		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0051417

Facility Name: Park Villa Nrsg & Rehab Center

Address: 12550 South Ridgeland Avenue (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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 12/26/18

	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)	111	36,925	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	111	36,925	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	5,081	3,451	15,455	23,987	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,081	3,451	15,455	23,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.96%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 12/1/2010

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 111 and days of care provided 6,439

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: 12/31/18 Fiscal Year: 12/31/18

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

STATE OF ILLINOIS

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	315,521	44,447	12,461	372,429		372,429		372,429			1
2	Food Purchase		139,531		139,531	(28,288)	111,244	553	111,797			2
3	Housekeeping		28,530	157,352	185,882		185,882		185,882			3
4	Laundry			103,096	103,096		103,096		103,096			4
5	Heat and Other Utilities			172,500	172,500		172,500	(14,391)	158,109			5
6	Maintenance	47,309	1,338	130,129	178,776		178,776	23,107	201,883			6
7	Other (specify):*											7
8	**TOTAL General Services**	362,830	213,846	575,538	1,152,214	(28,288)	1,123,927	9,269	1,133,196			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	2,220,450	138,397	89,057	2,447,904		2,447,904	(302)	2,447,602			10
10a	Therapy	69,364	3,658	8,375	81,397		81,397		81,397			10a
11	Activities	71,847	8,035		79,882		79,882		79,882			11
12	Social Services	148,463	10,186	320	158,969		158,969		158,969			12
13	CNA Training											13
14	Program Transportation			8,325	8,325		8,325		8,325			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,510,124	160,276	139,077	2,809,477		2,809,477	(302)	2,809,175			16
	C. General Administration											
17	Administrative	155,411			155,411		155,411		155,411			17
18	Directors Fees											18
19	Professional Services			498,021	498,021	(12,589)	485,432	(411,016)	74,416			19
20	Dues, Fees, Subscriptions & Promotions			88,686	88,686		88,686	(16,839)	71,847			20
21	Clerical & General Office Expenses	265,541	901	456,530	722,972		722,972	(84,542)	638,430			21
22	Employee Benefits & Payroll Taxes			784,333	784,333	28,288	812,621	(21,113)	791,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,142	7,142		7,142	(618)	6,524			24
25	Other Admin. Staff Transportation			16,207	16,207		16,207	4,549	20,756			25
26	Insurance-Prop.Liab.Malpractice			99,630	99,630		99,630	918	100,548			26
27	Other (specify):*							27,859	27,859			27
28	**TOTAL General Administration**	420,952	901	1,950,549	2,372,402	15,699	2,388,101	(500,803)	1,887,298			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,293,906	375,023	2,665,164	6,334,093	(12,589)	6,321,504	(491,836)	5,829,668			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 Center #0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			61,471	61,471		61,471	67,056	128,527			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,858	43,858		43,858	7,231	51,089			32
33	Real Estate Taxes			300,000	300,000	12,589	312,589	3,666	316,255			33
34	Rent-Facility & Grounds			766,292	766,292		766,292	241,555	1,007,847			34
35	Rent-Equipment & Vehicles			13,106	13,106		13,106	(587)	12,519			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,184,727	1,184,727	12,589	1,197,316	318,922	1,516,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	726,161	361,701	14,340	1,102,202		1,102,202	(7,606)	1,094,596			39
40	Barber and Beauty Shops			130	130		130		130			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,815	161,815		161,815		161,815			42
43	Other (specify):*		17,263	41,178	58,441		58,441	(58,441)	(0)			43
44	**TOTAL Special Cost Centers**	726,161	378,964	217,463	1,322,588		1,322,588	(66,047)	1,256,541			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,020,067	753,987	4,067,354	8,841,408		8,841,408	(238,961)	8,602,447			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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,200)	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	44,045	30		9
10	Interest and Other Investment Income	(8,487)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(201)	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	(3,571)	21		18
19	Entertainment				19
20	Contributions	(2,594)	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	(239,566)	21		24
25	Fund Raising, Advertising and Promotional	(10,687)	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	(185,318)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (422,579)		$	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)	183,618		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 183,618		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (238,961)		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 Center

