FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0051417

Facility Name: Park Villa Nrsg & Rehab Ctr

Address: 12550 S Ridgeland Av (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708) 597-9300 **Fax #** (708) 597-2472

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			12,517	12,517	8
9	SNF/PED					9
10	ICF	8,443	2,429	2,008	12,880	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,443	2,429	14,525	25,397	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.89%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 101 and days of care provided 12,517

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	268,533	50,334	11,865	330,732		330,732		330,732			1
2	Food Purchase		141,609		141,609	(27,375)	114,234	(37)	114,197			2
3	Housekeeping		10,231	169,257	179,488		179,488		179,488			3
4	Laundry			112,836	112,836		112,836		112,836			4
5	Heat and Other Utilities			156,058	156,058		156,058	(9,797)	146,261			5
6	Maintenance	40,389	261	89,274	129,924		129,924	20,226	150,150			6
7	Other (specify):*											7
8	**TOTAL General Services**	308,922	202,435	539,290	1,050,647	(27,375)	1,023,272	10,392	1,033,664			8
	B. Health Care and Programs											
9	Medical Director			78,000	78,000		78,000		78,000			9
10	Nursing and Medical Records	2,066,872	172,520		2,239,392		2,239,392		2,239,392			10
10a	Therapy	104,771	16,145		120,916		120,916		120,916			10a
11	Activities	67,777	8,775		76,552		76,552		76,552			11
12	Social Services	126,209			126,209		126,209		126,209			12
13	CNA Training											13
14	Program Transportation			40,028	40,028		40,028	(3,221)	36,807			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,365,629	197,440	118,028	2,681,097		2,681,097	(3,221)	2,677,876			16
	C. General Administration											
17	Administrative	116,364		100,000	216,364		216,364		216,364			17
18	Directors Fees											18
19	Professional Services			170,983	170,983	(12,179)	158,804	392	159,196			19
20	Dues, Fees, Subscriptions & Promotions			61,418	61,418		61,418	(19,228)	42,190			20
21	Clerical & General Office Expenses	274,121	1,115	326,012	601,248		601,248	(162,843)	438,405			21
22	Employee Benefits & Payroll Taxes			627,477	627,477	27,375	654,852		654,852			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,208	5,208		5,208	262	5,470			24
25	Other Admin. Staff Transportation			12,411	12,411		12,411	229	12,640			25
26	Insurance-Prop.Liab.Malpractice			67,967	67,967		67,967	(1,158)	66,809			26
27	Other (specify):*							3,987	3,987			27
28	**TOTAL General Administration**	390,485	1,115	1,371,476	1,763,076	15,196	1,778,272	(178,360)	1,599,912			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,065,036	400,990	2,028,794	5,494,820	(12,179)	5,482,641	(171,189)	5,311,452			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 Park Villa Nrsg & Rehab Ctr #0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			260,086	260,086		260,086	(152,434)	107,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,270	27,270		27,270	(4,347)	22,923			32
33	Real Estate Taxes			88	88	12,179	12,267	1,124	13,391			33
34	Rent-Facility & Grounds			788,752	788,752		788,752		788,752			34
35	Rent-Equipment & Vehicles			36,381	36,381		36,381	(18,631)	17,750			35
36	Other (specify):*			1,215	1,215		1,215	(1,215)	0			36
37	**TOTAL Ownership**			1,113,792	1,113,792	12,179	1,125,971	(175,503)	950,467			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		768,138	1,447,549	2,215,687		2,215,687		2,215,687			39
40	Barber and Beauty Shops			15	15		15		15			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,897	137,897		137,897		137,897			42
43	Other (specify):*			483,644	483,644		483,644	(483,644)	0			43
44	**TOTAL Special Cost Centers**		768,138	2,069,105	2,837,243		2,837,243	(483,644)	2,353,599			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,065,036	1,169,128	5,211,691	9,445,855		9,445,855	(830,336)	8,615,519			45

