FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/16 Ending: 12/31/16

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	36,966	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	36,966	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			11,331	11,331	8
9	SNF/PED					9
10	ICF	8,027	3,273	2,623	13,923	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,027	3,273	13,954	25,254	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.32%

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 11,331

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	288,354	46,060	11,415	345,829		345,829		345,829			1
2	Food Purchase		135,057		135,057	(26,352)	108,705	451	109,156			2
3	Housekeeping		11,100	192,326	203,426		203,426		203,426			3
4	Laundry			126,918	126,918		126,918		126,918			4
5	Heat and Other Utilities			169,102	169,102		169,102	(13,304)	155,798			5
6	Maintenance	99,145	2,454	117,217	218,816		218,816	28,287	247,103			6
7	Other (specify):*											7
8	TOTAL General Services	387,499	194,671	616,978	1,199,148	(26,352)	1,172,796	15,434	1,188,230			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,271,649	143,329	38,909	2,453,887		2,453,887	(12,774)	2,441,113			10
10a	Therapy	273,982	16,112	5,240	295,334		295,334		295,334			10a
11	Activities	76,210	13,211		89,421		89,421		89,421			11
12	Social Services	188,885	7,765	558	197,208		197,208		197,208			12
13	CNA Training											13
14	Program Transportation			12,450	12,450		12,450		12,450			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,810,726	180,417	87,157	3,078,300		3,078,300	(12,774)	3,065,526			16
	C. General Administration											
17	Administrative	125,890			125,890		125,890		125,890			17
18	Directors Fees											18
19	Professional Services			612,200	612,200	(30,845)	581,355	(477,921)	103,434			19
20	Dues, Fees, Subscriptions & Promotions			66,189	66,189		66,189	(11,042)	55,147			20
21	Clerical & General Office Expenses	256,050	1,950	331,607	589,607		589,607	(12,725)	576,882			21
22	Employee Benefits & Payroll Taxes			767,124	767,124	26,352	793,476	(2,775)	790,701			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,261	3,261		3,261	2,286	5,547			24
25	Other Admin. Staff Transportation			52,462	52,462		52,462	4,066	56,528			25
26	Insurance-Prop.Liab.Malpractice			123,054	123,054		123,054	758	123,812			26
27	Other (specify):*							35,462	35,462			27
28	TOTAL General Administration	381,940	1,950	1,955,897	2,339,787	(4,493)	2,335,294	(461,891)	1,873,403			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,580,165	377,038	2,660,032	6,617,235	(30,845)	6,586,390	(459,231)	6,127,160			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: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			814,966	814,966		814,966	(690,613)	124,353			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,703	35,703		35,703	18,320	54,023			32
33	Real Estate Taxes			300,000	300,000	30,845	330,845	4,695	335,540			33
34	Rent-Facility & Grounds			714,433	714,433		714,433	242,617	957,050			34
35	Rent-Equipment & Vehicles			19,717	19,717		19,717	(1,737)	17,980			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,884,819	1,884,819	30,845	1,915,664	(426,718)	1,488,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	239,480	559,804	786,868	1,586,152		1,586,152	(1,992)	1,584,160			39
40	Barber and Beauty Shops			95	95		95		95			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,966	135,966		135,966		135,966			42
43	Other (specify):*			48,457	48,457		48,457	(48,457)	0			43
44	**TOTAL Special Cost Centers**	239,480	559,804	971,386	1,770,670		1,770,670	(50,449)	1,720,221			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,819,645	936,842	5,516,237	10,272,724		10,272,724	(936,398)	9,336,326			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: 01/01/16 Ending: 12/31/16

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 Reference	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	(14,843)	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	(728,134)	30		9
10	Interest and Other Investment Income	(399)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(175)	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	(2,566)	21		18
19	Entertainment				19
20	Contributions	(2,270)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,259)	21		24
25	Fund Raising, Advertising and Promotional	(8,462)	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	(94,132)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,041,240)		$	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)	104,842		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 104,842		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (936,398)		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: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (27,561)	21	1
2	Misc. Income	(750)	21	2
3	Late Fees	(313)	21	3
4	Resident Retention	(10,402)	43	4
5	Referral Fees	(8,000)	43	5
6	Bank Fees	(13,994)	21	6
7	Marketing/Advertising/Promotion	(29,379)	43	7
8	Additional R&M	28,239	06	8
9	Capitalized R&M	(2,717)	06	9
10	Non-Allowable Legal	(1,104)	19	10
11	Prior Period Expenses	(8,892)	10	11
12	Medical Records Income	(777)	10	12
13	Building Co - Bank Fees	(598)	21	13
14	Marketing Expenses	(676)	43	14
15	Prior Year Expense	(621)	20	15
16	Prior Year Expense	(3,104)	10	16
17	Prior Year Expense	(1,272)	06	17
18	Prior Year Expense	(1,839)	19	18
19	Prior Year Expense	(1,992)	39	19
20	Prior Year Expense	(2,775)	22	20
21	PAC Dues	(3,300)	20	21
22	Non-Allowable Auto Lease	(2,304)	35	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**	(94,132)		49

