

Facility Name & ID Number Park Villa Nrsg & Rehab Center

0051417 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,773	3,302	18,593	25,668	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,773	3,302	18,593	25,668	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.63%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 101 and days of care provided 8,904

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	313,488	43,390	13,163	370,041		370,041		370,041		1
2	Food Purchase		137,733		137,733	(26,463)	111,271	546	111,817		2
3	Housekeeping		30,766	187,178	217,944		217,944		217,944		3
4	Laundry			117,816	117,816		117,816		117,816		4
5	Heat and Other Utilities			160,806	160,806		160,806	(16,606)	144,200		5
6	Maintenance	68,112	1,227	74,335	143,674		143,674	15,158	158,832		6
7	Other (specify):*										7
8	TOTAL General Services	381,600	213,116	553,298	1,148,014	(26,463)	1,121,552	(902)	1,120,649		8
	B. Health Care and Programs										
9	Medical Director			30,250	30,250		30,250		30,250		9
10	Nursing and Medical Records	2,042,966	146,798	314,316	2,504,080		2,504,080	(1,448)	2,502,632		10
10a	Therapy	75,183	2,765	13,288	91,236		91,236		91,236		10a
11	Activities	73,150	13,651		86,801		86,801		86,801		11
12	Social Services	195,238	14,965		210,203		210,203		210,203		12
13	CNA Training										13
14	Program Transportation			9,641	9,641		9,641		9,641		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,386,537	178,179	367,495	2,932,211		2,932,211	(1,448)	2,930,763		16
	C. General Administration										
17	Administrative	154,330			154,330		154,330		154,330		17
18	Directors Fees										18
19	Professional Services			632,211	632,211		632,211	(455,021)	177,190		19
20	Dues, Fees, Subscriptions & Promotions			55,346	55,346		55,346	(8,276)	47,070		20
21	Clerical & General Office Expenses	190,791	1,148	505,987	697,926		697,926	(150,720)	547,206		21
22	Employee Benefits & Payroll Taxes			835,561	835,561	26,463	862,024	(38,614)	823,410		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,665	2,665		2,665	414	3,079		24
25	Other Admin. Staff Transportation			10,024	10,024		10,024	2,288	12,312		25
26	Insurance-Prop.Liab.Malpractice			154,564	154,564		154,564	992	155,556		26
27	Other (specify):*							33,062	33,062		27
28	TOTAL General Administration	345,121	1,148	2,196,358	2,542,627	26,463	2,569,090	(615,873)	1,953,216		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,113,258	392,443	3,117,151	6,622,852		6,622,852	(618,224)	6,004,628		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			96,295	96,295		96,295	28,677	124,972		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			43,370	43,370		43,370	14,569	57,939		32
33	Real Estate Taxes			300,000	300,000		300,000	4,979	304,979		33
34	Rent-Facility & Grounds			744,592	744,592		744,592	241,107	985,699		34
35	Rent-Equipment & Vehicles			18,345	18,345		18,345	(2,828)	15,517		35
36	Other (specify):*										36
37	TOTAL Ownership			1,202,602	1,202,602		1,202,602	286,504	1,489,106		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	992,812	448,209	29,029	1,470,050		1,470,050	(14,752)	1,455,298		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			157,059	157,059		157,059		157,059		42
43	Other (specify):*	15,023	915	28,799	44,737		44,737	(44,737)	(0)		43
44	TOTAL Special Cost Centers	1,007,835	449,124	214,887	1,671,846		1,671,846	(59,489)	1,612,357		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,121,093	841,567	4,534,640	9,497,300		9,497,300	(391,209)	9,106,091		45

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

Park Villa Nrsg & Rehab Center

ID# 0051417

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration Expense	\$ (87,025)	21	1
2	Marketing Expenses	(18,647)	43	2
3	Resident Retention	(4,157)	43	3
4	Bank Fees	(9,144)	21	4
5	Director of Business Development	(15,023)	43	5
6	Medical Records Income	(1,448)	10	6
7	Miscellaneous Income	(4,843)	21	7
8	Non Allowable Auto Lease	(3,436)	35	8
9	Additional R&M	14,978	06	9
10	Bldg Co - Accounting Fees	(1,545)	19	10
11	Bldg Co - Legal Fees	(528)	19	11
12	Bldg Co - Professional Fees	(2,750)	19	12
13	Bldg Co - Bank Fees	(658)	21	13
14	Bldg Co - Penalties	(214)	21	14
15	Capitalized R&M	(2,895)	06	15
16	Non Allowable Seminar	(63)	24	16
17	PAC Dues	(5,656)	20	17
18	Marketing Consultants	(6,051)	43	18
19	Non Allowable Legal	(4,544)	19	19
20	Revenue Growth Consulting	(859)	43	20
21	Private Pay Dental Revenue	(573)	39	21
22	2015 Health Insurance & Pension Settlement	(38,614)	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	(193,696)		49

