

Facility Name & ID Number Village Inn-Cobden

0037770 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 5840

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 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	<u>5,083</u>			<u>5,083</u>	13
14	TOTALS	<u>5,083</u>			<u>5,083</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.04%

D. How many bed-hold days during this year were paid by the Department? 56 (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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Village Inn-Cobden # 0037770 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	42,711	788	1,116	44,615		44,615		44,615		1
2	Food Purchase		43,083		43,083		43,083		43,083		2
3	Housekeeping	11,474	2,972		14,446		14,446		14,446		3
4	Laundry										4
5	Heat and Other Utilities			12,375	12,375		12,375		12,375		5
6	Maintenance	340	9,029	9,582	18,951	(80)	18,871		18,871		6
7	Other (specify):*										7
8	TOTAL General Services	54,525	55,872	23,073	133,470	(80)	133,390		133,390		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	180,007	4,395	9,720	194,122		194,122		194,122		10
10a	Therapy		3,327	2,425	5,752		5,752		5,752		10a
11	Activities	17,880			17,880		17,880		17,880		11
12	Social Services			1,300	1,300		1,300		1,300		12
13	CNA Training	5,758		900	6,658		6,658		6,658		13
14	Program Transportation		11,216		11,216		11,216		11,216		14
15	Other (specify):* Day Training			155,342	155,342		155,342	(155,342)			15
16	TOTAL Health Care and Programs	203,645	18,938	172,087	394,670		394,670	(155,342)	239,328		16
	C. General Administration										
17	Administrative	20,500			20,500		20,500		20,500		17
18	Directors Fees										18
19	Professional Services			28,424	28,424		28,424		28,424		19
20	Dues, Fees, Subscriptions & Promotions			1,889	1,889	80	1,969	(635)	1,334		20
21	Clerical & General Office Expenses		4,633	13,087	17,720		17,720		17,720		21
22	Employee Benefits & Payroll Taxes			46,023	46,023		46,023		46,023		22
23	Inservice Training & Education			231	231		231		231		23
24	Travel and Seminar			74	74		74		74		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			11,611	11,611		11,611		11,611		26
27	Other (specify):* IDPH Penalty/Fine			5,000	5,000		5,000	(5,000)			27
28	TOTAL General Administration	20,500	4,633	106,339	131,472	80	131,552	(5,635)	125,917		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	278,670	79,443	301,499	659,612		659,612	(160,977)	498,635		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:

1/1/2010

Ending:

12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,190	9,190		9,190	18,008	27,198			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,601	4,601		4,601	2,561	7,162			32
33	Real Estate Taxes			5,776	5,776		5,776	413	6,189			33
34	Rent-Facility & Grounds			45,600	45,600		45,600	(45,600)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Federal Inc. Tax			(16,551)	(16,551)		(16,551)		(16,551)			36
37	TOTAL Ownership			48,616	48,616		48,616	(24,618)	23,998			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)	278,670	79,443	380,283	738,396		738,396	(185,595)	552,801			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (155,342)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,785	30		9
10	Interest and Other Investment Income	(203)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties	(5,000)	27		18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(315)	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 See Attached	343			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (149,982)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,613)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,613)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (185,595)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Village Inn-Cobden

ID# 0037770

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Under-Expensed Real Estate Taxes	\$ 413	33	1
2	PAC Dues	(70)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	343		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Village Inn-Cobden# 0037770

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	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):*	(155,342)	0	0	0	0	0	0	0	0	0	0	(155,342)	15
16	TOTAL Health Care and Programs	(155,342)	0	(155,342)	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	(635)	0	0	0	0	0	0	0	0	0	0	(635)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	27
28	TOTAL General Administration	(5,635)	0	(5,635)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,977)	0	(160,977)	29									

STATE OF ILLINOIS

Facility Name & ID Number Village Inn-Cobden# 0037770

Report Period Beginning:

1/1/2010 Ending:

Summary B

12/31/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	10,785	7,223	0	0	0	0	0	0	0	0	0	18,008	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(203)	2,764	0	0	0	0	0	0	0	0	0	2,561	32
33	Real Estate Taxes	413	0	0	0	0	0	0	0	0	0	0	413	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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	10,995	(35,613)	0	(24,618)	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)	(149,982)	(35,613)	0	0	0	0	0	0	0	0	0	(185,595)	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	Land Trust
				JR's Centre, Inc.	Anna, IL	Adult Workshop
				JR's Centre LT	Anna, IL	Land Trust

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%	7,223	7,223	2
3	V	32 Interest		Village Inn Land Trust	100.00%	2,764	2,764	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			\$ 9,987	\$ * (35,613)	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:

