

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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 Pkw Bx109 Sherman 62684

NumberCityZip Code

County: Sangamon

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

HFS ID Number:

Date of Initial License for Current Owners: 1991

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL
☒ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code 501 C 3	☐ Corporation	☐ Other
	☐ "Sub-S" Corp.	
	☐ Limited Liability Co.	
	☐ Trust	
	☐ Other	

In the event there are further questions about this report, please contact:

Name: Daniel CurryTelephone Number: 309-823-7164Email 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 01/01/2025 to 12/31/2025 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)
	(Type or Print Name) Daniel Curry
	(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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	7,259	5,466	2,802	25	12,071	3,479	2,458	33,560	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,259	5,466	2,802	25	12,071	3,479	2,458	33,560	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 84.35%

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 ☒

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 1991

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date Built New in 1991 NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 109

Medicare Intermediary WPS

IV. ACCOUNTING BASIS
ACCRUAL ☒ 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.

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	351,005	30,745	10,339	392,089		392,089		392,089			1
2	Food Purchase		305,251		305,251		305,251		305,251			2
3	Housekeeping	263,922	35,099		299,021		299,021		299,021			3
4	Laundry	88,362	28,696		117,058		117,058		117,058			4
5	Heat and Other Utilities			234,405	234,405		234,405		234,405			5
6	Maintenance	151,554	74,411	11,869	237,834		237,834		237,834			6
7	Other (specify):*											7
8	TOTAL General Services	854,843	474,202	256,613	1,585,658		1,585,658		1,585,658			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	3,238,596	148,418	1,296,890	4,683,904	(7,903)	4,676,001		4,676,001			10
10a	Therapy		318,678	38,659	357,337	(349,434)	7,903		7,903			10a
11	Activities	91,614	9,442		101,056		101,056		101,056			11
12	Social Services	106,358		4,165	110,523		110,523		110,523			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,436,568	476,538	1,349,314	5,262,420	(357,337)	4,905,083		4,905,083			16
	C. General Administration											
17	Administrative	127,925			127,925		127,925		127,925			17
18	Directors Fees											18
19	Professional Services			803,813	803,813		803,813	(118,757)	685,056			19
20	Dues, Fees, Subscriptions & Promotions			594,153	594,153	(512,141)	82,012	(56,972)	25,040			20
21	Clerical & General Office Expenses	325,835	32,985	155,608	514,428		514,428		514,428			21
22	Employee Benefits & Payroll Taxes			895,345	895,345		895,345		895,345			22
23	Inservice Training & Education			77	77		77		77			23
24	Travel and Seminar			6,909	6,909		6,909	(1,910)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			198,360	198,360		198,360		198,360			26
27	Other (specify):* Lost Resident Items			68,626	68,626		68,626	(68,500)	126			27
28	TOTAL General Administration	453,760	32,985	2,722,891	3,209,636	(512,141)	2,697,495	(246,139)	2,451,356			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,745,171	983,725	4,328,818	10,057,714	(869,478)	9,188,236	(246,139)	8,942,097			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			293,969	293,969		293,969		293,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			358,987	358,987		358,987	(8,357)	350,630			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,989	38,989		38,989		38,989			35
36	Other (specify):*											36
37	TOTAL Ownership			691,945	691,945		691,945	(8,357)	683,588			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			825,108	825,108	357,337	1,182,445		1,182,445			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					512,141	512,141		512,141			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			825,108	825,108	869,478	1,694,586		1,694,586			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,745,171	983,725	5,845,871	11,574,767		11,574,767	(254,496)	11,320,271			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,357)			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	(11,802)			17
18	Fines and Penalties	(32,500)			18
19	Entertainment	(1,910)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(118,757)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)			24
25	Fund Raising, Advertising and Promotional	(45,170)			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)	\$ (254,496)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (254,496)		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	xx		13,631	10a	42
43	Prescription Drugs	xx		318,678	10a	43
44	Hospital Services	xx		25,028	10a	44
45	Other-Attach Schedule				10a	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 357,337		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (10,519)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(36,000)	27	11
12		(8,357)	32	12
13		(32,500)	27	13
14		(34,651)	20	14
15		(11,802)	20	15
16		0	35	16
17		(1,910)	24	17
18		(118,757)	19	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	(254,496)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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)	
Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	(8,357)	0	0	0	0	0	0	0	0	0	0	(8,357)	32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
TOTAL Ownership	(8,357)	0	0	0	0	0	0	0	0	0	0	(8,357)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(254,496)	0	0	0	0	0	0	0	0	0	0	(254,496)	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
Villa Health Care Inc	100	None		Villa Healthcare West	Sherman IL	Sheltered care
(Not for Profit Organization)				Villa Vianney	Sherman IL	Ind Living Apts.
(Board Member list attached)						