Park Villa Nrsg & Rehab Center

Report Period Beginning: 01/01/17
 Ending: 12/31/17

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:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(177)		723									546	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(19,005)		2,399									(16,606)	5
6	Maintenance	12,083		3,062	13								15,158	6
7	Other (specify):*													7
8	TOTAL General Services	(7,099)		6,184	13								(902)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,448)											(1,448)	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	(1,448)											(1,448)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(9,367)	4,823	(450,607)	131								(455,021)	19
20	Fees, Subscriptions & Promotions	(13,890)		5,604	10								(8,276)	20
21	Clerical & General Office Expenses	(375,270)	172	224,378									(150,720)	21
22	Employee Benefits & Payroll Taxes	(38,614)											(38,614)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(63)		478									414	24
25	Other Admin. Staff Transportation			2,288									2,288	25
26	Insurance-Prop.Liab.Malpractice			548	444								992	26
27	Other (specify):*			33,062									33,062	27
28	TOTAL General Administration	(437,204)	4,994	(184,249)	585								(615,873)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(445,751)	4,994	(178,065)	598								(618,224)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Villa Nrsg & Rehab Center # 0051417 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(16,695)		23,760	21,612								28,677	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,047)	12,058	709	5,849								14,569	32
33	Real Estate Taxes				4,979								4,979	33
34	Rent-Facility & Grounds		241,106	8,242	(8,242)								241,107	34
35	Rent-Equipment & Vehicles	(3,436)		608									(2,828)	35
36	Other (specify):*													36
37	TOTAL Ownership	(24,178)	253,165	33,319	24,198								286,504	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(573)					(14,179)						(14,752)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(44,737)											(44,737)	43
44	TOTAL Special Cost Centers	(45,310)					(14,179)						(59,489)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(515,239)	258,159	(144,746)	24,796		(14,179)						(391,209)	45