ID# 0051417

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Auto Lease	$ (629)	35	1
2	Miscellaneous Income	(9,918)	21	2
3	Medical Records Income	(302)	10	3
4	Sequestration	(65,210)	21	4
5	Marketing Expense	(42,146)	43	5
6	Resident Retention	(8,024)	43	6
7	Bank Fees	(19,255)	21	7
8	Pension Settlement	(21,113)	22	8
9	Additional R&M	26,253	06	9
10	Capitalized R&M	(5,697)	06	10
11	Non Allowable Seminar	(1,164)	24	11
12	PAC Dues	(9,646)	20	12
13	Non Allowable Consulting	(8,271)	43	13
14	Non Allowable Legal	(15,987)	19	14
15	Non Allowable Equipment Rental	(400)	35	15
16	Bldg Co - Accounting Fees	(1,421)	19	16
17	Bldg Co - Legal Fees	(908)	19	17
18	Bldg Co - Non Recurring Misc. Expense	(508)	21	18
19	Bldg Co - Bank Fees	(644)	21	19
20	Bldg Co - Penalties	(41)	21	20
21	Non Allowable Dues	(288)	20	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(185,318)		49

Park Villa Nrsg & Rehab Center

ID# 0051417

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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 Center # 0051417 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	(201)		754									553	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,200)		1,809									(14,391)	5
6	Maintenance	20,556		2,551									23,107	6
7	Other (specify):*													7
8	**TOTAL General Services**	4,155		5,114									9,269	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(302)											(302)	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**	(302)											(302)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(18,316)	2,328	(395,074)	45								(411,016)	19
20	Fees, Subscriptions & Promotions	(23,215)		6,373	2								(16,839)	20
21	Clerical & General Office Expenses	(338,713)	1,193	252,979									(84,542)	21
22	Employee Benefits & Payroll Taxes	(21,113)											(21,113)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,164)		546									(618)	24
25	Other Admin. Staff Transportation			4,549									4,549	25
26	Insurance-Prop.Liab.Malpractice			602	317								918	26
27	Other (specify):*			27,859									27,859	27
28	**TOTAL General Administration**	(402,520)	3,521	(102,168)	364								(500,803)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(398,667)	3,521	(97,053)	364								(491,836)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Capital Expense D. Ownership	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)	
30	Depreciation	44,045		16,726	6,285								67,056	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,487)	10,594	452	4,672								7,231	32
33	Real Estate Taxes				3,666								3,666	33
34	Rent-Facility & Grounds		241,555	5,765	(5,765)								241,555	34
35	Rent-Equipment & Vehicles	(1,029)		442									(587)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	34,529	252,149	23,386	8,858								318,922	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(7,606)							(7,606)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(58,441)											(58,441)	43
44	**TOTAL Special Cost Centers**	(58,441)				(7,606)							(66,047)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(422,579)	255,670	(73,668)	9,222	(7,606)							(238,961)	45

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Rent Income	$ 765,792	Park Villa Realty		$	$ (765,792)	1
2	V	19	Accounting Fees		Park Villa Realty		1,421	1,421	2
3	V	19	Legal/Collection Fees		Park Villa Realty		908	908	3
4	V	21	Bank Fees		Park Villa Realty		644	644	4
5	V	21	Penalties & Fines		Park Villa Realty		41	41	5
6	V	32	Interest Expense -Capex Interest		Park Villa Realty		10,594	10,594	6
7	V	34	Rent Expense		Park Villa Realty		1,007,347	1,007,347	7
8	V	21	Non-Recurring Misc. Expense		Park Villa Realty		508	508	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 765,792			$ 1,021,462	$ * 255,670	14

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 754	$ 754	15
16	V	5	UTILITIES		VILLA FINANCIAL SERVICES, LLC		1,809	1,809	16
17	V	6	REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC		2,551	2,551	17
18	V	19	PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC		4,202	4,202	18
19	V	20	FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC		6,373	6,373	19
20	V	21	CLERICAL & GENERAL - SALARIES		VILLA FINANCIAL SERVICES, LLC		253,828	253,828	20
21	V	21	CLERICAL & GENERAL - OTHER EXPENSE		VILLA FINANCIAL SERVICES, LLC		(850)	(850)	21
22	V	24	SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC		546	546	22
23	V	25	ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC		4,549	4,549	23
24	V	26	INSURANCE		VILLA FINANCIAL SERVICES, LLC		602	602	24
25	V	27	EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC		27,859	27,859	25
26	V	30	DEPRECIATION		VILLA FINANCIAL SERVICES, LLC		16,726	16,726	26
27	V	32	INTEREST		VILLA FINANCIAL SERVICES, LLC		452	452	27
28	V	34	RENT		VILLA FINANCIAL SERVICES, LLC		5,765	5,765	28
29	V	35	EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC		442	442	29
30	V								30
31	V	19	HOME OFFICE	399,276				(399,276)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 399,276			$ 325,608	$ * (73,668)	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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							$	15
16	V	19	PROFESSIONAL FEES		3737 Chase, LLC		45	45	16
17	V	20	DUES & SUBSCRIPTIONS		3737 Chase, LLC		2	2	17
18	V	26	INSURANCE		3737 Chase, LLC		317	317	18
19	V	30	DEPRECIATION		3737 Chase, LLC		6,285	6,285	19
20	V	32	INTEREST EXPENSE		3737 Chase, LLC		4,672	4,672	20
21	V	33	REAL ESTATE TAXES		3737 Chase, LLC		3,666	3,666	21
22	V								22
23	V								23
24	V	34	RENT	5,765	3737 Chase, LLC			(5,765)	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			$ 5,765			$ 14,987	$ * 9,222	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	39	DME & Medical Supplies	$ 48,976	Integra Healthcare Equipment, LLC		$ 41,370	$ (7,606)	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			$ 48,976			$ 41,370	$ * (7,606)	39

