenses Fixed Assets

0

Villa Health Care East
2020 Cost Report
Supplemental Schedules
Reclassification Entries

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

Line Item		
Purchased Drugs and Medications	$	212,258
Purchased Hospital Services		46,852
Purchased Laboratory Services		13,752
Purchased Radiology Services		6,636
Amount Reclassified to Line 39	$	279,498

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

Line Item		
Provider Participation Fee - $1.50	$	(59,841)
Provider Assesment Fee - $6.07		(133,716)
	$	(193,557)
Provider Participation Fee	$	193,557

1. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Expense

Line Item		
Pharmacy Consultant	$	6,326