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 738,592	Park Villa Realty		\$	(738,592)	1
2	V	19 Accounting Fees		Park Villa Realty		1,545	1,545	2
3	V	19 Legal/Collection Fees		Park Villa Realty		528	528	3
4	V	19 Professional Fees		Park Villa Realty		2,750	2,750	4
5	V	21 Bank Fees		Park Villa Realty		658	658	5
6	V	21 Penalties & Fines		Park Villa Realty		214	214	6
7	V	32 Interest Expense		Park Villa Realty		12,058	12,058	7
8	V	34 Rent Expense		Park Villa Realty		979,698	979,698	8
9	V	21 Non-Recurring Misc. Expense	700	Park Villa Realty			(700)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 739,292			\$ 997,451	\$ * 258,159	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 FOOD	\$	VILLA FINANCIAL SERVICES, LLC	100.00%	\$ 723	\$	723	15
16	V	5 UTILITIES		VILLA FINANCIAL SERVICES, LLC	100.00%	2,399		2,399	16
17	V	6 REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	3,062		3,062	17
18	V	19 PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC	100.00%	3,686		3,686	18
19	V	20 FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC	100.00%	5,604		5,604	19
20	V	21 CLERICAL & GENERAL - SALARIES		VILLA FINANCIAL SERVICES, LLC	100.00%	220,887		220,887	20
21	V	21 CLERICAL & GENERAL - OTHER EXPENSE		VILLA FINANCIAL SERVICES, LLC	100.00%	3,492		3,492	21
22	V	24 SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC	100.00%	478		478	22
23	V	25 ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC	100.00%	2,288		2,288	23
24	V	26 INSURANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	548		548	24
25	V	27 EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC	100.00%	33,062		33,062	25
26	V	30 DEPRECIATION		VILLA FINANCIAL SERVICES, LLC	100.00%	23,760		23,760	26
27	V	32 INTEREST		VILLA FINANCIAL SERVICES, LLC	100.00%	709		709	27
28	V	34 RENT		VILLA FINANCIAL SERVICES, LLC	100.00%	8,242		8,242	28
29	V	35 EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC	100.00%	608		608	29
30	V								30
31	V	19 HOME OFFICE	454,293					(454,293)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 454,293			\$ 309,547	\$ *	(144,746)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS AND MAINTENANCE		3737 Chase, LLC	100.00%	13	\$	13	15
16	V	19 PROFESSIONAL FEES		3737 Chase, LLC	100.00%	131		131	16
17	V	20 DUES & SUBSCRIPTIONS		3737 Chase, LLC	100.00%	10		10	17
18	V	26 INSURANCE		3737 Chase, LLC	100.00%	444		444	18
19	V	30 DEPRECIATION		3737 Chase, LLC	100.00%	21,612		21,612	19
20	V	32 INTEREST EXPENSE		3737 Chase, LLC	100.00%	5,849		5,849	20
21	V	33 REAL ESTATE TAXES		3737 Chase, LLC	100.00%	4,979		4,979	21
22	V								22
23	V								23
24	V								24
25	V	34 RENT	8,242	3737 Chase, LLC	100.00%			(8,242)	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		\$ 8,242			\$ 33,038	\$ *	24,796	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 DME & Medical Supplies	\$ 66,662	Integra Healthcare Equipment, LLC		\$ 52,483	\$ (14,179)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 66,662			\$ 52,483	\$ * (14,179)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$	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 Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number Park Villa Nrsrg & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9		
Schedule V	Unit of Allocation	Unit of Allocation	Total Units	Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line	(i.e.,Days, Direct Cost,	(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference	Item	Square Feet)		Allocated Among	Allocated	in Column 6				
1	2	FOOD	FINCL. CONSLT. REV.	10,922,183	23	\$ 17,384	\$ 454,293	\$ 723	1	
2	5	UTILITIES	FINCL. CONSLT. REV.	10,922,183	23	57,667	454,293	2,399	2	
3	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	10,922,183	23	73,628	454,293	3,062	3	
4	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	10,922,183	23	88,608	454,293	3,686	4	
5	20	FEES SUBSCRIPTIONS	FINCL. CONSLT. REV.	10,922,183	23	134,735	454,293	5,604	5	
6	21	CLERICAL & GENERAL - SAL	FINCL. CONSLT. REV.	10,922,183	23	5,310,600	5,310,600	454,293	220,887	6
7	21	CLERICAL & GENERAL - OTH	FINCL. CONSLT. REV.	10,922,183	23	83,946	454,293	3,492	7	
8	24	SEMINARS AND EDUCATION	FINCL. CONSLT. REV.	10,922,183	23	11,481	454,293	478	8	
9	25	ADMIN. STAFF TRAVEL	FINCL. CONSLT. REV.	10,922,183	23	55,011	454,293	2,288	9	
10	26	INSURANCE	FINCL. CONSLT. REV.	10,922,183	23	13,183	454,293	548	10	
11	27	EMPLOYEE BEN. GEN. ADMIN	FINCL. CONSLT. REV.	10,922,183	23	794,879	454,293	33,062	11	
12	30	DEPRECIATION	FINCL. CONSLT. REV.	10,922,183	23	571,244	454,293	23,760	12	
13	32	INTEREST	FINCL. CONSLT. REV.	10,922,183	23	17,034	454,293	709	13	
14	34	RENT	FINCL. CONSLT. REV.	10,922,183	23	198,161	454,293	8,242	14	
15	35	EQUIPMENT RENTAL	FINCL. CONSLT. REV.	10,922,183	23	14,615	454,293	608	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 7,442,175	\$ 5,310,600	\$ 309,547	25	

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	10,922,183	23	305	454,293	13	1
2	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	10,922,183	23	3,151	454,293	131	2
3	20	DUES & SUBSCRIPTIONS	FINCL. CONSLT. REV.	10,922,183	23	250	454,293	10	3
4	26	INSURANCE	FINCL. CONSLT. REV.	10,922,183	23	10,669	454,293	444	4
5	30	DEPRECIATION	FINCL. CONSLT. REV.	10,922,183	23	519,594	454,293	21,612	5
6	32	INTEREST EXPENSE	FINCL. CONSLT. REV.	10,922,183	23	140,625	454,293	5,849	6
7	33	REAL ESTATE TAXES	FINCL. CONSLT. REV.	10,922,183	23	119,703	454,293	4,979	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					\$ 794,297	\$	\$ 33,038	25

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	DME & Medical Supplies	Direct		\$	\$		\$ 52,483	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				\$	\$		\$ 52,483	25

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center

0051417 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

Facility Name & ID Number Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number

Park Villa Nrsng & Rehab Center

0051417

Report Period Beginning:

01/01/17

Ending:

