



Facility Name & ID Number VILLA HEALTH CARE EAST

# 0037028 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	14,794	14,317	5,198	34,309	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,794	14,317	5,198	34,309	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.95%

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 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 5,198

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number VILLA HEALTH CARE EAST # 0037028 Report Period Beginning: 1/1/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	211,100	21,298	13,076	245,474		245,474	(5,809)	239,665		1
2	Food Purchase		191,273		191,273		191,273	(1,043)	190,230		2
3	Housekeeping	120,063	19,810		139,873		139,873		139,873		3
4	Laundry	46,485	23,903		70,388		70,388		70,388		4
5	Heat and Other Utilities			174,941	174,941		174,941		174,941		5
6	Maintenance	111,053	24,633	70,997	206,683		206,683		206,683		6
7	Other (specify):* <b>TRASH REMOVAL</b>			7,470	7,470		7,470		7,470		7
8	<b>TOTAL General Services</b>	488,701	280,917	266,484	1,036,102		1,036,102	(6,852)	1,029,250		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,486	20,486		20,486		20,486		9
10	Nursing and Medical Records	1,964,018	147,006	12,689	2,123,713		2,123,713		2,123,713		10
10a	Therapy			538,685	538,685		538,685		538,685		10a
11	Activities	57,431	1,546	11,181	70,158		70,158		70,158		11
12	Social Services	114,059	168	14,082	128,309		128,309		128,309		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,135,508	148,720	597,123	2,881,351		2,881,351		2,881,351		16
	<b>C. General Administration</b>										
17	Administrative	82,984			82,984		82,984		82,984		17
18	Directors Fees										18
19	Professional Services			410,858	410,858		410,858		410,858		19
20	Dues, Fees, Subscriptions & Promotions			48,570	48,570		48,570	(20,771)	27,799		20
21	Clerical & General Office Expenses	105,941	41,935	192,102	339,978		339,978	(170,565)	169,413		21
22	Employee Benefits & Payroll Taxes			377,165	377,165		377,165		377,165		22
23	Inservice Training & Education			2,357	2,357		2,357		2,357		23
24	Travel and Seminar			6,174	6,174		6,174		6,174		24
25	Other Admin. Staff Transportation			6,805	6,805		6,805	(6,805)			25
26	Insurance-Prop.Liab.Malpractice			120,001	120,001		120,001		120,001		26
27	Other (specify):* <b>EMP INJ CLAIM</b>			91	91		91		91		27
28	<b>TOTAL General Administration</b>	188,925	41,935	1,164,123	1,394,983		1,394,983	(198,141)	1,196,842		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,813,134	471,572	2,027,730	5,312,436		5,312,436	(204,993)	5,107,443		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			179,646	179,646		179,646		179,646		30
31	Amortization of Pre-Op. & Org.			7,308	7,308		7,308	(7,308)			31
32	Interest			249,841	249,841		249,841	(7,639)	242,202		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			1,351	1,351		1,351		1,351		35
36	Other (specify):* MORTGAGE INSURANCE PREMIUM			17,636	17,636		17,636		17,636		36
37	<b>TOTAL Ownership</b>			455,782	455,782		455,782	(14,947)	440,835		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		227,273	75,890	303,163		303,163		303,163		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,323	54,323		54,323		54,323		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		227,273	130,213	357,486		357,486		357,486		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,813,134	698,845	2,613,725	6,125,704		6,125,704	(219,940)	5,905,764		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:

1/1/09

Ending:

12/31/09

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,809)	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	(7,639)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,043)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(6,805)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,850)	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	(30,274)	21		24
25	Fund Raising, Advertising and Promotional	(20,771)	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	(125,441)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (212,632)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (7,308)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (219,940)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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VILLA HEALTH CARE EAST

