

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0037028

Facility Name: Villa Health Care East

Address: 100 Marion Parkway, PO Box 109 Sherman 62684
 Number City Zip Code

County: Sangamon

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

HFS ID Number: 27-1215144

Date of Initial License for Current Owners: _____

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" 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 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: Ken Marx, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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) _____
Paid Preparer	(Type or Print Name) <u>Clark Ribordy, THCSLLC, MGT. CO</u>
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) _____
	(Telephone) () Fax # ()

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

Facility Name & ID Number Villa Health Care East# 0037028 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,065</u>	<u>15,102</u>	<u>4,266</u>	<u>35,433</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,065</u>	<u>15,102</u>	<u>4,266</u>	<u>35,433</u>	14

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

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? 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 10/21/1991

J. 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 99 and days of care provided 4,266Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	201,015	16,560	6,012	223,587		223,587	(2,920)	220,667		1
2	Food Purchase		194,164		194,164		194,164	(1,050)	193,114		2
3	Housekeeping	109,434	18,383		127,817		127,817		127,817		3
4	Laundry	40,889	12,753		53,642		53,642		53,642		4
5	Heat and Other Utilities			152,746	152,746		152,746		152,746		5
6	Maintenance	84,633	20,635	52,799	158,067		158,067		158,067		6
7	Other (specify):* trash removal			6,008	6,008		6,008		6,008		7
8	TOTAL General Services	435,971	262,495	217,565	916,031		916,031	(3,970)	912,061		8
	B. Health Care and Programs										
9	Medical Director			15,385	15,385		15,385		15,385		9
10	Nursing and Medical Records	1,729,139	131,496	10,399	1,871,034		1,871,034		1,871,034		10
10a	Therapy		2,292	411,186	413,478		413,478		413,478		10a
11	Activities	61,101	1,309	7,544	69,954		69,954		69,954		11
12	Social Services	90,946	99	1,844	92,889		92,889		92,889		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,881,186	135,196	446,358	2,462,740		2,462,740		2,462,740		16
	C. General Administration										
17	Administrative	85,604			85,604		85,604		85,604		17
18	Directors Fees										18
19	Professional Services			341,015	341,015		341,015		341,015		19
20	Dues, Fees, Subscriptions & Promotions			55,328	55,328		55,328	(27,712)	27,616		20
21	Clerical & General Office Expenses	90,288	36,469	163,695	290,452		290,452	(31,845)	258,607		21
22	Employee Benefits & Payroll Taxes			427,258	427,258		427,258		427,258		22
23	Inservice Training & Education			400	400		400		400		23
24	Travel and Seminar			2,621	2,621		2,621		2,621		24
25	Other Admin. Staff Transportation			4,999	4,999		4,999		4,999		25
26	Insurance-Prop.Liab.Malpractice			104,622	104,622		104,622		104,622		26
27	Other (specify):*										27
28	TOTAL General Administration	175,892	36,469	1,099,938	1,312,299		1,312,299	(59,557)	1,252,742		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,493,049	434,160	1,763,861	4,691,070		4,691,070	(63,527)	4,627,543		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: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			163,412	163,412	163,412		163,412			30
31	Amortization of Pre-Op. & Org.			7,308	7,308	7,308	(7,308)				31
32	Interest			261,274	261,274	261,274	(2,677)	258,597			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			2,396	2,396	2,396		2,396			35
36	Other (specify):* mortgage insurance			19,758	19,758	19,758		19,758			36
37	TOTAL Ownership			454,148	454,148	454,148	(9,985)	444,163			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		167,690	22,200	189,890	189,890		189,890			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,318	54,318	54,318		54,318			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		167,690	76,518	244,208	244,208		244,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,493,049	601,850	2,294,527	5,389,426	5,389,426	(73,512)	5,315,914			45

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

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,920)	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	(2,677)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,050)	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	(13,772)	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	(18,073)	21		24
25	Fund Raising, Advertising and Promotional	(27,712)	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 misc income	(1,283)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (67,487)		\$	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	(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
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (74,795)		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

BHF USE ONLY						
48		49		50		51
						52

Villa Health Care East

ID# 0037028

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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 Villa Health Care East

0037028

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(2,920)	0	0	0	0	0	0	0	0	0	0	(2,920)	1
2	Food Purchase	(1,050)	0	0	0	0	0	0	0	0	0	0	(1,050)	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	(3,970)	0	0	0	0	0	0	0	0	0	0	(3,970)	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	(27,712)	0	0	0	0	0	0	0	0	0	0	(27,712)	20
21	Clerical & General Office Expenses	(31,845)	0	0	0	0	0	0	0	0	0	0	(31,845)	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	(59,557)	0	0	0	0	0	0	0	0	0	0	(59,557)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,527)	0	0	0	0	0	0	0	0	0	0	(63,527)	29