Park Villa Nrsg & Rehab Ctr

ID# 0051417

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr **#** 0051417 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(175)		626									451	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,843)		1,539									(13,304)	5
6	Maintenance	24,250		2,775	1,262								28,287	6
7	Other (specify):*													7
8	**TOTAL General Services**	9,232		4,940	1,262								15,434	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,774)											(12,774)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(12,774)											(12,774)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(2,943)		(475,386)	408								(477,921)	19
20	Fees, Subscriptions & Promotions	(14,653)		3,600	10								(11,042)	20
21	Clerical & General Office Expenses	(236,041)	598	222,719									(12,725)	21
22	Employee Benefits & Payroll Taxes	(2,775)											(2,775)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,286									2,286	24
25	Other Admin. Staff Transportation			4,066									4,066	25
26	Insurance-Prop.Liab.Malpractice			442	316								758	26
27	Other (specify):*			35,462									35,462	27
28	**TOTAL General Administration**	(256,412)	598	(206,810)	734								(461,891)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(259,954)	598	(201,870)	1,995								(459,231)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr **#** 0051417 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(728,134)		8,276	29,245								(690,613)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(399)	12,745	646	5,328								18,320	32
33	Real Estate Taxes				4,695								4,695	33
34	Rent-Facility & Grounds		242,617	12,595	(12,595)								242,617	34
35	Rent-Equipment & Vehicles	(2,304)		567									(1,737)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(730,837)	255,362	22,084	26,673								(426,718)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,992)											(1,992)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(48,457)											(48,457)	43
44	**TOTAL Special Cost Centers**	(50,449)											(50,449)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,041,240)	255,960	(179,787)	28,668								(936,398)	45

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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	Rental Income	$ 709,433	Park Villa Realty	100.00%	$	$ (709,433)	1
2	V	21	Bank Fees		Park Villa Realty	100.00%	598	598	2
3	V	32	Interest Expense		Park Villa Realty	100.00%	12,745	12,745	3
4	V	34	Rent Expense		Park Villa Realty	100.00%	952,050	952,050	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			$ 709,433			$ 965,393	$ * 255,960	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: 01/01/16 Ending: 12/31/16

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%	$ 626	$ 626	15
16	V	5	UTILITIES		VILLA FINANCIAL SERVICES, LLC	100.00%	1,539	1,539	16
17	V	6	REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	2,775	2,775	17
18	V	19	PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC	100.00%	262	262	18
19	V	20	FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC	100.00%	3,600	3,600	19
20	V	21	CLERICAL & GENERAL		VILLA FINANCIAL SERVICES, LLC	100.00%	222,719	222,719	20
21	V	24	SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC	100.00%	2,286	2,286	21
22	V	25	ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC	100.00%	4,066	4,066	22
23	V	26	INSURANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	442	442	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC	100.00%	35,462	35,462	24
25	V	30	DEPRECIATION		VILLA FINANCIAL SERVICES, LLC	100.00%	8,276	8,276	25
26	V	32	INTEREST		VILLA FINANCIAL SERVICES, LLC	100.00%	646	646	26
27	V	34	RENT		VILLA FINANCIAL SERVICES, LLC	100.00%	12,595	12,595	27
28	V	35	EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC	100.00%	567	567	28
29	V								29
30	V								30
31	V	19	HOME OFFICE	475,648	VILLA FINANCIAL SERVICES, LLC	100.00%		(475,648)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 475,648			$ 295,861	$ * (179,787)	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: 01/01/16 Ending: 12/31/16