ID# 0037028

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	HOME OFFICE ALLOCATION	\$ (124,965)	21	1
2	MISC INCOME	(476)	21	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	<b>Total</b>	(125,441)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number VILLA HEALTH CARE EAST# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(5,809)	0	0	0	0	0	0	0	0	0	0	(5,809)	1
2	Food Purchase	(1,043)	0	0	0	0	0	0	0	0	0	0	(1,043)	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	<b>TOTAL General Services</b>	<b>(6,852)</b>	<b>0</b>	<b>(6,852)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(20,771)	0	0	0	0	0	0	0	0	0	0	(20,771)	20
21	Clerical & General Office Expenses	(170,565)	0	0	0	0	0	0	0	0	0	0	(170,565)	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	(6,805)	0	0	0	0	0	0	0	0	0	0	(6,805)	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	<b>TOTAL General Administration</b>	<b>(198,141)</b>	<b>0</b>	<b>(198,141)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(204,993)</b>	<b>0</b>	<b>(204,993)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number VILLA HEALTH CARE EAST# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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)	
	<b>D. Ownership</b>													
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	(7,639)	0	0	0	0	0	0	0	0	0	0	(7,639)	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	<b>TOTAL Ownership</b>	<b>(14,947)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,947)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(219,940)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(219,940)</b>	<b>45</b>

Facility Name & ID Number VILLA HEALTH CARE EAST

# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	<b>Total</b>		\$			\$	\$ *	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: 1/1/09 Ending: 12/31/09

**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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	\$		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:

1/1/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

VILLA HEALTH CARE EAST

# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09

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**		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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	GMAC COMM MORT COMP		X	MORTGAGE	VARIOUS	11/1/1999	\$ 47,357,417	\$ 3,650,939	11/1/2029	0.0658	\$ 249,841	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 47,357,417	\$ 3,650,939			\$ 249,841	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 47,357,417	\$ 3,650,939			\$ 249,841	15							

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

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

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





Facility Name & ID Number VILLA HEALTH CARE EAST

# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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).

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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: 275,845 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>383,686</u>	<u>1991</u>	<u>\$ 465,019</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>383,686</b>		<b>\$ 465,019</b>	<b>3</b>

Facility Name & ID Number VILLA HEALTH CARE EAST# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09**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			1991	1991	\$ 2,146,102	\$ 71,537	30	\$ 71,537		\$ 1,305,546	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		1991 ADDITIONS	1991		691,048	23,035	VARIOUS	23,035		420,388	9
10		1992 ADDITIONS	1992		30,954	1,032	VAROU	1,032		18,298	10
11		1993 ADDITIONS	1993		14,489	483	VARIOUS	483		8,065	11
12		1994 ADDITIONS	1994		10,567	352	VARIOUS	352		5,391	12
13		1995 ADDITIONS	1995		42,038	1,208	VARIOUS	1,208		32,219	13
14		1996 ADDITIONS	1996		17,082	798	VARIOUS	798		13,965	14
15		1997 ADDITIONS	1997		35,201	100	VARIOUS	100		34,712	15
16		1998 ADDITIONS	1998		28,476	180	VARIOUS	180		27,782	16
17		1999 ADDITIONS	1999		75,741	3,824	VARIOUS	3,824		54,336	17
18		2000 ADDITIONS	2000		39,115	1,968	VARIOUS	1,968		18,991	18
19		2001 ADDITIONS	2001		14,254	1,205	VARIOUS	1,205		10,516	19
20		2004 ADDITIONS	2004		16,868	1,125	VARIOUS	1,125		16,868	20
21		2005 ADDITIONS	2005		37,670	2,511	VARIOUS	2,511		10,452	21
22		PAINTING	2006		8,048	1,610	5	1,610		6,304	22
23		CURTAINS	2006		5,434	1,087	5	1,087		4,166	23
24		FIRE ALARM PANEL	2006		2,352	235	10	235		882	24
25		REPLACE 2 BATH & 5 LIGHT FIXTURES	2006		2,965	297	10	297		1,112	25
26		UPGRADE FIRE SYSTEM PANELS	2006		2,156	216	10	216		755	26
27		STEEL EXTERIOR DOOR	2006		1,279	64	20	64		213	27
28		REPLACE HANDICAPPED SIDEWALKS & EXTERIOR LIGHTING	2006		3,222	322	10	322		1,074	28
29		LIGHT FIXTURES IN PUBLIC CORRIDORS	2006		6,272	627	10	627		2,091	29
30		DOORGUARD	2007		1,482	148	10	148		395	30
31		LIGHT FIXTURES	2007		8,445	845	10	845		1,971	31
32		LIGHTPOLES AND BASES	2007		5,715	571	10	571		1,333	32
33		DOOR EXTERIOR	2007		3,004	300	10	300		626	33
34		CARPET	2008		65,083	13,017	5	13,017		23,780	34
35		ROOF REPAIR	2008		912	91	10	91		137	35
36		REFINISH DRYWALL	2008		912	182	5	182		274	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 &amp; ID Number VILLA HEALTH CARE EAST