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	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	(10,163)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(153,713)	30		9
10	Interest and Other Investment Income	(4,763)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(135)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(171,220)	21		24
25	Fund Raising, Advertising and Promotional	(9,676)	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	(508,920)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (858,590)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	28,254		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 28,254		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (830,336)		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 Yes	2 No	3 Amount	4 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

Park Villa Nrsg & Rehab Ctr

ID# 0051417

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing	$ (826)	43	1
2	Non-allowable Travel	(57)	25	2
3	Prior Period - Insurance Premiums	(1,301)	26	3
4	Rental Income	(556)	06	4
5	Referral Fees	(33,899)	43	5
6	Promo/Art/Design/Print	(3,560)	43	6
7	Direct Mail	(8)	43	7
8	Resident Retention	(9,182)	43	8
9	Locater/Promo/Gifts	(2,792)	43	9
10	Marketing/Entertainment	(30,525)	43	10
11	Marketing Supplies	(6,240)	43	11
12	Bank Fees	(13,621)	21	12
13	Donations	(6,512)	20	13
14	Acquisition Costs	(1,215)	36	14
15	Non-allowable Auto Rental	(18,716)	35	15
16	Non-allowable Expense	(396,611)	43	16
17	PAC Dues	(3,600)	20	17
18	Additional R&M	20,302	06	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**	(508,920)		49

Park Villa Nrsg & Rehab Ctr

ID# 0051417

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(135)		98									(37)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,163)		196	170								(9,797)	5
6	Maintenance	19,746		476	4								20,226	6
7	Other (specify):*													7
8	**TOTAL General Services**	9,448		770	174								10,392	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(3,221)							(3,221)	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**					(3,221)							(3,221)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services			183	209								392	19
20	Fees, Subscriptions & Promotions	(19,787)		556	3								(19,228)	20
21	Clerical & General Office Expenses	(184,841)		21,998									(162,843)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			262									262	24
25	Other Admin. Staff Transportation	(57)		286									229	25
26	Insurance-Prop.Liab.Malpractice	(1,301)		53	90								(1,158)	26
27	Other (specify):*			3,987									3,987	27
28	**TOTAL General Administration**	(205,987)		27,325	302								(178,360)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(196,539)		28,095	476	(3,221)							(171,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr **#** 0051417 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(153,713)		141	1,138								(152,434)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,763)		12	404								(4,347)	32
33	Real Estate Taxes				1,124								1,124	33
34	Rent-Facility & Grounds			567	(567)									34
35	Rent-Equipment & Vehicles	(18,716)		85									(18,631)	35
36	Other (specify):*	(1,215)											(1,215)	36
37	TOTAL Ownership	(178,407)		805	2,099								(175,503)	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													42
43	Other (specify):*	(483,644)											(483,644)	43
44	TOTAL Special Cost Centers	(483,644)											(483,644)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(858,590)		28,900	2,575	(3,221)							(830,336)	45

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 788,752	Park Villa Realty	100.00%	$ 788,752	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 788,752			$ 788,752	$ *	14