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	6	REPAIRS AND MAINTENANCE		3737 Chase, LLC	100.00%	1,262	$ 1,262	15
16	V	19	PROFESSIONAL FEES		3737 Chase, LLC	100.00%	135	135	16
17	V	19	REAL ESTATE TAX PROTEST FEES		3737 Chase, LLC	100.00%	273	273	17
18	V	20	DUES & SUBSCRIPTIONS		3737 Chase, LLC	100.00%	10	10	18
19	V	26	INSURANCE		3737 Chase, LLC	100.00%	316	316	19
20	V	30	DEPRECIATION		3737 Chase, LLC	100.00%	29,245	29,245	20
21	V	32	INTEREST EXPENSE		3737 Chase, LLC	100.00%	5,328	5,328	21
22	V	33	REAL ESTATE TAXES		3737 Chase, LLC	100.00%	4,695	4,695	22
23	V								23
24	V								24
25	V	34	RENT	12,595	3737 Chase, LLC	100.00%		(12,595)	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			$ 12,595			$ 41,263	$ * 28,668	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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%	Holland Home	South Holland, IL	3737 CHASE, LLC	SKOKIE	BUILDING CO	1
2	MARK BERGER	35.05%	The Villa at Bradley Estates	Milwaukee, WI	VILLA FINANCIAL SERVICES	SKOKIE	MANAGEMENT	2
3	CHAIM RAJCHENBACH	10.00%	The Villa at Bryn Mawr	Minneapolis, MN	PARK VILLA REALTY	LINCOLNWOOD	BUILDING CO	3
4	MENACHEM SHABAT	10.00%	The Villa at City Center	Michigan	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	4
5	TODD STERN	4.95%	The Villa at Evergreen	Evergreen Park, IL	THE PINNACLE APARTMENTS		APARTMENTS	5
6			The Villa at Great Lakes Crossing	Michigan	DISTINCT LLC		APARTMENTS	6
7			The Villa at Green Lake Estates	Michigan				7
8			The Villa at Lincoln Park	Wisconsin				8
9			The Villa at Middleton Village	Wisconsin				9
10			The Villa at Osseo	Osseo, MN				10
11			The Villa at PA Peterson	Rockford, IL				11
12			The Villa at Parkridge	Michigan				12
13			The Villa at River Parkway	Wisconsin				13
14			The Villa at Rose City	Michigan				14
15			The Villa at Silverbell Estates	Michigan				15
16			The Villa at South Holland	South Holland, IL				16
17			The Villa at St. Louis Park	St. Louis Park, MN				17
18			The Villa at The Bay	Michigan				18
19			The Villa at The Park	Michigan				19
20			The Villa at Traverse Point	Michigan				20
21			The Villa at West Branch	Michigan				21
22			Windsor Park Nursing & Living Center	Chicago, IL				22
23			Trinity Senior Community	Milwaukee, WI				23
24			ADD PLACE II	East Lansing, MI				24
25			Addington Place	Northville, MI				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	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	$		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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	FINCL. CONSLT. REV.	11,549,901	25	$ 15,191	$	475,632	$ 626	1
2	5	UTILITIES	FINCL. CONSLT. REV.	11,549,901	25	37,375		475,632	1,539	2
3	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	11,549,901	25	67,393		475,632	2,775	3
4	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	11,549,901	25	6,368		475,632	262	4
5	20	FEES SUBSCRIPTIONS	FINCL. CONSLT. REV.	11,549,901	25	87,429		475,632	3,600	5
6	21	CLERICAL & GENERAL	FINCL. CONSLT. REV.	11,549,901	25	5,408,336	5,366,442	475,632	222,719	6
7	24	SEMINARS AND EDUCATION	FINCL. CONSLT. REV.	11,549,901	25	55,513		475,632	2,286	7
8	25	ADMIN. STAFF TRAVEL	FINCL. CONSLT. REV.	11,549,901	25	98,738		475,632	4,066	8
9	26	INSURANCE	FINCL. CONSLT. REV.	11,549,901	25	10,735		475,632	442	9
10	27	EMPLOYEE BEN. GEN. ADMIN	FINCL. CONSLT. REV.	11,549,901	25	861,135		475,632	35,462	10
11	30	DEPRECIATION	FINCL. CONSLT. REV.	11,549,901	25	200,966		475,632	8,276	11
12	32	INTEREST	FINCL. CONSLT. REV.	11,549,901	25	15,683		475,632	646	12
13	34	RENT	FINCL. CONSLT. REV.	11,549,901	25	305,851		475,632	12,595	13
14	35	EQUIPMENT RENTAL	FINCL. CONSLT. REV.	11,549,901	25	13,760		475,632	567	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,184,473	$ 5,366,442		$ 295,861	25