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.

STATE OF ILLINOIS				Ownership Listing-1			
Villa Health Care East							
ID#		0037028					
Report Period Beginning:		01/01/2025		Heritage Operations Gr			
Ending:		12/31/2025		Villa Health Care Inc.			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)						Management	
-Owners of companies must be listed instead of company names.				Operator/Licensee		Building Co.	Co./Home Office
-Names of trust beneficiaries must be listed.						Ownership	Ownership
First Name	M.I.	Last Name	Place of Residence	City	State	Ownership Percentage	Ownership Percentage
1							1
2		Villa Health Care Inc. - an Illinois Not for Profit	Sherman	IL		100.00000	100.00000
3		Company					3
4							4
5							5
6	Craig	Hart Trust	Hudson	IL			28.42000
7	Joseph	Warner Trust	Bloomington	IL			4.00000
8	Linda	Hagi Trust	Bloomington	IL			2.41000
9	Janice	Hart Trust	Streator	IL			2.41000
10	Timothy	Jefferson	Champaign	IL			16.10000
11	Paul	Jefferson	Bloomington	IL			16.10000
12	Robert	Dickson Family Trust	Naples	IL			1.28000
13	Cheryl	Lowney	Lincoln	IL			0.77000
14	Steven	Wannemacher	Bloomington	IL			1.85000
15	Bruce	Hart	Phoenix	IL			7.30700
16	Brian	Hart	Lake Forest	IL			7.30700
17	Benjamin	Hart Trust	Bloomington	IL			7.30700
18	Jerry	Westwood Trust	Naples	IL			1.60000
19	Van	Freiderich	Congerville	IL			0.70000
20	Todd	Hart Trust	Bloomington	IL			0.69000
21	Allan	Hart	Morton	IL			0.69000
22	Connie	Hoselton	Lexington	IL			0.34000
23	David	Fehrenbacher	Lincoln	IL			0.08000
24	David	Wegman	Normal	IL			0.08000
25	David	Hoeper	Fishers	IL			0.05000
26	David	Underwood	Peoria	IL			0.08000
27	Jane	Hart Trust	Hudson	IL			0.43000
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
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64							64
65							65
66							66
67							67
68							68
69							69
70							70
71							71
72							72
73							73
74							74
75							75

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	Note - Board Members are not compensated by								\$		1
2	Villa Care East 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: 01/01/2025 Ending: 2/31/2025

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	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	Heartland Bank		xx	Initial Mortgage			\$	3,177,416			\$	286,728	1
2	Heartland Bank		xx	2017 Addition				3,717,797					2
3	Heartland Bank		xx	Interest Rate Swap				(78,965)				72,259	3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	6,816,248			\$	358,987	9
	B. Non-Facility Related*												
10	Interest Income											(8,357)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(8,357)	14
15	TOTALS (line 9+line14)						\$	6,816,248			\$	350,630	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.)