STATE OF ILLINOIS

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/2007 Ending:

Summary B

12/31/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(7,308)	0	0	0	0	0	0	0	0	0	0	(7,308)	31
32	Interest	(2,677)	0	0	0	0	0	0	0	0	0	0	(2,677)	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	(9,985)	0	(9,985)	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)	(73,512)	0	(73,512)	45									

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007 Ending: 2/31/2007

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	GMAC COMM MORT COMP		X	Mortgage	Varies	11/1/99	\$ 4,357,417	\$ 3,906,707	11/1/2029	0.0658	\$ 261,274	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Interest income		X								(2,677)	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 4,357,417	\$ 3,906,707			\$ 258,597	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	\$ 3,906,707			\$ 258,597	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,758 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Health Care East COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0037028

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,368 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 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	<u>Facility</u>	<u>38,368</u>	<u>1991</u>	<u>\$ 465,019</u>	1
2					2
3	TOTALS	38,368		\$ 465,019	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	\$ 2,837,150	\$ 94,572	30	\$ 94,572		\$ 1,536,791	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		STORM SEWERS		1995	14,500	483	30	483		7,894	9
10		Culvert		1998	5,103	284	18	284		2,764	10
11		CULVERT PROJECT		1998	31,107	1,728	18	1,728		16,273	11
12		Driveway sealer		1998	3,547	296	12	296		2,709	12
13		CULVERTS		1999	2,025	113	18	113		1,013	13
14		CULVERTS		2000	50,860	2,826	18	2,826		21,194	14
15		Entrance Sign		2001	2,358	197	12	197		1,294	15
16		Black Top Patching, Man Hole Drains		2001	565	57	10	57		372	16
17		Parking Lot & Sidewalk - materials		2001	7,974	532	15	532		3,500	17
18		Parking Lot & Sidewalk - labor		2001	16,225	1,082	15	1,082		7,121	18
19		Landscaping		2001	2,514	126	20	126		817	19
20		Concrete		2001	1,270	127	10	127		826	20
21		Aerating Bubbler Floating Fountain		2001	1,905		5			1,905	21
22		Concrete		2001	7,257	726	10	726		4,657	22
23		Culvert Project		2002	93,157	5,175	18	5,175		31,052	23
24		Road		2002	17,020	2,128	8	2,128		12,765	24
25		Landscaping		2003	8,545	855	10	855		3,560	25
26		60 inch culvert and drainage ditch		2005	27,126	1,507	18	1,507		3,516	26
27		Paving parking lot		2005	9,665	1,208	8	1,208		2,718	27
28		LAUNDRY RM PLMBING/VENT		1992	11,150	372	30	372		5,917	28
29		FIRE ALARM DOOR MONIT		1992	3,222	107	30	107		1,699	29
30		LAUNDRY ROOM WIRING		1992	2,744	91	30	91		1,447	30
31		LAUNDRY TM RENOVATION		1992	10,946	365	30	365		5,686	31
32		FIRE SPRINKLER ADD.		1992	2,892	96	30	96		1,485	32
33		FLOOR COVERING		1993	6,708	224	30	224		3,299	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 Villa Health Care East

0037028

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PARTITION WALLS	1993	\$ 606	\$ 20	30	\$ 20	\$	\$ 296	37
38	LAWN EDGER	1993	419	14	30	14		202	38
39	GREEN TREAT LUMBER	1993	1,564	52	30	52		756	39
40	STEEL TBL, BRICKTACE, UMBRELLAS, GAZEBO, ETC	1993	811	27	30	27		393	40
41	FLOOR COVERING	1993	3,194	106	30	106		1,571	41
42	FLOOR COVERING	1993	1,187	40	30	40		584	42
43	CONCRETE WALKWAY	1994	1,108	37	30	37		505	43
44	CARPET	1994	4,107	137	30	137		1,826	44
45	SPANN FLOOR-TILE ALZHEIMERS UNIT	1994	1,375	46	30	46		608	45
46	SIDEWALKS	1994	809	27	30	27		358	46
47	LAND SURVEY	1994	1,931	64	30	64		848	47
48	588 FT WALL GUARD	1994	1,236	41	30	41		543	48
49	OUTDOOR SIGN	1995	1,985	66	30	66		860	49
50	ARCHITECT BLDG DESIGN	1995	14,000	933	30	933		11,197	50
51	TILE	1995	6,263	209	15	209		2,610	51
52	METAL CULVERTS	1995	3,153		30			2,413	52
53	METAL CULVERTS	1995	16,636		7			12,724	53
54	TRAY LINE	1996	1,000		7			992	54
55	FIRE DOORS & EXIT DEVICES	1996	1,624	108	10	108		1,353	55
56	INSTALL RECEPTACLES & CABLE TV OUTLETS	1996	3,100	207	15	207		2,583	56
57	CARPET IN DINING AREA	1996	706		15			706	57
58	TILE IN BATHROOMS	1996	607		10			607	58
59	HOT WATER HEATER & PUMP	1996	1,344	90	10	90		1,008	59
60	LAUNDRY VENTING PROJECT	1996	7,506	375	15	375		4,379	60
61	OUTSIDE SIGNS	1996	470		20			470	61
62	DOORS W/ 10"X10" WINDOW (DIETARY DEPT)	1996	726	18	10	18		272	62
63	Exhaust fan-beauty salon	1997	1,495	100	40	100		1,088	63
64	Land surveyor-John Raynolds	1997	4,875		15			4,834	64
65	Land Surveyor-John Raynolds	1997	5,966	298	10	298		5,917	65
66	Carpet main hall,file-nurses station	1997	20,270	1,182	10	1,182		20,101	66
67	Land Surveyor John Raynolds	1997	981	65	10	65		973	67
68	VRA PONDS & SIGNS	1997	1,613	134	10	134		1,600	68
69	Wallpaper-zone 2,3,Alz	1998	8,480	848	10	848		8,480	69
70	TOTAL (lines 4 thru 69)		\$ 3,298,682	\$ 120,519		\$ 120,519	\$	\$ 1,775,928	70

