

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 Parkway, PO Box 109 Sherman 62684
Number City Zip Code

County: Sangamon

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

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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) Craig Ater

(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) _____ Fax # () _____

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

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

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,302</u>	<u>11,950</u>	<u>6,820</u>	<u>34,072</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,302</u>	<u>11,950</u>	<u>6,820</u>	<u>34,072</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.03%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

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

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

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

Date started 1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 6,820Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: _____ Fiscal Year: _____

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	245,353	15,963		261,316		261,316		261,316			1
2	Food Purchase		219,566		219,566		219,566		219,566			2
3	Housekeeping		161,864		161,864		161,864		161,864			3
4	Laundry		108,291		108,291		108,291		108,291			4
5	Heat and Other Utilities			162,100	162,100		162,100		162,100			5
6	Maintenance	120,288	67,749	36,373	224,410		224,410		224,410			6
7	Other (specify):*											7
8	TOTAL General Services	365,641	573,433	198,473	1,137,547		1,137,547		1,137,547			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	2,093,222	263,333	21,762	2,378,317		2,378,317		2,378,317			10
10a	Therapy		249,883	956,080	1,205,963	(339,186)	866,777		866,777			10a
11	Activities	78,268	17,882		96,150		96,150		96,150			11
12	Social Services	113,846	10,694	1,397	125,937		125,937		125,937			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,285,336	541,792	983,239	3,810,367	(339,186)	3,471,181		3,471,181			16
	C. General Administration											
17	Administrative	99,209			99,209		99,209		99,209			17
18	Directors Fees											18
19	Professional Services			556,781	556,781		556,781	(1,677)	555,104			19
20	Dues, Fees, Subscriptions & Promotions			93,016	93,016	(54,351)	38,665	(20,569)	18,096			20
21	Clerical & General Office Expenses	189,037	37,561	15,669	242,267		242,267		242,267			21
22	Employee Benefits & Payroll Taxes			455,287	455,287		455,287		455,287			22
23	Inservice Training & Education			6,029	6,029		6,029	(4,030)	1,999			23
24	Travel and Seminar			16,138	16,138		16,138	(14,139)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,440	110,440		110,440		110,440			26
27	Other (specify):*			63,997	63,997		63,997	(61,916)	2,081			27
28	TOTAL General Administration	288,246	37,561	1,317,357	1,643,164	(54,351)	1,588,813	(102,331)	1,486,482			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,939,223	1,152,786	2,499,069	6,591,078	(393,537)	6,197,541	(102,331)	6,095,210			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			243,994	243,994		243,994		243,994			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			330,256	330,256		330,256	(11,566)	318,690			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,546	6,546		6,546		6,546			35
36	Other (specify):*											36
37	TOTAL Ownership			580,796	580,796		580,796	(11,566)	569,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					339,186	339,186		339,186			39
40	Barber and Beauty Shops			1,050	1,050		1,050		1,050			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,351	54,351		54,351			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,050	1,050	393,537	394,587		394,587			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,939,223	1,152,786	3,080,915	7,172,924		7,172,924	(113,897)	7,059,027			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,566)			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)	(4,030)			16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(14,139)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,677)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,916)			24
25	Fund Raising, Advertising and Promotional	(20,569)			25
	Income Taxes and Illinois Personal				
26	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)	\$ (113,897)		\$	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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (113,897)		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	2	3	4	
		Yes	No	Amount	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: 01/01/12

Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,677)	19	22
23				23
24		(61,916)	27	24
25		(20,569)	20	25
26				26
27				27
28				28
29			33	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	(84,162)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,677)	0	0	0	0	0	0	0	0	0	0	(1,677)	19
20	Fees, Subscriptions & Promotions	(20,569)	0	0	0	0	0	0	0	0	0	0	(20,569)	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	(4,030)	0	0	0	0	0	0	0	0	0	0	(4,030)	23
24	Travel and Seminar	(14,139)	0	0	0	0	0	0	0	0	0	0	(14,139)	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):*	(61,916)	0	0	0	0	0	0	0	0	0	0	(61,916)	27
28	TOTAL General Administration	(102,331)	0	0	0	0	0	0	0	0	0	0	(102,331)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(102,331)	0	0	0	0	0	0	0	0	0	0	(102,331)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	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	(11,566)	0	0	0	0	0	0	0	0	0	0	(11,566)	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	(11,566)	0	0	0	0	0	0	0	0	0	0	(11,566)	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)	(113,897)	0	0	0	0	0	0	0	0	0	0	(113,897)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
none						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	attached								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Cambridge Capital Realty		x	mortgage			\$	6,199,659			\$	330,256	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	6,199,659			\$	330,256	9
	B. Non-Facility Related*												
10	Interest Income										(11,566)	10	
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(11,566)	14
15	TOTALS (line 9+line14)						\$	6,199,659			\$	318,690	15