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	11,549,901	25	30,644		475,632	1,262	1
2	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	11,549,901	25	3,275		475,632	135	2
3	19	REAL ESTATE TAX PROTEST	FINCL. CONSLT. REV.	11,549,901	25	6,626		475,632	273	3
4	20	DUES & SUBSCRIPTIONS	FINCL. CONSLT. REV.	11,549,901	25	250		475,632	10	4
5	26	INSURANCE	FINCL. CONSLT. REV.	11,549,901	25	7,662		475,632	316	5
6	30	DEPRECIATION	FINCL. CONSLT. REV.	11,549,901	25	710,163		475,632	29,245	6
7	32	INTEREST EXPENSE	FINCL. CONSLT. REV.	11,549,901	25	129,383		475,632	5,328	7
8	33	REAL ESTATE TAXES	FINCL. CONSLT. REV.	11,549,901	25	114,000		475,632	4,695	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					$ 1,002,003	$		$ 41,263	25

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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				867,000			35,703	6
7	MB Financial		X	Construction Loan				258,024			12,745	7
8					-							8
9	TOTAL Facility Related						$	$ 1,125,024			$ 48,448	9
	B. Non-Facility Related*											
10	Interest Income		X								(399)	10
11	Allocated from 3737 Chase, LLC		X								5,328	11
12	Allocated from Villa Financial		X								646	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ 5,575	14
15	TOTALS (line 9+line14)						$	$ 1,125,024			$ 54,023	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: 01/01/16 Ending: 12/31/16

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	296,050	2
3. Under or (over) accrual (line 2 minus line 1).	$	296,050	3
4. Real Estate Tax accrual used for 2016 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.)**	$	30,845	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** $ 91,646 **For** 2011,2012,2(&2013 **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.	$	326,895	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	215,854	8
	2012	230,687	9
	2013	237,473	10
	2014	282,871	11
	2015	291,355	12

Facility does not accrue for R/E taxes
Allocated from 3737 Chase, LLC = $4,695

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 291,354.82	$ 291,354.82
2.	10-26-318-023-0000	See Attached	$ 112,632.76	$ 4,638.29
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 403,987.58	$ 295,993.11

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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				$	1
2	Allocated from 3737 Chase, LLC			10,594	2
3	TOTALS			$ 10,594	3

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Various			2011	1,329,438		20	69,015	69,015	416,326	9
10	Various			2012	12,999		20	1,670	1,670	7,883	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: 01/01/16 Ending: 12/31/16

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	15,040	67
68	Related Party Allocations (Pages 12H & 12I)		126,572	25,287		4,870	(20,417)	11,779	68
69	Financial Statement Depreciation			814,966			(814,966)		69
70	TOTAL (lines 4 thru 69)		$ 1,528,559	$ 840,253		$ 78,583	$ (761,669)	$ 451,028	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: 01/01/16 Ending: 12/31/16

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		$ 1,528,559	$ 840,253		$ 78,583	$ (761,669)	$ 451,028	1
2	Pipe Capping, Wiring And Drywall Replacement	2013	7,092		20	355	355	1,153	2
3	Vinyl Flooring	2013	13,377		20	669	669	2,174	3
4	Sinks	2013	3,001		20	150	150	488	4
5	Wallcoverings	2013	5,969		20	298	298	970	5
6	Exit Signs	2013	4,043		20	202	202	657	6
7	Parking Lot Pavement - Full Depth Removal & Replace	2014	20,546		20	1,370	1,370	3,425	7
8	Install Exhaust Fan & Round Flue Piping For 3 Dryers	2014	8,736		20	437	437	1,201	8
9	Repair Replace Damaged Drywall & Studs In Resident Rooms	2014	5,500		20	275	275	619	9
10	1 New Hvac Roof Top Unit.	2014	10,050		20	503	503	1,089	10
11	Dining Area Exit Door	2014	2,637		20	132	132	264	11
12	Replace Smoke Detectors	2015	3,084		20	154	154	308	12
13	Replace Physical Therapy Tru	2015	3,350		20	168	168	335	13
14	Replace Ceiling Grid & Tile In Corridors & Entries	2015	40,200		20	2,010	2,010	4,020	14
15	Remove & Replace Dry Valve Air Compressor	2015	3,594		20	180	180	359	15
16	New Water Heater	2015	16,800		20	840	840	1,680	16
17	Replace 300 Wing Ac Unit	2015	2,500		20	125	125	250	17
18	Change Grill Diffusers	2015	5,900		20	295	295	590	18
19	Replace Dry Pendant Fire Sprinkler Heads	2015	6,786		20	339	339	679	19
20	Install Nurse Call Master Station	2015	9,089		20	454	454	909	20
21	Grease Trap Pipe Repair	2015	2,800		20	140	140	280	21
22	Nurse Call System Wiring	2015	3,350		20	168	168	335	22
23	On-Line Communication Alarm System	2016	8,371		20	419	419	419	23
24	Installation Of Smoke Detectors In Concierge Area	2016	3,425		20	171	171	171	24
25	New Call Light Station	2016	5,875		20	294	294	294	25
26	A/C Service And Repair	2016	2,717		20	136	136	136	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	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: 01/01/16 Ending: 12/31/16