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	VILLA FINANCIAL SERVICES, LLC	100.00%	$ 98	$ 98	15
16	V	5	UTILITIES		VILLA FINANCIAL SERVICES, LLC	100.00%	196	196	16
17	V	6	REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	476	476	17
18	V	19	PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC	100.00%	183	183	18
19	V	20	FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC	100.00%	556	556	19
20	V	21	CLERICAL & GENERAL		VILLA FINANCIAL SERVICES, LLC	100.00%	21,998	21,998	20
21	V	24	SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC	100.00%	262	262	21
22	V	25	ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC	100.00%	286	286	22
23	V	26	INSURANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	53	53	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC	100.00%	3,987	3,987	24
25	V	30	DEPRECIATION		VILLA FINANCIAL SERVICES, LLC	100.00%	141	141	25
26	V	32	INTEREST		VILLA FINANCIAL SERVICES, LLC	100.00%	12	12	26
27	V	34	RENT		VILLA FINANCIAL SERVICES, LLC	100.00%	567	567	27
28	V	35	EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC	100.00%	85	85	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 28,900	$ * 28,900	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	3737 Chase, LLC	100.00%	$ 170	$ 170	15
16	V	6	REPAIRS AND MAINTENANCE		3737 Chase, LLC	100.00%	4	4	16
17	V	19	PROFESSIONAL FEES		3737 Chase, LLC	100.00%	25	25	17
18	V	19	REAL ESTATE TAX PROTEST FEES		3737 Chase, LLC	100.00%	184	184	18
19	V	20	DUES & SUBSCRIPTIONS		3737 Chase, LLC	100.00%	3	3	19
20	V	26	INSURANCE		3737 Chase, LLC	100.00%	90	90	20
21	V	30	DEPRECIATION		3737 Chase, LLC	100.00%	1,138	1,138	21
22	V	32	INTEREST EXPENSE		3737 Chase, LLC	100.00%	404	404	22
23	V	33	REAL ESTATE TAXES		3737 Chase, LLC	100.00%	1,124	1,124	23
24	V								24
25	V								25
26	V	34	RENT	567	3737 Chase, LLC	100.00%		(567)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 567			$ 3,142	$ * 2,575	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Ambulance	$ 13,874	Lifeline Ambulance	100.00%	$ 10,653	$ (3,221)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,874			$ 10,653	$ * (3,221)	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES, LLC	40.00%	ADDINGTON PLACE	NORTHVILLE, MICHIGAN	3737 CHASE, LLC	SKOKIE	BUILDING CO	1
2	MARK BERGER	35.05%	HARBOR HOUSE	WHEELING	VILLA FINANCIAL SERVICES	SKOKIE	MANAGEMENT	2
3	CHAIM RAJCHENBACH	10.00%	HOLLAND HOME	SOUTH HOLLAND	PARK VILLA REALTY	LINCOLNWOOD	BUILDING CO	3
4	MENACHEM SHABAT	10.00%	VILLA AT SOUTH HOLLAND	SOUTH HOLLAND	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	4
5	TODD STERN	4.95%	THE VILLA AT BRADLEY ESTATES	MILWAUKEE, WISCONSIN	THE PINNACLE APARTMENTS		APARTMENTS	5
6			THE VILLA AT BRYN MAWR	MINNEAPOLIS, MINNESOTA	DISTINCT LLC		APARTMENTS	6
7			THE VILLA AT EVERGREEN	EVERGREEN PARK				7
8			THE VILLA AT MILLWAY	MILWAUKEE, WISCONSIN				8
9			THE VILLA AT OSSEO	OSSEO, MINNESOTA				9
10			THE VILLA AT ST. LOUIS PARK	ST LOUIS PARK, MINNESOTA				10
11			THE VILLA AT WINDSOR PARK	CHICAGO				11
12			TRINITY SENIOR COMMUNITY	MILWAUKEE, WISCONSIN				12
13			VILLA AT PA PETERSOM	ROCKFORD				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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Berger	Owner	Administrative	35.05%	See Attached	1.72	2.15%	Salary	$ 100,000	17-03	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 100,000		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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: VILLA FINANCIAL SERVICES, LLC
Street Address: 3755 WEST CHASE AVENUE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 440-2660
Fax Number: (847) 430-3538