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 2024 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 2025 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
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 13					
Not for profit entity operating under exemption from paying real estate taxes					
				14	FOR BHF USE ONLY
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

FACILITY NAME	Villa Health Care East	COUNTY	Sangamon
---------------	------------------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

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. List the bed capacity for the building if it differs from the licensed total. Same
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Nursing Facility		1991	\$ 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			1991	\$ 2,181,687	\$		\$	\$	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 - None			2012						30
31	2013 Additions			2013	130,260					31
32	2014 Additions			2014	153,922					32
33	2015 Additions			2015	363,957					33
34										34
35	Depreciation Expense					233,578		233,578		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:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2016 Additions	2016	\$ 9,321	\$		\$	\$	\$	37
38	2017 Additions	2017	236,310						38
39	2018 Additions - None	2018							39
40	2019 Additions - None	2019							40
41									41
42	Replace condensing unit in Walk-In Cooler	2020	3,702						42
43	Replace siding and trim surrounding courtyard	2020	12,878						43
44	Converted 12 rooms in the wing adjacent to the Rehab Unit								44
45	from double rooms to private rooms. Work consisted of	2020	40,197						45
46	removal of all privacy drapes and associated ceiling metal,								46
47	moving lighting to meet private room needs, paint all rooms and								47
48	install new base board and chair rail moldings								48
49									49
50	Replaced HVAC unit	2021	6,885						50
51									51
52									52
53	Replaced and painted siding and trim throughout the entire facility	2022	6,254						53
54	Installed 22 dry heads - sprinkler system	2022	7,840						54
55	Replaced 100 gallon water heater - kitchen	2022	14,868						55
56									56
57	Replaced dry sprinkler system head	2023	5,238						57
58	Removed (2) interior doors - installed replacements for both	2023	4,957						58
59	including new base and trim								59
60	Demolished damaged gazebo roof and constructed replacement	2023	2,648						60
61									61
62	Replaced air compressor and accelerator on sprinkler	2024	6,912						62
63	Repaired leaks in the dry sprinkler system throughout the facility	2024	8,162						63
64	Replaced backflow preventer system	2024	8,500						64
65									65
66	Installed new 5-ton Carrier air conditioner	2025	9,040						66
67	Replaced fire sprinkler heads throughout the entire facility	2025	9,258						67
68	Installed new street light - previous light was damaged	2025	9,582						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,508,041	\$ 233,578		\$ 233,578	\$	\$	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	\$1,724,790	\$53,586	\$53,586	\$		\$	71
72	Current Year Purchases	18,028						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,742,818	\$53,586	\$53,586	\$		\$	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	Transport	2021 Chrysler Voyager	2023	\$47,635	\$6,805	\$6,805	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$47,635	\$6,805	\$6,805	\$		\$	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)	\$11,763,513	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$293,969	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$293,969	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: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: *

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: \$38,989Description:Oxygen concentrators, copiers and printers
(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	None		\$	\$	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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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)	\$			

(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.

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	

(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.)