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	The Villa at Bradley Estates	Milwaukee, WI	PARK VILLA REALTY	LINCOLNWOOD	BUILDING CO	1
2	MARK BERGER	35.05%	The Villa at Bryn Mawr	Minneapolis, MN	3737 CHASE, LLC	SKOKIE	BUILDING CO	2
3	CHAIM RAJCHENBACH	10.00%	The Villa at City Center	Warren, MI	VILLA FINANCIAL SERVICES	SKOKIE	BOOKEEPING	3
4	MENACHEM SHABAT	10.00%	The Villa at Evergreen	Evergreen Park, IL	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	4
5	TODD STERN	4.95%	The Villa at Great Lakes Crossing	Detroit, MI	REMED SERVICES LLC	LINCOLNWOOD	DME SALES	5
6			The Villa at Green Lake Estates	Orchard Lake, MI	SEASONS HOSPICE	DES PLAINES	HOSPICE	6
7			The Villa at Lincoln Park	Racine, WI	INTEGRA HC EQUIP	ELMHURST	DME	7
8			The Villa at Middleton Village	Middleton, WI	INTEGRA RESP SERV	ELMHURST	RESPIRATORY SUPP.	8
9			The Villa at Osseo	Osseo, MN				9
10			The Villa at Parkridge	Ypsilanti, MI				10
11			The Villa at River Parkway	Milwaukee, WI				11
12			The Villa at Rose City	Rose City, MI				12
13			The Villa at Silverbell Estates	Orion, MI				13
14			The Villa at South Holland	South Holland, IL				14
15			The Villa at St. Louis Park	St. Louis Park, MN				15
16			The Villa at The Bay	Petoskey, MI				16
17			The Villa at The Park	Highland Park, MI				17
18			The Villa at Traverse Point	Traverse City, MI				18
19			The Villa at West Branch	West Branch, MI				19
20			The Villa at Windsor Park	Chicago, IL				20
21			Ambassador, a Villa Center	Detroit, MI				21
22			Father Murray, a Villa Center	Center Line, MI				22
23			Imperial, a Villa Center	Dearborn Heights, MI				23
24			Regency, a Villa Center	Taylor, MI				24
25			St. Joseph, a Villa Center	Hamtramck, MI				25
26			Westland, a Villa Center	Westland, MI				26
27			Astor House, a Villa Center	Holland, OH				27
28			Spring Meadows, a Villa Center	Holland, OH				28
29								29
30								30

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.	13,724,750	32	$ 25,934	$	399,276	$ 754	1
2	5	UTILITIES	FINCL. CONSLT. REV.	13,724,750	32	62,183		399,276	1,809	2
3	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	13,724,750	32	87,685		399,276	2,551	3
4	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	13,724,750	32	144,447		399,276	4,202	4
5	20	FEES SUBSCRIPTIONS	FINCL. CONSLT. REV.	13,724,750	32	219,061		399,276	6,373	5
6	21	CLERICAL & GENERAL - SALA	FINCL. CONSLT. REV.	13,724,750	32	8,725,104	8,725,104	399,276	253,828	6
7	21	CLERICAL & GENERAL - OTHI	FINCL. CONSLT. REV.	13,724,750	32	(29,206)		399,276	(850)	7
8	24	SEMINARS AND EDUCATION	FINCL. CONSLT. REV.	13,724,750	32	18,770		399,276	546	8
9	25	ADMIN. STAFF TRAVEL	FINCL. CONSLT. REV.	13,724,750	32	156,350		399,276	4,549	9
10	26	INSURANCE	FINCL. CONSLT. REV.	13,724,750	32	20,680		399,276	602	10
11	27	EMPLOYEE BEN. GEN. ADMIN.	FINCL. CONSLT. REV.	13,724,750	32	957,610		399,276	27,859	11
12	30	DEPRECIATION	FINCL. CONSLT. REV.	13,724,750	32	574,948		399,276	16,726	12
13	32	INTEREST	FINCL. CONSLT. REV.	13,724,750	32	15,547		399,276	452	13
14	34	RENT	FINCL. CONSLT. REV.	13,724,750	32	198,162		399,276	5,765	14
15	35	EQUIPMENT RENTAL	FINCL. CONSLT. REV.	13,724,750	32	15,206		399,276	442	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 11,192,479	$ 8,725,104		$ 325,608	25

