

Facility Name & ID Number Village Inn-Cobden

0037770 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,092			5,092	13
14	TOTALS	5,092			5,092	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.19%

D. How many bed-hold days during this year were paid by the Department? 17 (Do not include bed-hold days in Section B.)

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

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/29/1989

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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 Village Inn-Cobden # 0037770 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
	A. General Services										
1	Dietary	22,007	766	1,104	23,877		23,877		23,877		1
2	Food Purchase		42,878		42,878		42,878		42,878		2
3	Housekeeping	15,590	2,173		17,763		17,763		17,763		3
4	Laundry		334		334		334		334		4
5	Heat and Other Utilities			13,561	13,561		13,561		13,561		5
6	Maintenance	6,101	4,180	4,337	14,618		14,618		14,618		6
7	Other (specify):*										7
8	TOTAL General Services	43,698	50,331	19,002	113,031		113,031		113,031		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	192,750	1,103	14,947	208,800		208,800		208,800		10
10a	Therapy		2,500		2,500		2,500		2,500		10a
11	Activities		2,342		2,342		2,342		2,342		11
12	Social Services		400	760	1,160		1,160	(205)	955		12
13	CNA Training	4,702		735	5,437		5,437		5,437		13
14	Program Transportation		6,206		6,206		6,206		6,206		14
15	Other (specify):* Day Training			146,109	146,109		146,109	(146,109)			15
16	TOTAL Health Care and Programs	197,452	12,551	164,951	374,954		374,954	(146,314)	228,640		16
	C. General Administration										
17	Administrative	10,150	67		10,217		10,217		10,217		17
18	Directors Fees										18
19	Professional Services			26,789	26,789		26,789		26,789		19
20	Dues, Fees, Subscriptions & Promotions			2,003	2,003		2,003	(662)	1,341		20
21	Clerical & General Office Expenses	10,769	331	12,294	23,394		23,394		23,394		21
22	Employee Benefits & Payroll Taxes			44,943	44,943		44,943	(52)	44,891		22
23	Inservice Training & Education			63	63		63		63		23
24	Travel and Seminar			2,840	2,840		2,840	(125)	2,715		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,350	10,350		10,350		10,350		26
27	Other (specify):* Tax Penalty/Late Fee			435	435		435	(435)			27
28	TOTAL General Administration	20,919	398	99,717	121,034		121,034	(1,274)	119,760		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	262,069	63,280	283,670	609,019		609,019	(147,588)	461,431		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

Village Inn-Cobden

#0037770

Report Period Beginning:

1/1/09

Ending:

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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			18,984	18,984		18,984	11,544	30,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,186	3,186		3,186	2,238	5,424			32
33	Real Estate Taxes			8,136	8,136		8,136	(3,240)	4,896			33
34	Rent-Facility & Grounds			45,600	45,600		45,600	(45,600)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See Pg. 25			18,815	18,815		18,815	(18,815)				36
37	TOTAL Ownership			94,721	94,721		94,721	(53,873)	40,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,168	30,168		30,168		30,168			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			30,168	30,168		30,168		30,168			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	262,069	63,280	408,559	733,908		733,908	(201,461)	532,447			45

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

Village Inn-Cobden

ID# 0037770
 Report Period Beginning: 1/1/09
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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Travel Expense	\$ (125)	24	1
2	Flowers	(205)	12	2
3	CILA Start-Up Expense	(200)	20	3
4	PAC Dues	(83)	20	4
5	Over-Expensed Real Estate Taxes	(3,240)	33	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	(3,853)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Village Inn-Cobden# 0037770

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(205)	0	0	0	0	0	0	0	0	0	0	(205)	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):*	(146,109)	0	0	0	0	0	0	0	0	0	0	(146,109)	15
16	TOTAL Health Care and Programs	(146,314)	0	(146,314)	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	(662)	0	0	0	0	0	0	0	0	0	0	(662)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(52)	0	0	0	0	0	0	0	0	0	0	(52)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(125)	0	0	0	0	0	0	0	0	0	0	(125)	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):*	(435)	0	0	0	0	0	0	0	0	0	0	(435)	27
28	TOTAL General Administration	(1,274)	0	(1,274)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(147,588)	0	(147,588)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Village Inn-Cobden