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		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	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: 01/01/16 Ending: 12/31/16

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		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	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: 01/01/16 Ending: 12/31/16

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		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 1,727,352	$ 840,253		$ 88,866	$ (751,387)	$ 473,831	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: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									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	9,500	9
10	Install Drywall & Plastering Above Suspended Ceiling	2012	7,200		20	360	360	1,800	10
11	Landscaping	2012	7,671		20	384	384	1,920	11
12	Paving	2011	6,680		20	384	384	1,820	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	$ 15,040	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: 01/01/16 Ending: 12/31/16

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	$ 15,040	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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	$ 15,040	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: 01/01/16 Ending: 12/31/16

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 3737 Chase, LLC	2013	60,034	2,937	20	1,715	(1,222)	5,503	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Villa Financial Services	2015	655	131	20	33	(98)	43	9
10									10
11	Allocated from 3737 Chase, LLC	2014	38,090	17,538	20	1,904	(15,634)	4,841	11
12	Allocated from 3737 Chase, LLC	2015	20,935	4,187	20	1,047	(3,140)	1,221	12
13	Allocated from 3737 Chase, LLC	2016	6,858	494	20	171	(323)	171	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)		$ 126,572	$ 25,287		$ 4,870	$ (20,417)	$ 11,779	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: 01/01/16 Ending: 12/31/16

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		$ 126,572	$ 25,287		$ 4,870	$ (20,417)	$ 11,779	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 126,572	$ 25,287		$ 4,870	$ (20,417)	$ 11,779	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: 01/01/16 Ending: 12/31/16

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	$ 219,045	$ 4,282	$ 31,587	$ 27,305	10	$ 138,304	71
72	Current Year Purchases	72,872	7,952	3,900	(4,052)	10	3,900	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 291,917	$ 12,234	$ 35,487	$ 23,253		$ 142,204	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)	$ 2,029,862	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 852,487	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,353	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (728,134)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 616,035	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	CIP	$ 119,474	92
93			93
94			94
95		$ 119,474	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: 01/01/16 Ending: 12/31/16

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		$ 952,050			3
4	Additions							4
5	Church Parking Lot Rental				5,000			5
6								6
7	TOTAL		101		$ 957,050 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 10,608 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	Facility	Infiniti	$	$ 7,372	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 7,372	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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 - 01	hrs	$ 147,317		$ 316,952	$		$ 464,269	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	34,230		83,039			117,269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	57,933		386,877			444,810	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				417,633		417,633	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						142,171		142,171	13
14	TOTAL			$ 239,480		$ 786,868	$ 559,804		$ 1,586,152	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:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 9,643	$ 9,643	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,865,978	1,865,978	3
4	Supply Inventory (priced at)		606,000	4
5	Short-Term Investments			5
6	Prepaid Insurance	32,248	32,248	6
7	Other Prepaid Expenses	11,661	11,661	7
8	Accounts Receivable (owners or related parties)		(263,400)	8
9	Other(specify): See Attached Schedule	120,085	120,085	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,039,615	$ 2,382,215	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,096,279	1,096,279	15
16	Equipment, at Historical Cost	1,073,255	1,073,255	16
17	Accumulated Depreciation (book methods)	(1,943,914)	(1,943,914)	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): See Attached Schedule	79,383	79,383	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 305,003	$ 305,003	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,344,618	$ 2,687,218	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 689,277	$ 689,277	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	867,000	1,125,024	29
30	Accrued Salaries Payable	273,984	273,984	30
31	Accrued Taxes Payable (excluding real estate taxes)	73,074	73,074	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	287,030	287,030	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,190,365	$ 2,448,389	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	See Attached Schedule	63,715	55,784	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 63,715	$ 55,784	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,254,080	$ 2,504,173	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 90,538	$ 183,045	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,344,618	$ 2,687,218	48