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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										1
2	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	13,724,750	32	1,545		399,276	45	2
3	20	DUES & SUBSCRIPTIONS	FINCL. CONSLT. REV.	13,724,750	32	75		399,276	2	3
4	26	INSURANCE	FINCL. CONSLT. REV.	13,724,750	32	10,882		399,276	317	4
5	30	DEPRECIATION	FINCL. CONSLT. REV.	13,724,750	32	216,050		399,276	6,285	5
6	32	INTEREST EXPENSE	FINCL. CONSLT. REV.	13,724,750	32	160,582		399,276	4,672	6
7	33	REAL ESTATE TAXES	FINCL. CONSLT. REV.	13,724,750	32	126,000		399,276	3,666	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					$ 515,134	$		$ 14,987	25

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: Integra Healthcare Equipment, LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	39	DME & Medical Supplies	Direct			$	$		$ 41,370	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					$	$		$ 41,370	25

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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				553,000			33,564	6
7	Seasons Adv		X								10,294	7
8	See Supplemental Schedule							169,944			10,594	8
9	TOTAL Facility Related						$	$ 722,944			$ 54,452	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,487)	10
11	Allocated from Villa Financial S	X									452	11
12	Allocated from 3737 Chase, LLC	X									4,672	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,363)	14
15	TOTALS (line 9+line14)						$	$ 722,944			$ 51,089	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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	$	340,964	2
3. Under or (over) accrual (line 2 minus line 1).	$	340,964	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	12,589	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	353,553	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	237,473	8
	2014	282,871	9
	2015	291,355	10
	2016	297,557	11
	2017	337,298	12

Facility does not accrue for R/E taxes
Allocated from 3737 Chase, LLC = $3,666

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Villa Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051417

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 337,298.00	$ 337,298.00
2.	10-26-318-023-0000	See Attached	$ 128,381.74	$ 3,734.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 465,679.74	$ 341,032.84

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Villa Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051417

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (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	Allocated from 3737 Chase, LLC			$ 7,484	1
2					2
3	TOTALS			$ 7,484	3

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	68,672	68,672	553,670	9
10	Various			2012	12,999		20	651	651	9,185	10
11	Various			2013	33,482		20	1,674	1,674	8,789	11
12	Various			2014	47,469		20	2,717	2,717	11,899	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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			2,978	2,978	20,996	67
68	Related Party Allocations (Pages 12H & 12I)		97,889	6,407		3,929	(2,478)	16,039	68
69	Financial Statement Depreciation			61,471			(61,471)		69
70	TOTAL (lines 4 thru 69)		$ 1,580,827	$ 67,878		$ 80,620	$ 12,742	$ 620,577	70