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	MNMGT FEE REV	4,361,823	17	$ 9,627	$	44,253	$ 98	1
2	5	UTILITIES	MNMGT FEE REV	4,361,823	17	19,315		44,253	196	2
3	6	REPAIRS AND MAINTENANCE	MNMGT FEE REV	4,361,823	17	46,962		44,253	476	3
4	19	PROFESSIONAL FEES	MNMGT FEE REV	4,361,823	17	18,033		44,253	183	4
5	20	FEES SUBSCRIPTIONS	MNMGT FEE REV	4,361,823	17	54,760		44,253	556	5
6	21	CLERICAL & GENERAL	MNMGT FEE REV	4,361,823	17	2,168,215	2,050,495	44,253	21,998	6
7	24	SEMINARS AND EDUCATION	MNMGT FEE REV	4,361,823	17	25,783		44,253	262	7
8	25	ADMIN. STAFF TRAVEL	MNMGT FEE REV	4,361,823	17	28,164		44,253	286	8
9	26	INSURANCE	MNMGT FEE REV	4,361,823	17	5,202		44,253	53	9
10	27	EMPLOYEE BEN. GEN. ADMIN	MNMGT FEE REV	4,361,823	17	392,983		44,253	3,987	10
11	30	DEPRECIATION	MNMGT FEE REV	4,361,823	17	13,873		44,253	141	11
12	32	INTEREST	MNMGT FEE REV	4,361,823	17	1,146		44,253	12	12
13	34	RENT	MNMGT FEE REV	4,361,823	17	55,844		44,253	567	13
14	35	EQUIPMENT RENTAL	MNMGT FEE REV	4,361,823	17	8,370		44,253	85	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,848,277	$ 2,050,495		$ 28,900	25

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: 3737 Chase, LLC
Street Address: 3755 Chase Ave.
City / State / Zip Code: Skokie, IL, 60076
Phone Number: (847) 440-2660
Fax Number: (847) 430-3538

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MANAGEMENT FEE REVE	4,361,823	17	$ 16,738	$	44,253	$ 170	1
2	6	REPAIRS AND MAINTENANCE	MANAGEMENT FEE REVE	4,361,823	17	420		44,253	4	2
3	19	PROFESSIONAL FEES	MANAGEMENT FEE REVE	4,361,823	17	2,415		44,253	25	3
4	19	REAL ESTATE TAX PROTEST	MANAGEMENT FEE REVE	4,361,823	17	18,141		44,253	184	4
5	20	DUES & SUBSCRIPTIONS	MANAGEMENT FEE REVE	4,361,823	17	270		44,253	3	5
6	26	INSURANCE	MANAGEMENT FEE REVE	4,361,823	17	8,858		44,253	90	6
7	30	DEPRECIATION	MANAGEMENT FEE REVE	4,361,823	17	112,126		44,253	1,138	7
8	32	INTEREST EXPENSE	MANAGEMENT FEE REVE	4,361,823	17	39,847		44,253	404	8
9	33	REAL ESTATE TAXES	MANAGEMENT FEE REVE	4,361,823	17	110,809		44,253	1,124	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					$ 309,624	$		$ 3,142	25

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Avenue
City / State / Zip Code: Chicago, IL 60616
Phone Number: ((312) 949-9595
Fax Number: ((312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Ambulance	Direct Allocation			$	$		$ 10,653	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					$	$		$ 10,653	25

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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
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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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				500,000	8/10/2015	4.5000	2,014	6
7	MB Financial		X	Construction Loan				384,790	05/10/2016	5.0000	25,256	7
8	See Supplemental Schedule										416	8
9	TOTAL Facility Related						$	$ 884,790			$ 27,686	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,763)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,763)	14
15	TOTALS (line 9+line14)						$	$ 884,790			$ 22,923	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated - Villa Financial Services		X				$	$			$ 12	8
9	Allocated - 3737 Chase, LLC		X								404	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										416	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 237,385	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.)		$ 238,597	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,212	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 12,179	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 $ 10,279 For 2010 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.		$ 13,391	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010	191,176	9
2011	215,854	10
2012	230,687	11
2013	237,473	12

Beginning Accrual Adjusted
Allocated - 3737 Chase, LLC - $1,124

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Villa Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051417

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-30-404-033-0000	Long Term Care Property	$ 237,472.83	$ 237,472.83
2.	10-35-104-076-0000	See Attached	$ 96,109.63	$ 975.08
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 333,582.46	$ 238,447.91

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Villa Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051417

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,446 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 38,463	1
2	Alloc - 3737 Chase, LLC			2,610	2
3	TOTALS			$ 41,073	3