# 0037028

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	REMODEL COURTYARD WING	2008	\$ 2,617	\$ 262	10	\$ 262	\$	\$ 371	37
38	EXTERIOR DOORS	2009	7,772	130	20	130		130	38
39	DOWN SPOUTS DRAINS	2009	29,000	967	10	967		967	39
40	ROOF	2009	98,896	1,236	20	1,236		1,236	40
41	REMODEL INTERMEDIATE DINING ROOM	2009	10,541	176	10	176		176	41
42	LIGHTING	2009	23,644	197	10	197		197	42
43	REMODEL REHAB WING ✓	2009	57,062		20				43
44	REMODEL REHAB DINING ROOM ✓	2009	23,149		20				44
45									45
46									46
47									47
48									48
49	1995 LAND ADDITIONS	1995	14,500	483	30	483		8,861	49
50	1998 LAND ADDITIONS	1998	39,757	2,308	VARIOUS	2,308		26,361	50
51	1999 LAND ADDITIONS	1999	2,025	112	18	112		1,238	51
52	2000 LAND ADDITIONS	2000	50,860	2,826	18	2,826		26,845	52
53	2001 LAND ADDITIONS	2001	40,068	2,845	VARIOUS	2,845		26,180	53
54	2002 LAND ADDITIONS	2002	110,177	7,303	VARIOUS	7,303		58,423	54
55	2003 LAND ADDITIONS	2003	8,545	854	10	854		5,269	55
56	2005 LAND ADDITIONS	2005	36,791	2,715	VARIOUS	2,715		11,665	56
57	PARKING LOT REPAIR & STRIPING	2009	1,400	408	2	408		408	57
58									58
59	ADJUSTMENT TO ACCRUED DEPRECIATION			93		93		2	59
60									60
61									61
62									62
63									63
64	✓ Items were purchased on 12/31/09, therefore no depreciation was taken.								
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,873,690	\$ 151,885		\$ 151,885	\$	\$ 2,190,971	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	\$ 833,570	\$ 25,030	\$ 25,030	\$		\$ 722,282	71
72	Current Year Purchases	96,183	2,731	2,731			2,731	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 929,753	\$ 27,761	\$ 27,761	\$		\$ 725,013	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)	\$ 5,268,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,646	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,646	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)	\$ 2,915,984	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

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: \$ 1,351 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

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	4,124	\$ 207,105	\$	4,124	\$ 207,105	1
2	Licensed Speech and Language Development Therapist		hrs		1,727	106,934		1,727	106,934	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,482	224,646		5,482	224,646	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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	11,333	\$ 538,685	\$	11,333	\$ 538,685	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: **1/1/09**

Ending:

**12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 831,577	\$	1
2	Cash-Patient Deposits	16,917		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (22,700) )	553,633		3
4	Supply Inventory (priced at )	10,512		4
5	Short-Term Investments			5
6	Prepaid Insurance	32,355		6
7	Other Prepaid Expenses	25,587		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,470,581	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	465,019		13
14	Buildings, at Historical Cost	3,570,373		14
15	Leasehold Improvements, at Historical Cost	304,122		15
16	Equipment, at Historical Cost	929,753		16
17	Accumulated Depreciation (book methods)	(2,916,078)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	275,845		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(76,775)		20
21	Restricted Funds	170,513		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,722,772	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,193,353	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 473,004	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,917		28
29	Short-Term Notes Payable	88,115		29
30	Accrued Salaries Payable	205,838		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,727		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
<b>Other Current Liabilities(specify):</b>				
36	<b>OTHER ACCRUED EXPENSES</b>	17,796		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 843,397	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,650,939		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,650,939	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,494,336	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (300,983)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,193,353	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(430,637)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(430,637)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>129,654</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>129,654</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(300,983)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number VILLA HEALTH CARE EAST

# 0037028

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,324,895	1
2	Discounts and Allowances for all Levels	(551,752)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,773,143	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	961,006	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 961,006	8
<b>C. Other Operating Revenue</b>			
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	5,809	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	385,575	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,516	19
20	Radiology and X-Ray		20
21	Other Medical Services	96,130	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 513,030	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,639	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,639	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISC INCOME</b>	540	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 540	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,255,358	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,036,102	31
32	Health Care	2,881,351	32
33	General Administration	1,394,983	33
<b>B. Capital Expense</b>			
34	Ownership	455,782	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	303,163	35
36	Provider Participation Fee	54,323	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,125,704	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	129,654	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 129,654	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:

1/1/09

Ending:

12/31/09

**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	12,606	12,531	\$ 324,527	\$ 25.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,724	3,780	92,042	24.35	3
4	Licensed Practical Nurses	28,473	28,635	606,661	21.19	4
5	CNAs & Orderlies	70,125	70,457	875,357	12.42	5
6	CNA Trainees	3,766	3,849	53,677	13.95	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,605	5,989	57,431	9.59	10
11	Social Service Workers	5,695	5,796	114,058	19.68	11
12	Dietician	17,935	18,111	211,100	11.66	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,835	7,883	111,054	14.09	17
18	Housekeepers	11,589	11,674	120,063	10.28	18
19	Laundry	5,450	5,488	46,486	8.47	19
20	Administrator	1,944	2,000	87,115	43.56	20
21	Assistant Administrator					21
22	Other Administrative	5,936	5,985	101,224	16.91	22
23	Office Manager					23
24	Clerical					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	944	984	12,339	12.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,627	183,162	\$ 2,813,134 *	\$ 15.36	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**

Report Period Beginning: 1/1/09

**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		\$ 82,984	Workers' Compensation Insurance	\$ 111,091	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	5,721	
				FICA Taxes	223,422	Health Care Worker Background Check		
				Employee Health Insurance	33,495	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		EMPLOYMENT EXPENSE	15,291	
				OTHER BENEFITS	9,157	ADVERTISING & PR	20,771	
						DUES & SUBSCRIPTIONS	5,757	
						LICENSES	1,030	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,984					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 377,165	Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	(20,771)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
PLEASE SEE ATTACHED	PURCHASED SERVICES		20,696					
TUTERA HEALTH CARE	MANAGEMENT FEES		281,170					
PLEASE SEE ATTACHED	LEGAL FEES		49,884					
BKD, LLP	ACCOUNTING FEES		17,184				In-State Travel	6,174
PLEASE SEE ATTACHED	DATA PROCESSING FEES		39,097					
PLEASE SEE ATTACHED	PROFESSIONAL SERVICES		720					
	TRUSTEE FEES		2,107				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 410,858	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,174

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number VILLA HEALTH CARE EAST

# 0037028

Report Period Beginning: 1/1/09

Ending: 12/31/09

**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. \$5,464 IL HEALTH ASSOC
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,699 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,323  
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. \$ 5,809
- (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? NO
- 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
- (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.