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,580,827	$ 67,878		$ 80,620	$ 12,742	$ 620,577	1
2	Replace Smoke Detectors	2015	3,084		20	154	154	463	2
3	Replace Physical Therapy Tru	2015	3,350		20	168	168	503	3
4	Replace Ceiling Grid & Tile In Corridors & Entries	2015	40,200		20	2,010	2,010	6,030	4
5	Remove & Replace Dry Valve Air Compressor	2015	3,594		20	180	180	539	5
6	New Water Heater	2015	16,800		20	840	840	2,520	6
7	Replace 300 Wing Ac Unit	2015	2,500		20	125	125	375	7
8	Change Grill Diffusers	2015	5,900		20	295	295	885	8
9	Replace Dry Pendant Fire Sprinkler Heads	2015	6,786		20	339	339	1,018	9
10	Install Nurse Call Master Station	2015	9,089		20	454	454	1,363	10
11	Grease Trap Pipe Repair	2015	2,800		20	140	140	420	11
12	Nurse Call System Wiring	2015	3,350		20	168	168	503	12
13	On-Line Communication Alarm System	2016	8,371		20	419	419	837	13
14	Installation Of Smoke Detectors In Concierge Area	2016	3,425		20	171	171	343	14
15	New Call Light Station	2016	5,875		20	294	294	588	15
16	A/C Service And Repair	2016	2,717		20	136	136	272	16
17	Smoke Detector Sprinkler & Base	2017	4,582		20	229	229	458	17
18	Repair Condensing Unit	2017	2,895		20	145	145	290	18
19	Sprinkler Repair	2018	5,167		20	258	258	258	19
20	Generator Control Board	2018	2,859		20	143	143	143	20
21	Hot Water Heater Repair	2018	2,711		20	136	136	136	21
22	Rtu Replace Motor	2018	2,986		20	149	149	149	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)		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	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
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19									19
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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)		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,719,868	$ 67,878		$ 87,572	$ 19,694	$ 638,668	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	13,300	9
10	Install Drywall & Plastering Above Suspended Ceiling	2012	7,200		20	360	360	2,520	10
11	Landscaping	2012	7,671		20	384	384	2,688	11
12	Paving	2011	6,680		20	334	334	2,488	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	$		$ 2,978	$ 2,978	$ 20,996	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$		$ 2,978	$ 2,978	$ 20,996	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 59,551	$		$ 2,978	$	$ 20,996	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	42,411	1,414	20	1,212	(202)	6,311	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Villa Financial Services, LLC	2015	463	93	20	23	(69)	76	9
10	Allocated from Villa Financial Services, LLC	2017	102	20	20	5	(15)	10	10
11	Allocated from Villa Financial Services, LLC	2018	1,286	9	20	8	(2)	8	11
12	Allocated from 3737 Chase, LLC	2014	26,908		20	1,345	1,345	6,110	12
13	Allocated from 3737 Chase, LLC	2015	14,790	2,958	20	739	(2,218)	2,342	13
14	Allocated from 3737 Chase, LLC	2016	4,845	969	20	242	(727)	592	14
15	Allocated from 3737 Chase, LLC	2017	7,085	945	20	354	(590)	590	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)		$ 97,889	$ 6,407		$ 3,929	$ (2,478)	$ 16,039	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 97,889	$ 6,407		$ 3,929	$ (2,478)	$ 16,039	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
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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)		$ 97,889	$ 6,407		$ 3,929	$ (2,478)	$ 16,039	34

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 238,306	$ 16,293	$ 33,576	$ 17,283	10	$ 167,000	71
72	Current Year Purchases	79,535	312	7,380	7,069	10	7,380	72
73	Fully Depreciated Assets	35,619				10	35,619	73
74								74
75	TOTALS	$ 353,460	$ 16,605	$ 40,956	$ 24,352		$ 210,000	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)	$ 2,080,813	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,483	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,528	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 44,045	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 848,667	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	Facility Expansion	$ 407,100	92
93			93
94			94
95		$ 407,100	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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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:		111		$ 1,007,347			3
4	Additions							4
5	Church Parking Lot Rental				500			5
6								6
7	TOTAL		111		$ 1,007,847 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 11,521 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	Toyota	$ 83.05	$ 997	17
18					18
19					19
20					20
21	TOTAL		$ 83.05	$ 997	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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 335,351		$	$		$ 335,351	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	64,419					64,419	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	326,391					326,391	4
5	Physician Care	39 - 03	visits			14,340			14,340	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				212,326		212,326	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						149,375		149,375	13
14	TOTAL			$ 726,161		$ 14,340	$ 361,701		$ 1,102,202	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.

STATE OF ILLINOIS

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 1,500	$ 6,485	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,147,748	1,147,748	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,164	3,164	6
7	Other Prepaid Expenses	7,865	7,865	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		606,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,160,277	$ 1,771,262	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	1,120,318	1,120,318	15
16	Equipment, at Historical Cost	1,179,132	1,179,132	16
17	Accumulated Depreciation (book methods)	(2,101,680)	(2,101,680)	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	407,100	407,100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 604,870	$ 604,870	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,765,147	$ 2,376,132	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 286,401	$ 286,401	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	553,000	722,944	29
30	Accrued Salaries Payable	327,439	327,439	30
31	Accrued Taxes Payable (excluding real estate taxes)	(505)	(505)	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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,166,335	$ 1,336,279	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	2,131,121	2,395,303	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,131,121	$ 2,395,303	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,297,456	$ 3,731,582	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,532,309)	$ (1,355,450)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,765,147	$ 2,376,132	48

*(See instructions.)

