

Facility Name & ID Number Villa Health Care East# 0037028 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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		Other	Total	
		Recipient	Private Pay			
8	SNF	15,187	15,543	4,624	35,354	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,187	15,543	4,624	35,354	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.84%D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N.A- NoneF. Does the facility maintain a daily midnight census? YesG. 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 10/21/1991J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/21/1991 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 4,624Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	192,639	13,885	5,588	212,112		212,112	(2,827)	209,285		1
2	Food Purchase		177,680		177,680		177,680	(970)	176,710		2
3	Housekeeping	94,533	21,204		115,737		115,737		115,737		3
4	Laundry	42,963	16,389	80	59,432		59,432		59,432		4
5	Heat and Other Utilities			135,338	135,338		135,338		135,338		5
6	Maintenance	77,362	19,186	62,216	158,764		158,764		158,764		6
7	Other (specify):*			7,481	7,481		7,481		7,481		7
8	TOTAL General Services	407,497	248,344	210,703	866,544		866,544	(3,797)	862,747		8
B. Health Care and Programs											
9	Medical Director			14,169	14,169		14,169		14,169		9
10	Nursing and Medical Records	1,642,892	133,425	10,247	1,786,564		1,786,564		1,786,564		10
10a	Therapy		5,177	370,371	375,548		375,548		375,548		10a
11	Activities	77,328	2,334	9,003	88,665		88,665		88,665		11
12	Social Services	87,882	221	2,533	90,636		90,636		90,636		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,808,102	141,157	406,323	2,355,582		2,355,582		2,355,582		16
C. General Administration											
17	Administrative	77,060			77,060		77,060		77,060		17
18	Directors Fees										18
19	Professional Services			333,311	333,311		333,311		333,311		19
20	Dues, Fees, Subscriptions & Promotions			46,819	46,819		46,819	(22,418)	24,401		20
21	Clerical & General Office Expenses	89,708	36,762	163,839	290,309		290,309	(35,606)	254,703		21
22	Employee Benefits & Payroll Taxes			415,601	415,601		415,601		415,601		22
23	Inservice Training & Education			3,133	3,133		3,133		3,133		23
24	Travel and Seminar			3,573	3,573		3,573		3,573		24
25	Other Admin. Staff Transportation			5,564	5,564		5,564		5,564		25
26	Insurance-Prop.Liab.Malpractice			105,050	105,050		105,050		105,050		26
27	Other (specify):*										27
28	TOTAL General Administration	166,768	36,762	1,076,890	1,280,420		1,280,420	(58,024)	1,222,396		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,382,367	426,263	1,693,916	4,502,546		4,502,546	(61,821)	4,440,725		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Villa Health Care East

#0037028

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			167,204	167,204		167,204		167,204			30
31	Amortization of Pre-Op. & Org.			7,308	7,308		7,308	(7,308)				31
32	Interest			267,338	267,338		267,338	(1,186)	266,152			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,693	1,693		1,693		1,693			35
36	Other (specify):*			20,131	20,131		20,131		20,131			36
37	TOTAL Ownership			463,674	463,674		463,674	(8,494)	455,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,351	30,335	205,686		205,686		205,686			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,218	54,218		54,218		54,218			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		175,351	84,553	259,904		259,904		259,904			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,382,367	601,614	2,242,143	5,226,124		5,226,124	(70,315)	5,155,809			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.)

		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	(2,827)	1		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	(1,186)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(970)	2		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	(23,628)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,612)	21		24
25	Fund Raising, Advertising and Promotional	(22,418)	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	(1,366)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,007)		\$	30

BHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(7,308)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (7,308)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (70,315)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Villa Health Care East

ID# 0037028

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (1,366)	21	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	(1,366)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(2,827)	0	0	0	0	0	0	0	0	0	0	(2,827)	1
2	Food Purchase	(970)	0	0	0	0	0	0	0	0	0	0	(970)	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	(3,797)	0	0	0	0	0	0	0	0	0	0	(3,797)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,418)	0	0	0	0	0	0	0	0	0	0	(22,418)	20
21	Clerical & General Office Expenses	(35,606)	0	0	0	0	0	0	0	0	0	0	(35,606)	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	(58,024)	0	0	0	0	0	0	0	0	0	0	(58,024)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(61,821)	0	0	0	0	0	0	0	0	0	0	(61,821)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Health Care East# 0037028