1/1/2010

Ending:

12/31/2010

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	50.00	None	20	45.00	Salary	\$ 20,500	17-1	1
2		QSP	Programs	50.00		20	45.00	Salary	20,500	10-1	2
3											3
4	Traci A Chamness	Activity Director	Programs	0.00	None	20	50.00	Salary	17,880	11-1	4
5		Food Service	Payroll	0.00	None	20	50.00	Salary	17,880	1-1	5
6										10-1	6
7											7
8	Matthew Chamness	Maintenance	Maintenance	0.00	None	20	100.00		298	6-1	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 77,058		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:

1/1/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

Facility Name & ID Number

Village Inn-Cobden

0037770

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	Anna-Jonesboro Nat'l Bank		X	Vehicle Purchase	\$488.80	9/23/09	\$ 20,566	\$ 14,734	9/15/13	6.5000	\$ 1,102	1							
2	Robert L. Chamness	X		Stock Redemption	\$455.93	7/1/04	30,000		5/10/10	5.0000	71	2							
3	Southern Trust Bank		X	Van Purchase	\$398.68	8/5/06	16,620		5/1/10	7.0000	764	3							
4	Credit Card Finance Charge		X								11	4							
5	Walmart Credit Card Fin. Charge		X								25	5							
	Working Capital																		
6	Southern Trust Bank		X	Line of Credit	N/A	9/29/10		61,500	9/29/11	5.0000	2,628	6							
7												7							
8												8							
9	TOTAL Facility Related				\$1,343.41		\$ 67,186	\$ 76,234			\$ 4,601	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 67,186	\$ 76,234			\$ 4,601	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 Village Inn-Cobden

0037770

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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 is owned and operated by Bevery 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

0037770

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	\$ 7,223	26	\$ 7,223	\$	\$
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	102,214
15	Driveway Pavement	1997		5,175	345	15	345		4,629
16	Rebuilt Fire Escape	1999		3,500	233	15	233		2,641
17	Water Heaters	1999		1,627	109	15	108	(1)	1,215
18	Furnace	2001		1,936	129	15	129		1,161
19	Fire Doors	2001		3,137	209	15	209		2,055
20	Roof & Gutters	2002		11,412	533	15	761	228	6,468
21	Floors	2002		2,555	119	15	170	51	1,417
22	Bath Fixtures	2003		675	20	15	45	25	323
23	Kitchen Remodeling	2004		8,196	484	15	546	62	3,595
24	Carpet	2004		7,410		5			7,410
25	Remodeling	2004		517	31	15	34	3	221
26	Air Conditioner	2006		3,039	434	7	434		1,953
27	Bathroom Remodeled	2008		4,555	195	15	304	109	659
28									
29									
30									
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:

1/1/2010

Ending:

12/31/2010

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	\$ 10,064		\$ 15,370	\$ 5,306	\$ 208,283	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:

1/1/2010

Ending:

12/31/2010

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	\$ 29,300	\$ 195	\$ 4,089	\$ 3,894		\$ 21,686	71
72	Current Year Purchases	842	842	90	(752)		90	72
73	Fully Depreciated Assets	33,892					33,892	73
74								74
75	TOTALS	\$ 64,034	\$ 1,037	\$ 4,179	\$ 3,142		\$ 55,668	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	\$	\$	\$		\$ 27,199	76
77	Resident Transportation	2006 Pontiac Van	2006	18,261	2,104	3,652	1,548		16,434	77
78	Resident Transportation	2009 Toyota Rav4	2009	19,074	3,052	3,815	763		5,722	78
79	Generator		2009	1,275	156	182	26		273	79
80	TOTALS			\$ 65,809	\$ 5,312	\$ 7,649	\$ 2,337		\$ 49,628	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)	\$ 413,542	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,413	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,198	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,785	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 313,579	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: Related Party

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>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)	264	625		889
4	Clinical Wages (b)	515	1,218		1,733
5	In-House Trainer Wages (c)	932	2,204		3,136
6	Transportation		600		600
7	Contractual Payments	300			300
8	CNA Competency Tests				
9	TOTALS	\$ 2,011	\$ 4,647	\$	\$ 6,658
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,658			

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
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
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# 0037770Report Period Beginning: 1/1/2010Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 87,379	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(1,989)		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>Pg. 24</u>	38,179		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 181,569	\$	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	183,577		16
17	Accumulated Depreciation (book methods)	(161,657)		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)	\$ 21,920	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 203,489	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,679	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	61,500		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	(370)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,145		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	237		35
	Other Current Liabilities(specify):			
36	<u>See pg. 24</u>	4,261		36
37	<u>Day Training Payable</u>	38,102		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 121,554	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,710		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)	\$ 14,710	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 136,264	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 67,225	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 203,489	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 100,352	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 100,352	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(33,127)	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)	\$ (33,127)	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)	\$ 67,225	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Village Inn-Cobden# 0037770Report Period Beginning: 1/1/2010Ending: 12/31/2010