0037770

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,140	7,404	0	0	0	0	0	0	0	0	0	11,544	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(235)	2,473	0	0	0	0	0	0	0	0	0	2,238	32
33	Real Estate Taxes	(3,240)	0	0	0	0	0	0	0	0	0	0	(3,240)	33
34	Rent-Facility & Grounds	0	(45,600)	0	0	0	0	0	0	0	0	0	(45,600)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(18,815)	0	0	0	0	0	0	0	0	0	0	(18,815)	36
37	TOTAL Ownership	(18,150)	(35,723)	0	(53,873)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(165,738)	(35,723)	0	0	0	0	0	0	0	0	0	(201,461)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert Chamness	100			Village Inn LT	Cobden, IL	Facility Rental
				JR's Centre, Inc.	Anna, IL	Adult Workshop
				JR's Centre LT	Anna, IL	Facility Rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent - Facility & Grounds	\$ 45,600	Village Inn Land Trust	100.00%	\$	(45,600)	1
2	V	30 Depreciation		Village Inn Land Trust	100.00%	7,404	7,404	2
3	V	32 Interest		Village Inn Land Trust	100.00%	2,473	2,473	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		\$ 45,600			\$ 9,877	\$ * (35,723)	14

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

Facility Name & ID Number

Village Inn-Cobden

0037770

Report Period Beginning:

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	Robert M Chamness	Administrator	Administrator	100.00	None	40	90.00	Salary	\$ 10,150	17-1	1
2		QMRRP	Programs						30,450	10-1	2
3											3
4	Traci A Chamness	DSP	Programs		None	40	100.00	Salary	8,735	10-1	4
5		Clerical	Payroll						8,735	22-1	5
6		RSD	Res Serv Dir						17,470	10-1	6
7											7
8	Matthew Chamness	Maintenance	Maintenance		None	21	100.00		6,101	6-1	8
9		Clerical	Clerical						2,034	21-1	9
10											10
11											11
12											12
13								TOTAL	\$ 83,675		13

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

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

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

1/1/09

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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.

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

Facility Name & ID Number

Village Inn-Cobden

0037770

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			
A. Directly Facility Related																			
Long-Term																			
1	Robert L. Chamness	X		Stock Redemption	\$455.93	7/1/04	\$ 30,000	\$ 5,015	7/1/10	5.0000	\$ 300	1							
2	Anna - Jonesboro Nat'l Bank		X	Vehicle Purchase	\$488.80	9/23/09	20,566	19,473	9/15/13	6.5000	299	2							
3	Southern Trust Bank		X	Van Purchase	\$398.68	8/5/06	16,620	1,465	7/5/10	7.0000		3							
4	Anna - Jonesboro Nat'l Bank		X	Van Purchase	\$402.00	12/19/06	16,786		12/19/10	7.0000	485	4							
5	Credit Card Finance Charge		X								120	5							
Working Capital																			
6	Southern Trust Bank		X	Line of Credit	N/A	9/29/09		19,000	9/29/10	5.0000	1,918	6							
7	Anna - Jonesboro Nat'l Bank		X	Line of Credit	N/A	12/19/06			9/23/09	Variable	64	7							
8												8							
9	TOTAL Facility Related				\$1,745.41		\$ 83,972	\$ 44,953			\$ 3,186	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 83,972	\$ 44,953			\$ 3,186	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	7,013	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	4,926	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,087)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	6,983	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	4,896	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	4,398	8	
	2005	4,290	9	
	2006	4,515	10	
	2007	4,745	11	
	2008	4,926	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

Facility Name & ID Number Village Inn-Cobden

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1/1/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
Located adjacent to the facility is a CILA facility. The CILA is one of three facilities operated in a closely-held corporation licensed under the provider name, "Chamness Care, Inc."
The adjacent CILA is licensed for 8 beds, and provides care to residents funded by DHS-Mental Health. Chamness Care, Inc. is owned and operated by Beverly Tweedy, sister of Robert M Chamness.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>21,960</u>	<u>1968</u>	<u>\$ 2,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	21,960		\$ 2,000	3