Report Period Beginning:

01/01/2006 Ending:12/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	(7,308)	0	0	0	0	0	0	0	0	0	0	(7,308) 31
32	Interest	(1,186)	0	0	0	0	0	0	0	0	0	0	(1,186) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(8,494)	0	0	0	0	0	0	0	0	0	0	(8,494) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(70,315)	0	0	0	0	0	0	0	0	0	0	(70,315) 45

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Villa Health Care East

0037028 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC COMM MORT COMP		X	Mortgage	Varies	11/1/99	\$ 4,357,417	\$ 3,982,725	11/1/2029	0.0650	\$ 267,338	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Income		X								(1,186)	6
7												7
8												8
9	TOTAL Facility Related						\$ 4,357,417	\$ 3,982,725			\$ 266,152	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,357,417	\$ 3,982,725			\$ 266,152	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,131 Line # 36

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 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 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Health Care East COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0037028

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

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

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Villa Health Care East# 0037028 Report Period Beginning:01/01/2006 Ending: 12/31/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 36,368 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1C. 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: 243,075 2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 7,308 4. Dates Incurred: Various

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	Facility	38,368	1991	\$ 465,019	1
2					2
3	TOTALS	38,368		\$ 465,019	3

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	1991	\$ 2,837,150	\$ 94,571	30	\$ 94,571		\$ 1,442,219	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	1992 Additions		1992	30,954	970		970		15,202	9
10	1993 Additions		1993	14,489	483		483		6,615	10
11	1994 Additions		1994	10,567	352		352		4,335	11
12	1995 Additions		1995	56,538	1,692		1,692		36,006	12
13	1996 Additions		1996	17,082	900		900		11,572	13
14	1997 Additions		1997	35,201	3,470		3,470		32,733	14
15	1998 Additions		1998	68,233	3,447		3,447		45,621	15
16	1999 Additions		1999	77,766	4,173		4,173		43,288	16
17	2000 Additions		2000	89,865	4,794		4,794		31,455	17
18	2001 Additions		2001	54,328	4,275		4,275		24,550	18
19	2002 Additions		2002	110,177	7,302		7,302		36,514	19
20	Landscaping		2003	8,545	855		855		2,706	20
21	Paint Interior of Building		2004	16,868	3,374		3,374		8,996	21
22	Paving Parking Lot		2005	9,665	1,208		1,208		1,510	22
23	Culvert and Drainage Ditch		2005	27,126	1,507		1,507		2,009	23
24	Repairs and Refinishing to Entrance		2005	9,750	650		650		867	24
25	Repairs to Therapy Room		2005	10,932	729		729		850	25
26	Repair and Refinish Entrance Canopy		2005	6,272	418		418		453	26
27	Repairs to Business Office		2005	2,731	182		182		197	27
28	Repairs to Laundry Room		2005	7,984	515		515		551	28
29	Painting		2006	8,048	1,475		1,475		1,475	29
30	Curtains		2006	5,434	906		906		906	30
31	Fire Alarm Panel		2006	2,352	176		176		176	31
32	Replace 2 Bath Fans and 5 Light Fixtures		2006	2,965	222		222		222	32
33	Upgrade Fire System Panels		2006	2,156	108		108		108	33
34	Steel Exterior Door		2006	129	21		21		21	34
35	Light Fixtures in Public Corridors		2006	6,272	209		209		209	35
36	Replace Handicap Sidewalks		2006	3,222	107		107		107	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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)		\$ 3,532,801	\$ 139,091		\$ 139,091	\$	\$ 1,751,473	70

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

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	\$ 758,474	\$ 27,299	\$ 27,299	\$	Various	\$ 646,772	71
72	Current Year Purchases	7,330	814	814		Various	814	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 765,804	\$ 28,113	\$ 28,113	\$		\$ 647,586	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,763,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,204	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 167,204	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)	\$ 2,399,059	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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: \$ 1,694 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

* 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.