	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	\$		\$ 368,197	\$		\$ 368,197	1
2	Licensed Speech and Language Development Therapist		hrs			74,601			74,601	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			382,310	0		382,310	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				318,678		318,678	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					38,659			38,659	13
14	TOTAL			\$		\$ 863,767	\$ 318,678		\$ 1,182,445	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	\$ 440,663	\$	1
2	Cash-Patient Deposits	36,597		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	739,813		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,814		6
7	Other Prepaid Expenses	13,117		7
8	Accounts Receivable (owners or related parties)	(163,572)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,079,432	\$	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	9,026,078		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,790,452		16
17	Accumulated Depreciation (book methods)	(7,942,112)		17
18	Deferred Charges	116,110		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	117,238		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,519,768	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,599,200	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 386,472	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,597		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	288,771		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,752		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,323		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	44,179		36
37	Current Portion - Mortgage	403,423		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,196,517	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,491,790		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest Rate Swap	(78,965)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,412,825	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,609,342	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,010,142)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,599,200	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,535,807)	1
2	Restatements (describe):		2
3	Post filing adjustment - interest rate swap income	(13,367)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,549,174)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	539,032	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)	\$ 539,032	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)	\$ (2,010,142)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,793,116	1
2	Discounts and Allowances for all Levels	(2,180,901)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,612,215	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,988,167	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,988,167	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	19,044	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	547,665	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)	\$ 566,709	23
	D. Non-Operating Revenue		
24	Contributions	61,040	24
25	Interest and Other Investment Income***	8,357	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 69,397	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Extraordinary Item - Recovery of Employee</u>	877,311	28
28a	<u>Retention Credit</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 877,311	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,113,799	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,585,658	31
32	Health Care	5,262,420	32
33	General Administration	3,209,636	33
	B. Capital Expense		
34	Ownership	691,945	34
	C. Ancillary Expense		
35	Special Cost Centers	825,108	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)*	\$ 11,574,767	40
41	Income before Income Taxes (line 30 minus line 40)**	539,032	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 539,032	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,697,560.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,282,665.56	45
46	MMAI-Medicaid is the Primary Payer	657,533.44	46
47	MMAI-Medicare is the Primary Payer	-10,758.00	47
48	Private Pay	3,025,614.09	48
49	Medicare Part A	1,344,656.00	49
50	Other-(specify) <u>Private insurance</u>	616,193.91	50
51	Other-(specify) <u>Equipment Rental</u>	8,371.00	51
52	Other-(specify) <u>Medicare Cost Report Settlement</u>	13,634.00	52
53	Other-(specify) <u>Medicare Bad Debts</u>	-23,255.00	53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,612,215	56

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	1,976	2,080	\$ 119,995	\$ 57.69	1
2	Assistant Director of Nursing	2,124	2,236	117,676	52.63	2
3	Registered Nurses	16,307	17,165	733,241	42.72	3
4	Licensed Practical Nurses	21,848	22,998	850,484	36.98	4
5	CNAs & Orderlies	54,388	57,250	1,417,200	24.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,881	5,138	91,614	17.83	10
11	Social Service Workers	4,241	4,464	106,358	23.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,140	18,042	351,005	19.45	15
16	Dishwashers					16
17	Maintenance Workers	6,626	6,975	151,554	21.73	17
18	Housekeepers	14,158	14,903	263,922	17.71	18
19	Laundry	3,226	3,396	88,362	26.02	19
20	Administrator	1,976	2,080	127,925	61.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,114	14,857	325,835	21.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	163,005	171,584	\$ 4,745,171 *	\$ 27.66	34

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		\$ 10,339	Ln 1 Col 3	35
36	Medical Director		9,600	Ln 9 Col 3	36
37	Medical Records Consultant		1,741	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,903	Ln 10a Col 3	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		4,165	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,748		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	957	\$ 68,155	Ln10 Col 3	50
51	Licensed Practical Nurses	8,477	440,476	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides	24,900	753,464	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	34,334	\$ 1,262,095		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	10,518
	10,518 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	10,519
	10,519 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	21,037
	21,037 Total
- (5)

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

\$5,000

Line10
- (6)

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

Yes

If NO, attach a complete explanation.
- (7)

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

\$512,141

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$None

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$11
- (12)

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.

\$
- (13)

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

Yes

Firm Name:

Kerber Eck & Braeckel (KEB)
- (14)

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

Yes
- (15)

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.

[illegible]

Villa Health Care East
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 318,678
Purchased Hospital Services	25,028
Purchased Laboratory Services	7,633
Purchased Radiology Services	5,998
Amount Reclassified to Line 39	\$ <u>357,337</u>

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

<u>Line Item</u>	
Provider Participation Fee	<u>512,141</u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Cost

<u>Line Item</u>	
Pharmacy Consultant	\$ <u>7,903</u>