Facility Name & ID Number Village Inn-Cobden

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	16	1975		\$ 10,772	\$	26	\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	Building Improvement	1981		8,623		26			8,623
10	Building Improvement	1982		7,242		26			7,242
11	Building Improvement	1983		12,987		26			12,987
12	Sprinkler System	1983		18,340		26			18,340
13	Building Improvement	1984		25,130		26			25,130
14	Building Improvement	1989		144,871		30	4,829	4,829	97,385
15	Driveway Pavement	1997		5,175	345	15	345		4,312
16	Fire Escape Upgrade	1999		3,500	233	15	233		3,733
17	Water Heaters (2)	1999		1,627	109	15	108	(1)	1,144
18	Furnace	2001		1,936	129	15	129		1,096
19	Fire Doors (9)	2001		3,137	209	15	209		1,776
20	Roof & Gutters	2002		11,412	533	15	761	228	7,421
21	Floors	2002		2,555	119	15	170	51	1,660
22	Bath Fixtures	2003		675	20	15	45	25	506
23	Kitchen Remodeling	2004		8,196	511	15	546	35	3,600
24	Carpet	2004		7,410	426	5	741	315	7,410
25	Remodeling Bathroom	2004		517	32	15	34	2	227
26	Air Conditioner	2006		3,039	434	7	434		1,519
27	Remodeling Bathroom	2008		4,555	216	15	304	88	2,608
28									
29	* Village Inn Land Trust 2009 Depreciation						7,404	7,404	
30	See Sch. VII Line 2								
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 281,699	\$ 3,316		\$ 16,292	\$ 12,976	\$ 206,719	70

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

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	\$ 7,306	\$ 460	\$ 621	\$ 161	7	\$ 7,130	71
72	Current Year Purchases	626	358	45	(313)	7	358	72
73	Fully Depreciated Assets	55,260		4,684	4,684	7	54,952	73
74								74
75	TOTALS	\$ 63,192	\$ 818	\$ 5,350	\$ 4,532		\$ 62,440	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	2001 Ford Van	2001	\$ 27,199	\$	\$	\$	5	\$ 27,199	76
77	Resident Transportation	2006 Pontiac Van	2006	18,261	2,104	3,652	1,548	5	15,106	77
78	Resident Transportation	2006 Chev Van	2006	18,339	1,057	3,236	2,179	5	14,114	78
79	See Pg. 24			20,349	11,689	1,998	(9,691)		11,689	79
80	TOTALS			\$ 84,148	\$ 14,850	\$ 8,886	\$ (5,964)		\$ 68,108	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)	\$ 431,039	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,984	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,528	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,544	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 337,267	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: _____

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: \$ _____ 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		690		690
4	Clinical Wages (b)		1,346		1,346
5	In-House Trainer Wages (c)		2,666		2,666
6	Transportation				
7	Contractual Payments		735		735
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,437	\$	\$ 5,437
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,437		

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning: 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 34,707	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	42,144		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	58,000		8
9	Other(specify): <u>See pg. 25</u>	81,135		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 215,986	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	182,735		16
17	Accumulated Depreciation (book methods)	(152,467)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 30,268	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 246,254	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 49,149	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	58,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	(690)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Assessment Payable</u>	7,157		36
37	<u>Employee Benefits Payable</u>	954		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 121,170	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	24,732		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 24,732	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 145,902	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 100,352	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 246,254	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 162,661	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 162,661	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,309)	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)	\$ (62,309)	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)	\$ 100,352	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Village Inn-Cobden# 0037770Report Period Beginning: 1/1/09Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 519,966	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 519,966	3
B. Ancillary Revenue			
4	Day Care	151,398	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 151,398	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	235	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 235	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 671,599	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	113,031	31
32	Health Care	374,954	32
33	General Administration	121,034	33
B. Capital Expense			
34	Ownership	94,721	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	30,168	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 733,908	40
41	Income before Income Taxes (line 30 minus line 40)**	(62,309)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (62,309)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number Village Inn-Cobden

0037770

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		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses		1,375		4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician	2,478	2,522	22,007	8.73
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	766	766	6,101	7.96
18	Housekeepers	1,415	1,461	15,590	10.67
19	Laundry				19
20	Administrator	510	520	10,150	19.52
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	691	711	10,769	15.15
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,879	1,915	36,022	18.81
29	Resident Services Coordinator	1,698	1,750	28,613	16.35
30	Habilitation Aides (DD Homes)	13,638	13,838	131,442	9.50
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	23,075	23,483	\$ 262,069 *	\$ 11.16