***(See instructions.)**

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,223,222	1
2	Restatements (describe):		2
3	**Late Journal Entries**	147,646	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,370,868	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(635,330)	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	(645,000)	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)**	$ (1,280,330)	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)**	$ 90,538	24 *

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

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,610,143	1
2	Discounts and Allowances for all Levels	(559,786)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,050,357	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,833,357	6
7	Oxygen	95	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,833,452	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	444,703	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,756	19
20	Radiology and X-Ray	39,660	20
21	Other Medical Services	26,554	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 617,673	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	399	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 399	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	135,513	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 135,513	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,637,394	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,199,148	31
32	Health Care	3,078,300	32
33	General Administration	2,339,787	33
	B. Capital Expense		
34	Ownership	1,884,819	34
	C. Ancillary Expense		
35	Special Cost Centers	1,634,704	35
36	Provider Participation Fee	135,966	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,272,724	40
41	**Income before Income Taxes (line 30 minus line 40)****	(635,330)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (635,330)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,277,316	44
45	Private Pay - Net Inpatient Revenue	775,048	45
46	Medicare - Net Inpatient Revenue	3,438,853	46
47	Other-(specify) Hospice Medicaid	129,395	47
48	Other-(specify) Managed Care	429,745	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,050,357	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: 01/01/16 Ending: 12/31/16

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	1,852	1,953	$ 94,643	$ 48.47	1
2	Assistant Director of Nursing	1,207	1,242	46,971	37.82	2
3	Registered Nurses	16,074	16,920	599,655	35.44	3
4	Licensed Practical Nurses	26,155	27,561	802,032	29.10	4
5	CNAs & Orderlies	52,520	55,806	694,227	12.44	5
6	CNA Trainees					6
7	Licensed Therapist	5,066	5,567	239,480	43.02	7
8	Rehab/Therapy Aides	18,890	19,727	273,982	13.89	8
9	Activity Director	1,917	2,084	32,109	15.41	9
10	Activity Assistants	3,610	3,924	44,101	11.24	10
11	Social Service Workers	8,617	9,366	188,885	20.17	11
12	Dietician					12
13	Food Service Supervisor	1,925	2,092	48,023	22.96	13
14	Head Cook	5,060	5,500	100,985	18.36	14
15	Cook Helpers/Assistants	11,805	12,831	139,346	10.86	15
16	Dishwashers					16
17	Maintenance Workers	3,546	3,773	99,145	26.28	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,950	2,091	125,890	60.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,458	12,978	256,050	19.73	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	1,925	2,092	34,121	16.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,578	185,507	$ 3,819,645 *	$ 20.59	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	207	$ 11,415	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	19,743	10-03	38
39	Pharmacist Consultant	Monthly	7,538	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	87	5,240	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	11	558	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	$ 74,494		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	388	11,628	10-03	52
53	TOTAL (lines 50 - 52)	388	$ 11,628		53

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eliana Mejia	Administrator	0	$ 125,890
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,890

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 16,526
Paycor	Payroll Services	25,898
Villa Financial Services	Financial Consulting Fees	475,648
See Attached	Legal	6,407
Personnel Planners	Unemployment Consultant	3,662
Achieve Accreditation LLC	Accreditation	8,881
Illinois Rytes Corp.	Liability Management	11,011
Compliagent Consulting	Compliance Consulting	203
e-Health Data Solutions	Computer Services	3,636
Westcom solutions	Computer Services	16,857
ProClaim Partners	Computer Services	1,400
See Supplemental Schedule		42,071
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 612,200

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 231,550
Unemployment Compensation Insurance	33,124
FICA Taxes	264,174
Employee Health Insurance	202,903
Employee Meals	26,352
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	4,594
401K Employer Contribution	9,647
Employee Retention	18,358
TOTAL (agree to Schedule V, line 22, col.8)	$ 790,702

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,041
Health Care Worker Background Check	
(Indicate # of checks performed)	12,487
Patient Background Checks	
Dues & Subscriptions	21,552
Licensing & Permiting	6,456
Allocated from Villa	3,600
Allocated from 3737 Chase, LLC	10
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,146

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,261
Allocated from Villa	2,286
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,547

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Villa Nrsg & Rehab Ctr # 0051417 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $9,999**

(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. $ **23,587** 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? **X** YES _____ 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. $ **135,966**
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. $ **26,352** 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 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