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)		59,551			3,028	3,028	8,984	67
68	Related Party Allocations (Pages 12H & 12I)		26,307	518		939	421	1,018	68
69	Financial Statement Depreciation			260,086			(260,086)		69
70	TOTAL (lines 4 thru 69)		$ 85,858	$ 260,604		$ 3,967	$ (256,637)	$ 10,002	70

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 85,858	$ 260,604		$ 3,967	$ (256,637)	$ 10,002	1
2	Exhausted Fan	2011	2,520		20	504	504	1,890	2
3	Panel	2011	3,252		20	650	650	2,385	3
4	Leasehold Improvements	2011	3,560		20	237	237	831	4
5	Lighting	2011	3,110		20	207	207	726	5
6	Front Renovation - Se Up Fountain Element / Landscaping	2011	20,520		20	1,368	1,368	4,902	6
7	Cable	2011	10,000		20	667	667	2,334	7
8	Roofing	2011	6,223		20	415	415	1,452	8
9	Wires	2011	2,646		20	176	176	618	9
10	Structural Engingeering	2011	3,374		20	169	169	619	10
11	Courtyard Renovation-Seat Walls, Fence, Landscaping, Paint, Fou	2011	41,935		20	2,097	2,097	8,387	11
12	Awning - Custom Shaped Canopy Over Main Entrance And Sidew	2011	9,950		20	498	498	1,990	12
13	Plumbing - Removed And Installed New Pvc Drains & Kitchen Ha	2011	8,870		20	444	444	1,774	13
14	Replace Water Heater	2011	6,848		20	342	342	1,370	14
15	Res Rms-Wall Repair, Electrical, Hvac, Flooring, Cubicle Curtains	2011	428,114		20	21,436	21,436	85,742	15
16	Res Bathrms-Window Covering, Flooring, Plumbing	2011	136,589		20	6,829	6,829	27,318	16
17	Corridors-Wallcovering	2011	57,629		20	2,881	2,881	11,526	17
18	Bldg Exterior-Lighting, Sidewalk, Doors,	2011	24,863		20	1,243	1,243	4,973	18
19	Rehab/Med/Thrpy-Cabinet, Kitchen Sink, Paint, Flooring, Walls, I	2011	56,005		20	2,800	2,800	11,201	19
20	Offices & Copy Rm-Flooring, Electrical & Ceiling	2011	46,699		20	2,335	2,335	9,340	20
21	Conference Room-Flooring, Wallcovering, Electrical	2011	4,115		20	206	206	823	21
22	Vestibule/Lobby-Flooring, Walls, Window Covering, Lighting	2011	58,159		20	2,908	2,908	11,632	22
23	Kitchen-Flooring, Electric, Cabinets, Plumbing, Door	2011	16,649		20	832	832	3,330	23
24	Res Bathrms-Electrical, Plumbing, Fixtures, Walls & Floors	2011	70,338		20	3,517	3,517	14,068	24
25	Library-Flooring, Wallcovering, Fireplace	2011	10,977		20	549	549	2,195	25
26	Dining Rm-Flooring, Wallcovering, Chandeliers	2011	39,740		20	1,987	1,987	7,948	26
27	Nurses Station-Custom Stations	2011	31,672		20	1,584	1,584	6,334	27
28	Res Rms-Light Fixtures, Wall Prep& Painting, Electrical	2011	25,214		20	1,261	1,261	5,043	28
29	Corridors-Floorings, Wallcovering, Corner Guards, Electrical	2011	132,942		20	6,647	6,647	26,588	29
30	Res Rms/Corridors/Offices-Walls, Signage, Light Fixtures, Doorfra	2011	64,060		20	4,894	4,894	19,574	30
31	Signs-Fabrication, Installation Of 2 Sets, Non-Illuminated Letters	2011	2,865		20	143	143	573	31
32	Fire Safety - Sprinkler System	2012	6,195		20	310	310	800	32
33	Security Cameras	2012	6,804		20	1,361	1,361	3,742	33
34	TOTAL (lines 1 thru 33)		$ 1,428,294	$ 260,604		$ 75,464	$ (185,140)	$ 292,028	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,428,294	$ 260,604		$ 75,464	$ (185,140)	$ 292,028	1
2	Pipe Capping, Wiring And Drywall Replacement	2013	7,092		20	355	355	443	2
3	Vinyl Flooring	2013	13,377		20	669	669	836	3
4	Sinks	2013	3,001		20	150	150	188	4
5	Wallcoverings	2013	5,969		20	298	298	373	5
6	Exit Signs	2013	4,043		20	202	202	253	6
7	Parking Lot Pavement - Full Depth Removal And Replace	2014	20,546		20	684	684	684	7
8	Installed Exhaust Fan And Round Flue Piping For 3 Dryers	2014	8,736		20	328	328	328	8
9	Repair Replace Damaged Drywall And Studs In Resident Rooms	2014	5,500		20	69	69	69	9
10	1 New Hvac Roof Top Unit.	2014	10,050		20	140	140	140	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	TOTAL (lines 1 thru 33)		$ 1,506,608	$ 260,604		$ 78,358	$ (182,246)	$ 295,341	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,506,608	$ 260,604		$ 78,358	$ (182,246)	$ 295,341	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,506,608	$ 260,604		$ 78,358	$ (182,246)	$ 295,341	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,506,608	$ 260,604		$ 78,358	$ (182,246)	$ 295,341	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,506,608	$ 260,604		$ 78,358	$ (182,246)	$ 295,341	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Replace Dry Pendant Sprinkler Heads, Misc Pipe & Fitting	2012	38,000		20	1,900	1,900	5,700	9