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 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 2011 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 2011.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,368

B. General Construction Type: Exterior brick Frame block

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 465,019	1
2					2
3	TOTALS			\$ 465,019	3

XI. OWNERSHIP COSTS (continued)

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

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

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									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,231,436	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,051,016	\$243,994	\$243,994	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,051,016	\$243,994	\$243,994	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,747,471	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$243,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$243,994	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$6,546 Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 304,911	\$		\$ 304,911	1
2	Licensed Speech and Language Development Therapist		hrs			225,364			225,364	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			332,129	4,373		336,502	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				245,510		245,510	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					93,676			93,676	13
14	TOTAL			\$		\$ 956,080	\$ 249,883		\$ 1,205,963	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,282,498	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,259,788		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,293		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,698,579	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	886,303		13
14	Buildings, at Historical Cost	4,004,690		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,118,318		16
17	Accumulated Depreciation (book methods)	(3,584,910)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Fees</u>	130,729		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,555,130	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,253,709	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 311,892	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,029		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	305,690		30
31	Accrued Taxes Payable (excluding real estate taxes)	(31,470)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	24,529		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Assessment Tax</u>	124,399		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 744,069	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,199,659		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,199,659	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,943,728	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,690,019)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,253,709	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,759,389)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,759,389)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	69,370	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)	\$ 69,370	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)	\$ (1,690,019)	24 *

* This must agree with page 17, line 47.

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

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

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,903,815	1
2	Discounts and Allowances for all Levels	(2,362,737)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,541,078	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,171,011	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,171,011	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,065	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	517,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 518,639	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,566	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,566	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)	\$ 7,242,294	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,137,547	31
32	Health Care	3,810,367	32
33	General Administration	1,643,164	33
	B. Capital Expense		
34	Ownership	580,796	34
	C. Ancillary Expense		
35	Special Cost Centers	1,050	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)*	\$ 7,172,924	40
41	Income before Income Taxes (line 30 minus line 40)**	69,370	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 69,370	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,900	2,080	\$ 70,000	\$ 33.65	1
2	Assistant Director of Nursing	1,050	1,125	35,808	31.83	2
3	Registered Nurses	10,200	11,000	264,542	24.05	3
4	Licensed Practical Nurses	30,500	32,000	630,454	19.70	4
5	CNAs & Orderlies	95,000	98,000	1,073,238	10.95	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,000	1,000	19,180	19.18	8
9	Activity Director					9
10	Activity Assistants	8,000	9,200	78,268	8.51	10
11	Social Service Workers	10,000	10,800	113,846	10.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,500	24,750	245,353	9.91	15
16	Dishwashers					16
17	Maintenance Workers	9,000	9,500	120,288	12.66	17
18	Housekeepers			0		18
19	Laundry			0		19
20	Administrator	1,900	2,080	99,209	47.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,500	9,500	189,037	19.90	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)	200,550	211,035	\$ 2,939,223 *	\$ 13.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		4,000		36
37	Medical Records Consultant		940		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,754		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		1,397		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 11,091		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/12