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	\$ 549,305	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 549,305	3
B. Ancillary Revenue			
4	Day Care	155,342	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 155,342	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	419	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)	\$ 419	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	203	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 203	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)	\$ 705,269	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	133,470	31
32	Health Care	394,670	32
33	General Administration	131,472	33
B. Capital Expense			
34	Ownership	48,616	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)*	\$ 738,396	40
41	Income before Income Taxes (line 30 minus line 40)**	(33,127)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (33,127)	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:

1/1/2010

Ending:

12/31/2010

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	62	62	2,613	42.15	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,020	1,040	17,880	17.19	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,020	1,040	17,880	17.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,735	1,735	24,831	14.31	15
16	Dishwashers					16
17	Maintenance Workers	40	40	340	8.50	17
18	Housekeepers	955	1,011	11,474	11.35	18
19	Laundry					19
20	Administrator	1,020	1,040	20,500	19.71	20
21	Assistant Administrator					21
22	Other Administrative					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)	1,020	1,040	20,500	19.71	28
29	Resident Services Coordinator	2,080	2,080	31,339	15.07	29
30	Habilitation Aides (DD Homes)	14,302	14,594	131,313	9.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,254	23,682	\$ 278,670 *	\$ 11.77	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	24	\$ 1,116	1-3	35
36	Medical Director	As Needed	2,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	As Needed	8,520	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	1,050	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	32	1,300	12-3	45
46	Other(specify) <u>Dental Consult.</u>	As Needed	1,200	10-3	46
47	<u>Psychology Consultant</u>	32	1,300	10a-3	47
48	<u>Behavioral Consultant</u>	As Needed	75	10a-3	48
49	TOTAL (lines 35 - 48)	88	\$ 16,961		49

C. CONTRACT NURSES

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

Facility Name & ID Number Village Inn-Cobden

Report Period Beginning: 1/1/2010

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	\$ 20,500	Workers' Compensation Insurance	\$ 11,381	IDPH License Fee	\$		
				Unemployment Compensation Insurance	5,592	Advertising: Employee Recruitment	94		
				FICA Taxes	21,185	Health Care Worker Background Check			
				Employee Health Insurance	7,865	(Indicate # of checks performed <u>7</u>)	80		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		See Pg. 24	1,160		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 20,500						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 46,023	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Barnett & Levine	CPA Services	\$ 5,335				\$	Out-of-State Travel	\$	
FMGR	Attorney	694							
Polsinelli	Attorney	11,527					In-State Travel		
kel-Tech Management Co.	Accounting Services	2,116					SAMA Seminar - John A. Logan College	32	
Stratton, Giganti, Stone, Morgan, &	Attorney	8,753							
							Seminar Expense		
							SAMA Seminar - John A. Logan College	42	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 28,425					TOTAL	
								\$ 74	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Village Inn-Cobden

0037770

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

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. \$880
- (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. \$ 536 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
2010

Detail for Sch. XV. Line 9 Col. 1

Day Training Receivable	38,102
Employee Advances	65
Undeposited Funds	12
Total	\$38,179

Detail for Sch. XV. Line 36 Col. 1

Assesment Payable	(17)
IDPH Fines/Penalties Payable	1,667
Employee Health Ins. Payable	2,625
Payroll Taxes Payable	(14)
Total	\$4,261

Detail for Sch V Line 20, Col 8

IL Healthcare Assoc Dues	810
IL Healthcare Assoc PAC Dues	70
Advertising	315
Resident Surety Bond	200
Contributions	50
Corp. Annual Report	150
CILA Start-Up Fee	200
Less:	
PAC Dues	(70)
Advertising	(315)
Contributions	(50)
CILA Start-Up Fee	(200)
Total	\$1,160

Sch. V Line 6 to 20 Reclassification

Employee Background Checks were expensed as an Outside Service under Line 6. We reclassified the expense to Dues, Fees, Subscriptions Line 20.

Analysis Allocated Hours & Wages
Sch18

Allocation of wages:

QMRP	50%	\$ 20,500
Administrator	50%	\$ 20,500
Total	100%	\$ 41,000
Activity Director	50%	\$ 17,880
Food Service Supervisor	50%	\$ 17,880
Total		\$ 35,760