10	Install Drywall & Plastering Above Suspended Ceiling	2012	7,200		20	360	360	1,080	10
11	Landscaping	2012	7,671		20	384	384	1,152	11
12	Paving	2011	6,680		20	384	384	1,052	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	TOTAL (lines 1 thru 33)		$ 59,551	$		$ 3,028	$ 3,028	$ 8,984	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 59,551	$		$ 3,028	$ 3,028	$ 8,984	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 59,551	$		$ 3,028	$ 3,028	$ 8,984	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - 3737 Chase, LLC	2013	14,790	379	39	379		458	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - 3737 Chase, LLC	2014	11,517	139	20	560	421	560	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	TOTAL (lines 1 thru 33)		$ 26,307	$ 518		$ 939	$ 421	$ 1,018	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 26,307	$ 518		$ 939	$ 421	$ 1,018	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
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18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 26,307	$ 518		$ 939	$ 421	$ 1,018	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 146,088	$	$ 27,564	$ 27,564	10	$ 66,985	71
72	Current Year Purchases	22,944	760	1,728	968	10	1,728	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 169,032	$ 760	$ 29,292	$ 28,532		$ 68,714	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,716,713	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 261,364	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,651	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (153,713)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 364,055	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Ridgeland Property, LLC
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. [X] 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:		101		$ 788,752			3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 788,752 **			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: [X] YES [ ] NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 17,750 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 585,984	$		$ 585,984	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			164,204			164,204	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			697,361			697,361	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				585,345		585,345	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						182,793		182,793	13
14	TOTAL			$		$ 1,447,549	$ 768,138		$ 2,215,687	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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 3,053	$ 5,346	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,999,487	1,999,487	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,296	138,296	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	253,317	253,317	8
9	Other(specify):	294,466	294,466	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,688,619	$ 2,690,912	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	872,445	872,445	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	83,768	83,768	15
16	Equipment, at Historical Cost	990,724	990,724	16
17	Accumulated Depreciation (book methods)	(843,137)	(843,137)	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):		606,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,103,800	$ 1,709,800	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,792,419	$ 4,400,712	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 865,587	$ 865,587	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	884,790	884,790	29
30	Accrued Salaries Payable	208,556	208,556	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	497,732	993,595	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,456,665	$ 2,952,528	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,456,665	$ 2,952,528	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,335,754	$ 1,448,184	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,792,419	$ 4,400,712	48