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

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	1998	\$ 3,298,682	\$ 120,519	15	\$ 120,519	\$	\$ 1,775,928	1
2	Door-hand swing	1998	494	33	5	33		310	2
3	Carpet halls, offices, public areas 1st of 2	1998	6,470		10			6,470	3
4	Mats-doorway 4	1998	1,114	111	5	111		1,012	4
5	Carpet-13 rooms	1998	9,713		15			9,713	5
6	Panic Bar-4	1998	2,205	147	5	147		1,335	6
7	CARPETING/BLINDS	1999	9,684		5			9,684	7
8	PAINT	1999	2,733		15			2,733	8
9	ALZ UNIT	1999	3,623	242	15	242		2,174	9
10	2 OF 2 HALL CARPET SEE #131	1999	6,470	431	10	431		3,882	10
11	LANDSCAPE	1999	2,500	250	15	250		2,229	11
12	DRAINAGE	1999	3,010	201	15	201		1,739	12
13	FLOOR TILE WORK	1999	26,831	1,789	15	1,789		14,757	13
14	EXTERIOR LIGHTING AT REAR	1999	1,868	125	15	125		1,027	14
15	DOOR REPLACEMENT-3	1999	1,270	85	10	85		691	15
16	SURETEMP THERMOMETER-4	1999	1,058	106	20	106		855	16
17	FIREWALL IN ATTIC	1999	16,693	835	20	835		6,677	17
18	EMERGENCY CIRCUITS	2000	7,662	383	25	383		3,065	18
19	FIREWALL REPAIR	2000	5,010	196	25	196		1,550	19
20	FIREWALL REINFORCEMENT	2000	18,309	718	10	718		5,624	20
21	HEAT/COOL ZONELINE - 2	2000	1,435	143	15	143		1,064	21
22	TIMER SYSTEM OUTSIDE LIGHTING	2000	495	33	15	33		239	22
23	Door Access System	2000	1,337	89	12	89		639	23
24	Braille Signs (151 qty.)	2000	4,867	406	10	406		2,873	24
25	Sign	2001	3,800	380	15	380		2,628	25
26	Metal Doors, (1 set) service hall	2001	3,224	215	10	215		1,487	26
27	Telephone Jacks	2001	1,980	198	10	198		1,353	27
28	Telephone Jack	2001	548	55	15	55		370	28
29	Digital Keypads for doors (5 qty.)	2001	1,810	121	12	121		815	29
30	Credit - (Braille Signs)	2001	(151)	(13)	12	(13)		(85)	30
31	Braille Signs (remaining 6 qty.)	2001	240	20	12	20		135	31
32	A/C Unit(2)	2001	1,529	102	15	102		629	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,446,515	\$ 127,918		\$ 127,918	\$	\$ 1,863,605	34