Page 21

Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Frank Shepke			\$ 99,209	Workers' Compensation Insurance	\$	103,716	IDPH License Fee	\$ 0
				Unemployment Compensation Insurance		31,588	Advertising: Employee Recruitment	9,746
				FICA Taxes		224,851	Health Care Worker Background Check	
				Employee Health Insurance		92,585	(Indicate # of checks performed)	1,099
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
						0		6,000
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		2,547	Dues & Subscriptions	6,890
(List each licensed administrator separately.)			\$ 99,209	Central Office Allocation			License & Fees	361
B. Administrative - Other							Central Office Allocation	
Description			Amount				Less: Public Relations Expense	(6,000)
			\$				Non-allowable advertising	(0)
							Yellow page advertising	()
							TOTAL (agree to Sch. V, line 20, col. 8)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$	455,287	\$ 18,096	
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgt		\$ 150,980				Out-of-State Travel	\$
Tutera	Mgt		254,592					
Villa Retirement	Mgt		149,532				In-State Travel	
								10,456
								185
							Seminar Expense	5,497
								(14,139)
Legal adj to Zero			1,677				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 556,781				TOTAL	\$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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

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

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.

Illinois Health Care Association

(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 years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

5,000

Line

10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

x

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

54,351

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?

yes

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.

\$

4,418

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

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.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

no

Firm Name:

(18)

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

yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

yes

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	1,282,498				1,009		1,009	PETTY C 1,282,498
1010	CASH IN BANK					1,100		1,100	ACCTS R 1,259,788
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	1,259,788				1,110		1,110	ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125		1,125	ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135		1,135	ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140		1,140	UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145		1,145	A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200		1,200	PREPAID 156,293
1145	A/R SUSPENSE-REFUNDS					1,220		1,220	OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300		1,300	DIETARY INVENTORY
1200	PREPAID INSURANCE	156,293				1,310		1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY
1300	FOOD INVENTORY					1,409		1,409	LAND 886,303
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU 1,118,318
1409	LAND	886,303				1,460			(862,582)
1450	FURNITURE & EQUIPMENT	1,118,318				1,475		1,475	CODE AI 4,004,690
1460	ACCUM DEPR-FURN & EQU	-862,582				1,490		1,490	ACCUM I (2,722,328)
1475	BUILDING & IMPROVEMEN	4,004,690				1,530		1,530	RESIDEN 0
1490	ACCUM DEPR-BUILDING	-2,722,328				1,550		1,550	LOAN FE 130,729
1530	RESIDENT FUNDS	0				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	130,729				1,850		1,850	INTERCC 0
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN (311,892)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	0				2,100		2,100	ACCRUE (224,186)
2010	ACCOUNTS PAYABLE	-311,892				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-224,186				2,110		2,110	ACCRUE (81,504)
2110	ACCRUED VACATION PAY	-81,504				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	31,470
2125	FICA TAX PAYABLE	31,470	31,470	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	(24,529)
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(124,399)
2300	ACCRUED INTEREST PAYA	-24,529		2,350	2,350 REAL ES	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-124,399		2,400	2,400 CURRENT PORTION OF LT DI	
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(9,029)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(6,199,659)
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DI	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINI	1,759,389
2460	INCOME TAXES PAYABLE				net incom	(69,370)
2512	DUE TO RESIDENTS	-9,029				
2600	MORTGAGE PAYABLE	-6,199,659				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	1,759,389				
2970	PROFIT/LOSS FOR PERIOD	-69,370				
3007.1	PATIENT DAYS-PRIVATE	11,950				3,007