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

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 type="checkbox"/> YES <input checked="" 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$	2,876	\$	144,465	\$			2,876	\$	144,465	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,504		93,165				1,504		93,165	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a,3	hrs		3,239		132,741				3,239		132,741	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			\$	7,619	\$	370,371	\$			7,619	\$	370,371	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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	\$ 270,952	\$	1
2	Cash-Patient Deposits	8,995		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	636,041		3
4	Supply Inventory (priced at)	6,354		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,560		6
7	Other Prepaid Expenses	43,543		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 994,445	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	465,019		13
14	Buildings, at Historical Cost	3,231,332		14
15	Leasehold Improvements, at Historical Cost	302,722		15
16	Equipment, at Historical Cost	775,428		16
17	Accumulated Depreciation (book methods)	(2,399,060)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	243,075		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(54,851)		20
21	Restricted Funds	142,099		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,705,764	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,700,209	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 121,986	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,995		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,523		30
31	Accrued Taxes Payable (excluding real estate taxes)	69,384		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Other Accrued Expenses</u>	(71,594)		36
37	<u>Security Deposits</u>	9,574		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 242,868	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,982,725		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)	\$ 3,982,725	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,225,593	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (525,384)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,700,209	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (572,689)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (572,689)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	47,305	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)	\$ 47,305	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)	\$ (525,384)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2006

Ending:

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12/31/2006

VII. 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	\$ 4,813,252	1
2	Discounts and Allowances for all Levels	(586,627)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,226,625	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	688,667	6
7	Oxygen	2,876	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 691,543	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,827	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,918	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,510	19
20	Radiology and X-Ray		20
21	Other Medical Services	94,454	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 352,709	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,186	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,186	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,366	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,366	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,273,429	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	866,544	31
32	Health Care	2,355,582	32
33	General Administration	1,280,420	33
B. Capital Expense			
34	Ownership	463,674	34
C. Ancillary Expense			
35	Special Cost Centers	205,686	35
36	Provider Participation Fee	54,218	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,226,124	40
41	Income before Income Taxes (line 30 minus line 40)**	47,305	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 47,305	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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	8,457	8,542	\$ 223,667	\$ 26.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,797	1,837	35,317	19.23	3
4	Licensed Practical Nurses	27,181	27,444	585,087	21.32	4
5	CNAs & Orderlies	62,001	62,279	736,411	11.82	5
6	CNA Trainees	3,537	3,598	43,780	12.17	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,406	6,914	77,328	11.18	10
11	Social Service Workers	5,684	5,746	87,882	15.29	11
12	Dietician	18,433	18,556	192,639	10.38	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,099	6,165	77,362	12.55	17
18	Housekeepers	10,618	10,676	94,533	8.85	18
19	Laundry	5,225	5,244	42,963	8.19	19
20	Administrator	2,000	2,040	81,505	39.95	20
21	Assistant Administrator					21
22	Other Administrative	5,370	5,718	84,707	14.81	22
23	Office Manager					23
24	Clerical	856	864	8,970	10.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,020	1,060	10,216	9.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,684	166,683	\$ 2,382,367 *	\$ 14.29	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	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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 **Villa Health Care East**

0037028

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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	
Shannon Cassidy	Administrator		\$ 77,060	Workers' Compensation Insurance	\$ 138,216	IDPH License Fee	\$ 455	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	15,677	
				FICA Taxes	213,966	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	55,215	Patient Background Checks		
				Employee Meals		Advertising and Public Relations	22,419	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	7,113	
				Other Benefits	8,203	Licenses	1,155	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,060			Less: Public Relations Expense (
B. Administrative - Other						Non-allowable advertising	(22,418)	
Description			Amount			Yellow page advertising (
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 415,600	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,401	
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
Tutera Health Care Services	Management Fees		\$ 237,642				Out-of-State Travel	\$
BKD, LLP	Accounting Fees		8,568					
Pinnacle Consulting	Professional Services		660				In-State Travel	3,573
Galaxy Hosted Software	Data Processing Fees		14,300					
Mutual of Omaha	Data Processing Fees		42				Seminar Expense	
Tutera Health Care Services	Data Processing Fees		17,060					
Emdeon Business	Data Processing Fees		815				Entertainment Expense (
E-Health	Data Processing Fees		2,100				(agree to Sch. V,	
Please see attached	Legal Fees		27,656				line 24, col. 8)	\$ 3,573
Please see attached	Purchased Services		24,467					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 333,310	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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. _____
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,434 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,218
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,827
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A 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? Yes
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.