***(See instructions.)**

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,976,683	1	
2	Restatements (describe):		2	
3	**Bad Debt**	(133,762)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,842,921	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	432,833	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	(940,000)	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)**	$ (507,167)	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)**	$ 1,335,754	24	*

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,683,961	1
2	Discounts and Allowances for all Levels	(3,709,790)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,974,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,122,674	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,122,674	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	556	16
17	Sale of Drugs	590,030	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	137,785	19
20	Radiology and X-Ray	38,430	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 766,801	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,763	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,763	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,279	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,279	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,878,688	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,050,647	31
32	Health Care	2,681,097	32
33	General Administration	1,763,076	33
	B. Capital Expense		
34	Ownership	1,113,792	34
	C. Ancillary Expense		
35	Special Cost Centers	2,699,346	35
36	Provider Participation Fee	137,897	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,445,855	40
41	**Income before Income Taxes (line 30 minus line 40)****	432,833	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 432,833	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,272,598	44
45	Private Pay - Net Inpatient Revenue	641,954	45
46	Medicare - Net Inpatient Revenue	3,566,341	46
47	Other-(specify) Hospice	165,134	47
48	Other-(specify) Managed Care	328,144	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,974,171	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,031	2,116	$ 115,702	$ 54.68	1
2	Assistant Director of Nursing	1,368	1,425	47,452	33.30	2
3	Registered Nurses	24,087	25,090	914,267	36.44	3
4	Licensed Practical Nurses	14,764	15,379	403,507	26.24	4
5	CNAs & Orderlies	48,987	51,028	549,255	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,557	5,788	104,771	18.10	8
9	Activity Director					9
10	Activity Assistants	4,936	5,142	67,777	13.18	10
11	Social Service Workers	4,880	5,084	126,209	24.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,123	17,837	268,533	15.05	15
16	Dishwashers					16
17	Maintenance Workers	1,163	1,211	40,389	33.35	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,133	2,222	116,364	52.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,120	10,543	274,121	26.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,228	2,321	36,689	15.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,377	145,186	$ 3,065,036 *	$ 21.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	216	$ 11,865	01-03	35
36	Medical Director	Monthly	78,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	$ 89,865		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Harold R. Hennessy	Administrator	0	$ 43,217
Christopher Kropp	Administrator	0	73,146
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,363

B. Administrative - Other

Description	Amount
Central Park Healthcare - Management Fees	$ 100,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 100,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Paycor	Payroll Services	$ 16,076
Frost, Ruttenberg & Rothblatt	Accounting	45,589
Achieve Accreditation	Joint Commission	14,499
Fair Lead Consulting	Corporate Planning	127
Illinois Rytes Corp	Liability Management	12,009
Prescriptive Strategies	Quality Assurance	2,112
Resource Utilization Xperts	Reimb. Strategy Consultant	10,500
SocialWork Consultation Group	Long Term Care Consultant	1,022
Advantage Valet Parking	Valet Services	34,378
Personnel Planners	Unemployment Consulting	5,660
Legal	See Attached	20,261
See Supplemental Schedule		8,750
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 170,983

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,797
Unemployment Compensation Insurance	91,870
FICA Taxes	208,035
Employee Health Insurance	154,599
Employee Meals	27,375
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	2,641
Employee Retention	29,536
TOTAL (agree to Schedule V, line 22, col.8)	$ 654,853

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	2,719
Health Care Worker Background Check	3,283
(Indicate # of checks performed 336)	
Patient Background Checks	
Dues and Subscriptions	20,898
License and Dues	10,750
Allocated - 3737 Chase, LLC	3
Allocated - Villa Financial Services	556
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,190

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,208
Allocated - Financial Services	262
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,470

**See instructions.

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $10,908**

(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? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,298** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **137,897**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% LN 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.