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (740,274)	1
2	Restatements (describe):		2
3	Equity Adjustment	163,631	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (576,643)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(790,666)	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	(165,000)	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)**	$ (955,666)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,532,309)	24 *

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 6,023,133	1
2	Discounts and Allowances for all Levels	(2,591,162)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,431,971	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,235,894	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,235,894	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	329,499	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,041	19
20	Radiology and X-Ray	8,510	20
21	Other Medical Services	120	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 364,170	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,487	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,487	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	10,220	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,220	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,050,742	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,152,214	31
32	Health Care	2,809,477	32
33	General Administration	2,372,402	33
	B. Capital Expense		
34	Ownership	1,184,727	34
	C. Ancillary Expense		
35	Special Cost Centers	1,160,773	35
36	Provider Participation Fee	161,815	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,841,408	40
41	**Income before Income Taxes (line 30 minus line 40)****	(790,666)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (790,666)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 930,804	44
45	Private Pay - Net Inpatient Revenue	659,981	45
46	Medicare - Net Inpatient Revenue	287,555	46
47	Other-(specify) Hospice	610,102	47
48	Other-(specify) Managed Care	943,529	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,431,971	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 Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,572	1,665	$ 82,314	$ 49.44	1
2	Assistant Director of Nursing	1,897	2,038	73,379	36.01	2
3	Registered Nurses	19,635	20,036	678,021	33.84	3
4	Licensed Practical Nurses	22,732	23,422	706,793	30.18	4
5	CNAs & Orderlies	46,924	44,931	646,652	14.39	5
6	CNA Trainees					6
7	Licensed Therapist	17,356	19,134	726,161	37.95	7
8	Rehab/Therapy Aides	1,914	2,078	69,364	33.38	8
9	Activity Director	1,971	2,078	31,891	15.35	9
10	Activity Assistants	2,777	1,013	39,956	39.44	10
11	Social Service Workers	6,219	6,686	148,463	22.21	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,126	47,811	22.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,301	17,110	267,710	15.65	15
16	Dishwashers					16
17	Maintenance Workers	1,529	1,693	47,309	27.94	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,794	1,994	155,411	77.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,875	2,014	56,279	27.94	23
24	Clerical	15,331	15,805	209,262	13.24	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	1,829	2,094	33,291	15.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,621	165,917	$ 4,020,067 *	$ 24.23	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	227	$ 12,461	01-03	35
36	Medical Director	Monthly	33,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,424	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	48	2,905	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	1	320	12-03	45
46	Other(specify)				46
47	Therapy Consulting	Monthly	5,470	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	276	$ 65,580		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	2,588	77,633	10-03	52
53	TOTAL (lines 50 - 52)	2,588	$ 77,633		53

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eliana Mejia	Administrator	0	$ 155,411
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 155,411

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
Villa Financial Services	Bookkeeping Fees	$ 399,276
See Attached	Legal Fees	53,945
PMA Companies, Inc.	Worker's Compensation Audit	704
Marcum LLP	Accounting	20,473
Widlak and Petriches PC	Payroll Services	1,825
Achieve Accreditation LLC	Accreditation	12,877
MTS Consulting LLC	Tax Consulting	2,306
Zimmet Healthcare Services Group,	HC Innovative Solutions	3,600
Personnel Planners	Unemployment Consultant	1,965
Prospect Resources	Energy Procurement	1,050
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 498,021

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 236,816
Unemployment Compensation Insurance	24,599
FICA Taxes	281,190
Employee Health Insurance	177,037
Employee Meals	28,288
Illinois Municipal Retirement Fund (IMRF)*	
401K	18,723
Life Insurance	5,511
Dental	250
Vision	42
Employee Retention	19,052
TOTAL (agree to Schedule V, line 22, col.8)	$ 791,508

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,928
Health Care Worker Background Check	
(Indicate # of checks performed 143)	1,434
Patient Background Checks	
Dues & Subscriptions	51,205
Licenses & Permits	5,905
Allocated from Villa Financial Services, LLC	6,373
Allocated from 3737 Chase, LLC	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 71,847

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,978
Allocated from Villa Financial Services, LLC	546
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,524

**See instructions.

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **HCCI $19,291**

(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. $ **175** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **161,815**
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. $ **28,288** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **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