3007.2	PATIENT DAYS-IPA	15,302						3,007
3007.3	PATIENT DAYS-MEDICARE	6,820						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-6,837,751	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-52,410	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-517,574	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,171,011	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,362,737	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	0		6	0	6	0	3,530
3530	13 BEAUTY SHOP	0		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-1,065		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-13,654		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	175,492	189,037	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	99,209	99,209	17	1	0	0	4,120
4115	VACATION & SICK - G&A	13,545		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	2,547	455,287	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	0		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	37,561	37,561	21	2	0	0	4,275
4260	TELEPHONE	15,669	15,669	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	6,029	6,029	23	3	16	-4,030 **	4,280
4280	GENERAL TRAVEL	10,456	16,138	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	185		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	5,497		24	3	19	-14,139 ***	4,289
4290	HELP WANTED ADVERTISING	9,746	93,016	20	3	0	0 -54,351	4,290
4291	PROMOTIONAL ADVERTISING	14,569		20	3	25	-14,569	4,291
4292	PUBLIC RELATIONS	6,000		20	3	25	-6,000	4,292
4300	LICENSES & FEES	54,712		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	6,890		20	3	17	0	4,310
4320	CONTRIBUTIONS	0		27	3	20	0	4,320
4350	PROFESSIONAL FEES	61,704	556,781	19	3	22	-1,677	4,350
4355	MEDICAL DIRECTOR	4,000	4,000	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSULT	940		10	3	0	0	4,364
4363	PHARMACIST FEES	4,754		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	1,397	1,397	12	3	0	0	4,383
4370	TV RENTAL	2,877		35	3	5	0	4,390
4380	INCOME TAXES		63,997	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,099		20	3	26	0	4,401
4400	PAYROLL TAXES	253,822		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	2,617		22	3	0	0	4,420
4410	GROUP INSURANCE	92,585		22	3	0	0	4,430
4420	LIABILITY INSURANCE	110,440	110,440	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	103,716		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	495,077		19	3	34	0 **	4,460
4460	BAD DEBTS	61,916		27	3	24	-61,916	4,461
4470	LOST ITEMS-RESIDENTS	2,081		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	3,669	6,546	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	113,897	120,288	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	6,391		6	1	0	0	4,510
5130	ELECTRIC	54,274	162,100	5	3	0	0	4,600
5131	NATURAL GAS	14,688		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	93,138		5	3	0	0	5,130
5134	TRASH COLLECTION	5,745	36,373	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	21,040	67,749	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	46,709		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	30,628		6	3	0	0	5,140
5210	DIETARY WAGES	234,570	245,353	1	1	0	0	5,160
5220	DIETARY SICK & VAC	10,783		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	223,984	219,566	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	753	15,963	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	6,170		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,040		1	2	0	0	5,260
5295	MEAL CREDIT	-4,418		2	2	0	0	5,270
5310	LAUNDRY WAGES	0	0	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	0		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	0	108,291	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	108,291		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	0	0	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	0		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	0	161,864	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	161,864		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,093,222	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	251,793		10	1	0	0	6,020
6030	DON WAGES	70,000		10	1	0	0	6,030
6035	ADON	35,808		10	1	0	0	6,035
6040	RN SICK & VACATION	12,749		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	625,130		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	5,324		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	996,485		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	76,753		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	18,567		10	1	0	0	6,390
6275	REHAB SICK & VAC	613		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	116,683	263,333	10	2	0	0	7,281
6295	NURSING SUPPLIES	126,340		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	20,310		10	2	0	0	7,391
6490	NURSING OTHER	16,068	21,762	10	3	0	0	7,393
7280	DRUG PURCHASES	241,056	249,883	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	4,454		39	2			7,540
7380	LABORATORY SERVICES	93,676	956,080	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	74,490	78,268	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	3,778		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	17,882	17,882	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	332,129		39	3	0	0 ***	7,890
7660	PT SUPPLIES	4,373		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	107,905	113,846	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	5,941		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	10,694	10,694	12	2	0	0	8,130
7740	OT FEE	304,911		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	225,364		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	1,050	1,050	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	328,599	330,256	32	3	14	-11,566	
8130	DEPRECIATION	243,994	243,994	30	3	9	0	
8150	LOAN FEE AMORTIZATION	1,657		32	3	0	0	60,773
9510	INTEREST INCOME	-11,566		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		7,161,358	7,172,924					
			11,566					

GRAND TOTALS

-69,370

(NET INCOME)

-113,897

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	11,950	11,950
IPA	15,302	15,302
medicare	6,820	6,820
		34,072
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 11,950

