

		FOR OFF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0037770

Facility Name: Village Inn-Cobden

Address: PO Box 457, 114 Ash Street Cobden 62920
 Number City Zip Code

County: Union

Telephone Number: (618) 893-4222 **Fax #** (618) 833-5295

IDPA ID Number: 37-1159849-001

Date of Initial License for Current Owners: 11/16/89

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Jerry L Starnes **Telephone Number:** (618) 549-5356

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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) Robert M Chamness
 (Title) President

Paid Preparer

(Signed) _____ (Date) _____
 (Print Name and Title) Jerry L Starnes
Partner
 (Firm Name & Address) Barnett & Levine LLP
PO Box 2677, Carbondale, IL 62902
 (Telephone) (618) 549-5356 Fax # (618) 529-2783

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 Village Inn-Cobden

0037770 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,747</u>			<u>5,747</u>
14	TOTALS	<u>5,747</u>			<u>5,747</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.41%

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

None (Do not include bed-hold days in Section B.)

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 11/29/89

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 _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number

Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending:

12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	22,340	1,025	700	24,065		24,065		24,065			1
2	Food Purchase		43,322		43,322		43,322		43,322			2
3	Housekeeping		1,995		1,995		1,995		1,995			3
4	Laundry		700		700		700		700			4
5	Heat and Other Utilities			11,846	11,846		11,846		11,846			5
6	Maintenance	3,715	2,500	5,267	11,482		11,482		11,482			6
7	Other (specify):*											7
8	TOTAL General Services	26,055	49,542	17,813	93,410		93,410		93,410			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	191,525	1,877	14,055	207,457	(989)	206,468		206,468			10
10a	Therapy			2,505	2,505		2,505		2,505			10a
11	Activities	12,092	3,690		15,782		15,782		15,782			11
12	Social Services	8,050		1,733	9,783		9,783		9,783			12
13	CNA Training			245	245	989	1,234		1,234			13
14	Program Transportation			10,956	10,956		10,956		10,956			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	211,667	5,567	31,894	249,128		249,128		249,128			16
	C. General Administration											
17	Administrative	8,050	140		8,190		8,190		8,190			17
18	Directors Fees											18
19	Professional Services			9,795	9,795		9,795	(3,195)	6,600			19
20	Dues, Fees, Subscriptions & Promotions			2,340	2,340		2,340	(1,081)	1,259			20
21	Clerical & General Office Expenses	12,150	1,587	9,586	23,323		23,323		23,323			21
22	Employee Benefits & Payroll Taxes			42,590	42,590		42,590		42,590			22
23	Inservice Training & Education											23
24	Travel and Seminar			981	981		981		981			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,322	10,322		10,322		10,322			26
27	Other (specify):*											27
28	TOTAL General Administration	20,200	1,727	75,614	97,541		97,541	(4,276)	93,265			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	257,922	56,836	125,321	440,079		440,079	(4,276)	435,803			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.

Reclassification of Costs Relating to DSP Training:

Costs are being reclassified for wages and supplies relating to wages and supplies incurred in providing training to DSP staff as follows:

Wages	\$845
Supplies	<u>144</u>
Total	<u><u>\$989</u></u>

Note: See detail itemized on Schedule XIII

Facility Name & ID Number Village Inn-Cobden #0037770 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,908	15,908		15,908	8,396	24,304			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,830	1,830		1,830	6,398	8,228			32
33	Real Estate Taxes			4,798	4,798		4,798		4,798			33
34	Rent-Facility & Grounds			61,200	61,200		61,200	(60,000)	1,200			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			83,736	83,736		83,736	(45,206)	38,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			168,465	168,465		168,465		168,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,659	34,659		34,659		34,659			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			203,124	203,124		203,124		203,124			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	257,922	56,836	412,181	726,939		726,939	(49,482)	677,457			45

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

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning: 01/01/05

Ending: 12/31/05

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	1,634	30		9
10	Interest and Other Investment Income	(665)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,195)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(581)	20		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)	\$ (3,307)		\$	30

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)	(46,175)	Sch VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,175)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (49,482)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

Village Inn-Cobden

ID# 0037770

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,195)	0	0	0	0	0	0	0	0	0	0	(3,195)	19
20	Fees, Subscriptions & Promotions	(1,081)	0	0	0	0	0	0	0	0	0	0	(1,081)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,276)	0	0	0	0	0	0	0	0	0	0	(4,276)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,276)	0	0	0	0	0	0	0	0	0	0	(4,276)	29

STATE OF ILLINOIS

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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	1,634	6,762	0	0	0	0	0	0	0	0	0	8,396	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(665)	7,063	0	0	0	0	0	0	0	0	0	6,398	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(60,000)	0	0	0	0	0	0	0	0	0	(60,000)	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	969	(46,175)	0	(45,206)	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)	(3,307)	(46,175)	0	(49,482)	45								

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert M Chamness	100			Village Inn L T	Cobden, IL	Facility Rental
				JR's Centre, Inc	Anna, IL	Adult Workshop
				JR's Enterprises LLC	Anna, IL	Manufacturer
				JR's Centre L T	Anna, IL	Facility Rental