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

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	2001	\$ 3,446,515	\$ 127,918		\$ 127,918	\$	\$ 1,863,605	1
2	Dynalock	2004	1,273	127		127		774	2
3	Paint interior of building	2005	16,868	3,374		3,374		12,370	3
4	Repairs and Refinishing to Entrance	2005	9,750	650		650		1,517	4
5	Repairs to therapy room	2005	10,932	729		729		1,579	5
6	Repair and refinish entrance canopy	2005	6,272	418		418		871	6
7	Repairs to business office	2005	2,731	182		182		379	7
8	Repairs to laundry room	2005	7,984	532		532		1,083	8
9	Painting	2006	8,048	1,610		1,610		3,085	9
10	Curtains	2006	5,434	1,087		1,087		1,993	10
11	Fire alarm panel	2006	2,352	235		235		412	11
12	Replace 2 bath fans & 5 light fixtures	2006	2,965	297		297		519	12
13	Upgrade fire system panels	2006	2,156	216		216		323	13
14	Steel exterior door	2006	1,279	64		64		85	14
15	Replace handicaped sidewalks adn exterior light fixtures	2006	3,222	322		322		430	15
16	Light fixtures in public corridors	2006	6,272	627		627		836	16
17	DOORGUARD - Egress, Control, Lock Device	2007	1,482	99		99		99	17
18	LIGHT FIXTURES (QTY 31)	2007	8,445	282		282		282	18
19	LIGHT POLES AND BASES/LABOR & INSTALL	2007	5,715	190		190		190	19
20	DOORS EXTERIOR (QTY 3)	2007	3,004	25		25		25	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	TOTAL (lines 1 thru 33)		\$ 3,552,701	\$ 138,984		\$ 138,984	\$	\$ 1,890,457	34

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

Facility Name & ID Number Villa Health Care East # 0037028 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 775,728	\$ 23,171	\$ 23,171	\$		\$ 670,758	71
72	Current Year Purchases	19,240	1,257	1,257			1,257	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 794,968	\$ 24,428	\$ 24,428	\$		\$ 672,015	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)	\$	4,812,688	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	163,412	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	163,412	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)	\$	2,562,472	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 2,396 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 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Villa Health Care East# 0037028

Report Period Beginning:

01/01/2007 Ending:12/31/2007

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	3,268	\$ 164,122	\$	3,268	\$ 164,122	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,409	87,286		1,409	87,286	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,899	159,777		3,899	159,777	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$	8,576	\$ 411,185	\$	8,576	\$ 411,185	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 Villa Health Care East

0037028

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 421,992	\$	1
2	Cash-Patient Deposits	9,029		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	584,816		3
4	Supply Inventory (priced at)	5,517		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,263		6
7	Other Prepaid Expenses	20,606		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>prepaid road useage fees</u>	16,500		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,086,723	\$	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	3,249,978		14
15	Leasehold Improvements, at Historical Cost	302,722		15
16	Equipment, at Historical Cost	794,668		16
17	Accumulated Depreciation (book methods)	(2,562,471)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	243,075		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(62,159)		20
21	Restricted Funds	157,441		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,588,273	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,674,996	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 192,180	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,029		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,846		30
31	Accrued Taxes Payable (excluding real estate taxes)	61,189		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>	(127,405)		36
37	<u>security deposits</u>	9,558		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 251,397	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,906,707		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)	\$ 3,906,707	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,158,104	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (483,108)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,674,996	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (499,606)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (499,606)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	16,498	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)	\$ 16,498	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)	\$ (483,108)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	\$ 5,016,951	1
2	Discounts and Allowances for all Levels	(602,290)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,414,661	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	690,433	6
7	Oxygen	3,987	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 694,420	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	2,919	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	218,577	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,306	19
20	Radiology and X-Ray		20
21	Other Medical Services	76,033	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 314,835	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,677	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,677	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>miscellaneous income</u>	1,283	28
28a	<u>prior year adjustment</u>	(21,952)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (20,669)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,405,924	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	916,031	31
32	Health Care	2,462,740	32
33	General Administration	1,312,299	33
B. Capital Expense			
34	Ownership	454,148	34
C. Ancillary Expense			
35	Special Cost Centers	189,890	35
36	Provider Participation Fee	54,318	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,389,426	40
41	Income before Income Taxes (line 30 minus line 40)**	16,498	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 16,498	43

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

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

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

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

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	7,061	7,219	\$ 213,460	\$ 29.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,522	3,568	94,850	26.58	3
4	Licensed Practical Nurses	24,499	24,738	594,305	24.02	4
5	CNAs & Orderlies	55,810	56,234	763,291	13.57	5
6	CNA Trainees	2,367	2,405	41,281	17.16	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,364	5,364	61,101	11.39	10
11	Social Service Workers	5,128	5,300	90,946	17.16	11
12	Dietician	16,609	16,756	201,015	12.00	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,745	5,817	84,633	14.55	17
18	Housekeepers	10,450	10,506	109,434	10.42	18
19	Laundry	4,704	4,719	40,890	8.66	19
20	Administrator	1,848	1,880	89,707	47.72	20
21	Assistant Administrator					21
22	Other Administrative	5,183	5,233	85,661	16.37	22
23	Office Manager					23
24	Clerical	921	921	11,040	11.99	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	910	926	11,433	12.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,121	151,586	\$ 2,493,047 *	\$ 16.45	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

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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action 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? 9.13
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,690 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. \$ 54,318
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,287
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.