3,007 PATIENT	15,302
3,007 PATIENT	6,820
	0

3,010 BASIC CI	(6,837,751)
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3,020 BASIC CI	0
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3,030 BASIC CI	0
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	0
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3,080 NURSING	(52,410)
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3,081 NURSING	0
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3,082 NURSING	0
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3,083 NURSING	0
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3,100 DRUGS-M	(517,574)
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	0
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3,110 PHYSICAL	(2,171,011)
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	0
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3,112 PHYSICAL	0
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3,113 PHYSICAL	0
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3,140 LABORATORY INCOME	
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	0
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3,152 ST/OT TR	0
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3,153 ST/OT TR	0
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3,185 REHAB/ISOLATION/OTHER CHG	
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3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	2,290,078
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3,520 RENT IN	0
3,530 BEAUTY	0
	0
3,570 VENDING	(1,065)
3,590 EQUIPM	(13,654)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	175,492
4,111 ADMINIS	99,209
4,115 G&A PTC	13,545
4,120 EMPLOY	3,429
	0
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	21,192
4,255 POSTAGI	14,170
4,260 TELEPHC	15,669
4,275 TRAININ	6,029
	0
4,280 GENERA	10,456
4,281 MEAL EX	185
4,285 EDUCAT	5,497
4,289 MEETING	0
4,290 HELP WA	9,746
4,291 PROMOT	14,569
4,292 PUBLIC I	6,000
4,300 LICENSE	54,712
4,310 DUES & F	6,890
4,320 CONTRIB	0
4,350 PROFESS	61,704
4,355 MEDICAL	4,000
	940
	4,754

4,364 SOCIAL S	1,397
4,370 TV RENT	2,877
4,383 BACKGR	1,099
4,390 OTHER T	0
4,400 PAYROL	253,822
4,401 PAYROL	2,617
4,410 GROUP I	92,585
4,420 LIABILIT	110,440
4,430 WORKM	103,676
4,435 W/C-FIRS	40
4,436 DRUG TE	0
4,450 MANAGI	495,077
4,460 BAD DEF	61,916
4,461 BAD DEF	72,659
4,470 LOST ITE	2,081
4,475 UNIFORM	(882)
4,486 SERVICE	8,921
4,490 MISC EX	2,400
4,496 MISC. M.	2,199
4,510 REAL ES	0
4,600 LEASED	3,669
5,110 MAINTEN	113,897
5,120 MAINTEN	6,391
5,130 ELECTRI	54,274
5,131 NATURA	14,688
5,133 WATER &	93,138
5,134 TRASH C	5,745
5,140 PROP/PL	21,040
5,160 GENERA	46,709
5,165 MAINTEN	21,707
5,210 DIETARY	234,570
5,220 DIETARY	10,783
5,248 FOOD PU	221,584

5,250 SUPPLIES	753
5,260 REPLACEMENTS	6,170
5,270 KITCHEN	9,040
5,295 MEAL IN	(4,418)
5,310 LAUNDRY	0
5,340 LAUNDRY	0
5,370 REPLACEMENTS	0
	0
5,390 SUPPLIES	108,291
5,410 HOUSEKEEPING	0
5,440 HOUSEKEEPING	0
5,480 SUPPLIES	0
5,490 SUPPLIES	161,864
6,020 RN WAGES	251,793
6,030 DONOR WAGES	70,000
6,035 ADONOR WAGES	35,808
6,040 RN PTO & OVERTIME	12,749
6,120 LPN WAGES	625,130
6,140 LPN PTO	5,324
6,220 AIDES WAGES	996,485
6,240 AIDES PTO	76,753
	0
	0
	0
6,270 REHAB V	18,567
6,275 REHAB P	613
6,290 NURSING	116,683
6,295 NURSING	126,340
6,390 REPLACEMENTS	20,310
6,490 OTHER	16,068

7,280 DRUG PU	241,056
7,281 DRUG PU	4,454
7,380 LABORA	19,761
7,390 X-RAY S	17,713
	56,202
7,510 ACTIVIT	74,490
7,540 ACTIVIT	3,778
7,590 ACTIVIT	17,882
7,620 PHYSICA	332,129
7,660 P.T. SUP	4,373
7,710 SOCIAL S	107,905
7,720 SOCIAL S	5,941
7,730 SOCIAL S	10,694
7,740 OCCUPA	304,911
7,770 SPEECH '	225,364
7,820 BEAUTIC	1,050
	0
	0
8,120 INTERES	328,599
	0
8,130 DEPRECI	243,994
	1,657
9,510 INTERES	(11,566)
9,520 MISC NO	0
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(69,370)</u>

Expenses Fixed Assets