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent - Facility & Grounds	\$ 60,000	Village Inn Land Trust	100.00%	\$	\$ (60,000)	1
2	V	30 Depreciation				6,762	6,762	2
3	V	32 Interest				7,063	7,063	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		\$ 60,000			\$ 13,825	\$ * (46,175)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Village Inn-Cobden # 0037770 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Robert M Chamness	Administrator	Administration	100.00	None	40	90.00	Salary	\$ 8,050	17-1	1
2		QMRP	Programs						16,100	10	2
3		Social Services	Social Services						8,050	12	3
4											4
5	Traci A Chamness	RSD	Res Serv Director		None	40	100.00	Salary	36,113	10	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 68,313		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 Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

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

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	Anna State Bank		X	Van Purchase	\$654.62	05/04/01	\$ 27,199	\$	05/04/05	7.2500	\$ 66	1								
2	FNB - Jonesboro		X	Van Purchase	\$358.99	05/13/04	15,565	9,037	05/13/08	5.0000	456	2								
3	Robert L Chamness	X		Stock Redemption	\$483.22	07/01/04	30,000	23,707	07/01/10	5.0000	1,308	3								
4	FNB - Jonesboro		X	Mortgage	\$1,537.00	08/01/04	139,000	112,480	08/01/13	5.9000	7,063	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,033.83		\$ 211,764	\$ 145,224			\$ 8,893	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13	Less - Interest Income - Sch VI										(665)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (665)	14								
15	TOTALS (line 9+line14)						\$ 211,764	\$ 145,224			\$ 8,228	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Village Inn-Cobden COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037770

CONTACT PERSON REGARDING THIS REPORT Robert M Chamness

TELEPHONE (618) 893-4222 FAX #: (618) 833-5295

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-00-09-956</u>	<u>Lot 14 Blk F Ben L Wiley's Add</u>	\$ <u>4,176.66</u>	\$ <u>4,176.66</u>
2. <u>14-00-09-957</u>	<u>E 1/2 Lot 15 Blk F B L Wiley's Add</u>	\$ <u>110.46</u>	\$ <u>110.46</u>
3. <u>14-00-09-955</u>	<u>Lot 13 Blk F Ben L Wiley's Add</u>	\$ <u>110.46</u>	\$ <u>110.46</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,397.58</u>	\$ <u>4,397.58</u>

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 X NO

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Village Inn-Cobden

0037770 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,600 B. General Construction Type: Exterior Board Siding Frame Wood Number of Stories Two

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).

Located adjacent to the facility is a Community Integrated Living Arrangement (CILA) facility. The CILA is one of three facilities operated in a closely-held corporation licensed under the provider name, "Chamness Care, Inc." The adjacent CILA is licensed for 8 beds, and provides care to residents funded by DHS - Mental Health. Chamness Care, Inc. is owned and operated by Beverly A Tweedy, sister of Robert M Chamness.

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	<u>Facility</u>	<u>21,960</u>	<u>1968</u>	<u>\$ 2,000</u>	1
2					2
3	TOTALS	21,960		\$ 2,000	3

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1975		\$ 10,772	\$	26	\$	\$	\$ 10,772	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Building Improvement		1981	8,623		26			8,623	9
10		Building Improvement		1982	7,242		26			7,242	10
11		Building Improvement		1983	12,987		26	261	261	12,987	11
12		Sprinkler System		1983	18,340		26	705	705	18,290	12
13		Building Improvement		1984	25,130		26	967	967	23,322	13
14		Building Improvement		1989	144,871		30	4,829	4,829	78,069	14
15		Driveway Pavement		1997	5,175	345	15	345		2,904	15
16		Fire Escape Upgrade		1999	3,500	233	15	233		1,476	16
17		Water Heaters (2)		1999	1,627	109	15	108	(1)	675	17
18		Furnace		2001	1,936	129	15	129		516	18
19		Fire Doors (9)		2001	3,137	209	15	209		1,010	19
20		Roof & Gutters		2002	11,412	533	15	761	228	2,663	20
21		Floors		2002	2,555	119	15	170	51	567	21
22		Bath Fixtures		2003	675	29	15	45	16	98	22
23		Kitchen Remodeling		2004	8,196	779	15	546	(233)	865	23
24		Carpet		2004	7,410	2,371	5	1,482	(889)	2,223	24
25		Remodeling		2004	517	49	15	34	(15)	51	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											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 Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								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)	\$ 274,105	\$ 4,905		\$ 10,824	\$ 5,919	\$ 172,353	70

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

Facility Name & ID Number Village Inn-Cobden # 0037770 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 26,223	\$ 3,032	\$ 4,173	\$ 1,141		\$ 14,209	71
72	Current Year Purchases	1,860	1,860	172	(1,688)		172	72
73	Fully Depreciated Assets	16,562	198	230	32		16,562	73
74								74
75	TOTALS	\$ 44,645	\$ 5,090	\$ 4,575	\$ (515)		\$ 30,943	75