* 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	24	\$ 1,104	1-3
36	Medical Director	As Needed	2,400	9-3
37	Medical Records Consultant			
38	Nurse Consultant	As Needed	8,520	10-3
39	Pharmacist Consultant	As Needed	400	10-3
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant	As Needed	1,000	10a-3
44	Activity Consultant			
45	Social Service Consultant	19	760	10a-3
46	Other(specify) <u>Psychologist</u>	26	1,100	10-3
47	<u>Dentist</u>	As Needed	1,200	10-3
48	<u>Behavior Consultant</u>	As Needed	1,500	10a-3
49	TOTAL (lines 35 - 48)	69	\$ 17,984	

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Robert M. Chamness	Administrator	100	\$ 10,150	Workers' Compensation Insurance	\$ 11,195	IDPH License Fee	\$ 102	
				Unemployment Compensation Insurance	3,044	Advertising: Employee Recruitment		
				FICA Taxes	20,252	Health Care Worker Background Check		
				Employee Health Insurance	10,400	(Indicate # of checks performed <u>2</u>)	32	
				Employee Meals	52	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		See Pg. 25	1,207	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 10,150	Less:				
(List each licensed administrator separately.)				Employee Meals	(52)			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 44,891	
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
None			\$	Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$				In-State Travel	
(Attach a copy of any management service agreement)							IHCA Convention	566
C. Professional Services							IDPH Hearings	1,037
Vendor/Payee	Type		Amount				Seminar Expense	
Barnett & Levine	CPA Services		\$ 3,405				CC/CEU's	317
FMGR	Attorney		1,009				IHCA Convention	795
Polsinelli	Attorney		18,307				Entertainment Expense	()
kel-Tech Management Co.	Acct'g Services		4,068				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,715
TOTAL (agree to Schedule V, line 19, column 3)			\$ 26,789	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Village Inn-Cobden

0037770

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. IL Healthcare Assoc. \$1040
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 261 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Previously operated as Village Shelter Care under the same ID Number.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,168
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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.

Village Inn							
Enclosed Detail for Various Schedules 2009							
Detail for Sch. XV. Line 9 Col. 1							
Day Training Receivable			41036				
Employee Advances			65				
IDPA 11/2009 Pmt. Receivable			40034				
Total			\$81,135				
Village Inn, Inc.							
Sch 5, Pg 3, Line 20, Col 8							
IL Healthcare Assoc Dues			957				
IL Healthcare Assoc PAC Dues			83				
Advertising			379				
Franchise Fee			100				
IL CILA Lisence Fee			200				
Corp. Annual Report			150				
Less:							
PAC Dues			-83				
Advertising			-379				
IL CILA Lisence Fee			-200				
Total			1207				
Village Inn, Inc.							
Sch. XIX, Section G							
<u>IHCA Convention</u>							
	Dates	Location	Individuals Attended	Job Title	Hotel	Gas & Food	Seminar Cost
	9/14/09 - 09/17/09	Peoria, IL	Matt Chamness	Admin.	\$366	\$200	\$795
			Traci Chamness	RSD			
<u>IHCA Convention - ICF-DD Symposium</u>							
	Dates	Individuals Attended	Job Title	Seminar Cost			
	Jul-09	Matt Chamness	Admin.	\$170			
<u>CILA Application Seminar</u>							
	Dates	Location	Individuals Attended	Job Title	Hotel	Gas & Food	
	3/31/2009	Springfield, IL	Matt Chamness	Admin.	\$81	\$107	
			Traci Chamness	RSD			
<u>IDPH Hearing</u>							
	Dates	Location	Individuals Attended	Job Title	Hotel & Food		
	10/18/09 - 10/20/09	Chicago, IL	Matt Chamness	Admin.	\$924		
			Traci Chamness	RSD			
<u>Online CEU's</u>							
	Reimbursement for online purchase for CEU's for Matt Chamness, Village Inn Administrator					\$317	
Total Travel & Seminar Costs		\$2,960					
Less:							
Repayment Due from other fac for prior Travel Expenses		(\$245)					
Total Travel & Seminar Costs		\$2,715					