D. Vehicle Depreciation (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	Resident Transportation	2001 Ford Van	2001	\$ 27,199	\$ 369	\$ 5,440	\$ 5,071	5	\$ 25,387	76
77	Resident Transportation	2003 Ford Windstar Van	2004	17,325	5,544	3,465	(2,079)		5,775	77
78										78
79										79
80	TOTALS			\$ 44,524	\$ 5,913	\$ 8,905	\$ 2,992		\$ 31,162	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)		\$ 365,274	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 15,908	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 24,304	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 8,396	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 234,458	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: N/A

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

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>82</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		144		144
3	Classroom Wages (a)		312		312
4	Clinical Wages (b)		533		533
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		245		245
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,234	\$	\$ 1,234
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,234		

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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Village Inn-Cobden # 0037770 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 128,009	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	113,465		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 241,474	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	46,140		15
16	Equipment, at Historical Cost	89,169		16
17	Accumulated Depreciation (book methods)	(94,901)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 40,408	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 281,882	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 65,030	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	2,439		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 71,869	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	32,744		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)	\$ 32,744	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 104,613	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 177,269	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 281,882	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 196,336	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 196,336	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	20,933	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	(40,000)	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)	\$ (19,067)	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)	\$ 177,269	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 578,228	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 578,228	3
B. Ancillary Revenue			
4	Day Care	168,465	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 168,465	8
C. Other Operating Revenue			
9	Payments for Education	514	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$ 514	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	665	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 665	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)	\$ 747,872	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	93,410	31
32	Health Care	249,128	32
33	General Administration	97,541	33
B. Capital Expense			
34	Ownership	83,736	34
C. Ancillary Expense			
35	Special Cost Centers	168,465	35
36	Provider Participation Fee	34,659	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 726,939	40
41	Income before Income Taxes (line 30 minus line 40)**	20,933	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 20,933	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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.

Adjusted book income	\$20,933
Adjustment for accrual changes from January 1, 2005 to December 31, 2005	83,402
Adjustment for non-deductible expenses:	
Meals & entertainment	<u>194</u>
Taxable income	<u><u>\$104,529</u></u>

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

01/01/05

Ending:

12/31/05

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	48	48	1,500	31.25	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,345	1,453	12,092	8.32	10
11	Social Service Workers	500	520	8,050	15.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,319	2,468	22,340	9.05	15
16	Dishwashers					16
17	Maintenance Workers	256	272	3,715	13.66	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	500	520	8,050	15.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	810	882	12,150	13.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,000	1,040	16,100	15.48	28
29	Resident Services Coordinator	2,000	2,080	36,113	17.36	29
30	Habilitation Aides (DD Homes)	15,279	16,292	137,812	8.46	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,057	25,575	\$ 257,922 *	\$ 10.08	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	28	\$ 700	1-3	35
36	Medical Director	As Needed	2,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	171	8,520	10-3	38
39	Pharmacist Consultant	25	625	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	2,505	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	49	1,733	12-3	45
46	Other(specify) <u>Psychiatric</u>	78	3,710	10-3	46
47	<u>Dental</u>	As Needed	1,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	351	\$ 21,393		49

C. CONTRACT NURSES

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

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	
Robert M Chamness	Administrator	100	\$ 8,050	Workers' Compensation Insurance	\$ 7,786	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,846	Advertising: Employee Recruitment	35	
				FICA Taxes	20,328	Health Care Worker Background Check		
				Employee Health Insurance	9,810	(Indicate # of checks performed)		
				Employee Meals		Contributions	500	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	960	
				Misc Employee Fringes	820	Misc Dues & Subscriptions	341	
						Advertising - Promotion	504	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 8,050			Less: PAC Dues & Contributions	(577)	
(List each licensed administrator separately.)						Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(504)	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 42,590	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,259	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Barnett & Levine LLP	Accounting & Tax		\$ 6,600			\$	Out-of-State Travel	\$
FMGR	Corp Related Fees		3,195					
(Adjusted-out on Sch VI, Line 22)							In-State Travel	
							Meals - Staff Meetings	388
							01/20 RM Chamness - Springfield	
							Seminar	46
							Seminar Expense	
							Misc Local Seminars	547
TOTAL (agree to Schedule V, line 19, column 3)			\$ 9,795	TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 981

* Attach copy of IMRF notifications

**See instructions.

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. See Sch XIX-F
- (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. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Previously operated as Village Shelter Care under the same ID No.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,659
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? Yes 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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? No
- 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? N/A
- 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.

Allocation of Wages to More Than One Cost Center
Year Ended December 31, 2005

<u>Employee</u>	<u>Position</u>	<u>%</u>	<u>Amount</u>	<u>Sch V Ref</u>
McRaven, Tammy	Direct Service Personnel	25%	\$4,031	10-1
	Activities Assistant	75%	<u>12,092</u>	11-1
			<u>\$16,123</u>	
Poole, Rachel	Direct Service Personnel	50%	\$9,579	10-1
	Cook	50%	<u>9,579</u>	1-1
			<u>\$19,158</u>	