12/31/17

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Private Bank		X	Line of Credit				705,000		43,370										
7	MB Financial		X	Construction Loan				213,984		12,058										
8																				
9	TOTAL Facility Related							918,984		55,428										
B. Non-Facility Related*																				
10	Interest Income		X							(4,047)										
11	Allocated from 3737 Chase, LLC	X								5,849										
12	Allocated from Villa Financial	X								709										
13																				
14	TOTAL Non-Facility Related									2,511										
15	TOTALS (line 9+line14)							918,984		57,939										

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:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Allocated from 3737 Chase, LLC, \$ 10,701. Row 3: TOTALS, \$ 10,701.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2011	1,329,438		20	68,672	68,672	484,998	9
10	Various		2012	12,999		20	651	651	8,534	10
11	Various		2013	33,482		20	1,674	1,674	7,115	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		59,551			2,978	2,978	18,018	67
68		138,117	16,696		5,437	(11,259)	17,316	68
69			96,295			(96,295)		69
70		\$ 1,573,586	\$ 112,991		\$ 79,412	\$ (33,579)	\$ 535,980	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:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,573,586	\$ 112,991		\$ 79,412	\$ (33,579)	\$ 535,980	1
2	Parking Lot Pavement - Full Depth Removal & Replace	2014	20,546		20	1,370	1,370	4,795	2
3	Install Exhaust Fan & Round Flue Piping For 3 Dryers	2014	8,736		20	437	437	1,638	3
4	Repair Replace Damaged Drywall & Studs In Resident Rooms	2014	5,500		20	275	275	894	4
5	1 New Hvac Roof Top Unit.	2014	10,050		20	503	503	1,591	5
6	Dining Area Exit Door	2014	2,637		20	132	132	264	6
7	Replace Smoke Detectors	2015	3,084		20	154	154	308	7
8	Replace Physical Therapy Tru	2015	3,350		20	168	168	335	8
9	Replace Ceiling Grid & Tile In Corridors & Entries	2015	40,200		20	2,010	2,010	4,020	9
10	Remove & Replace Dry Valve Air Compressor	2015	3,594		20	180	180	359	10
11	New Water Heater	2015	16,800		20	840	840	1,680	11
12	Replace 300 Wing Ac Unit	2015	2,500		20	125	125	250	12
13	Change Grill Diffusers	2015	5,900		20	295	295	590	13
14	Replace Dry Pendant Fire Sprinkler Heads	2015	6,786		20	339	339	679	14
15	Install Nurse Call Master Station	2015	9,089		20	454	454	909	15
16	Grease Trap Pipe Repair	2015	2,800		20	140	140	280	16
17	Nurse Call System Wiring	2015	3,350		20	168	168	335	17
18	On-Line Communication Alarm System	2016	8,371		20	419	419	419	18
19	Installation Of Smoke Detectors In Concierge Area	2016	3,425		20	171	171	171	19
20	New Call Light Station	2016	5,875		20	294	294	294	20
21	A/C Service And Repair	2016	2,717		20	136	136	136	21
22	Smoke Detector Sprinkler & Base	2017	4,582		20	229	229	229	22
23	Repair Condensing Unit	2017	2,895		20	145	145	145	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)		\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	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		\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	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)	\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	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)	\$ 1,746,373	\$ 112,991		\$ 88,394	\$ (24,597)	\$ 556,301	34

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

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	11,400	9
10	Install Drywall & Plastering Above Suspended Ceiling	2012	7,200		20	360	360	2,160	10
11	Landscaping	2012	7,671		20	384	384	2,304	11
12	Paving	2011	6,680		20	334	334	2,154	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	\$ 18,018	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 59,551	\$		\$ 2,978	\$	\$ 18,018	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
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	\$	\$ 18,018	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 3737 Chase, LLC	2013	60,636	2,021	35	1,732	(289)	7,291	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Villa Financial Services	2015	661	161	20	33	(128)	76	9
10	Allocated from Villa Financial Services	2017	146	24	20	7	(17)	7	10
11									11
12	Allocated from 3737 Chase, LLC	2014	38,472	7,694	20	1,924	(5,770)	6,813	12
13	Allocated from 3737 Chase, LLC	2015	21,145	4,229	20	1,057	(3,172)	2,291	13
14	Allocated from 3737 Chase, LLC	2016	6,927	1,385	20	346	(1,039)	500	14
15	Allocated from 3737 Chase, LLC	2017	10,130	1,182	20	338	(844)	338	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)		\$ 138,117	\$ 16,696		\$ 5,437	\$ (11,259)	\$ 17,316	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 138,117	\$ 16,696		\$ 5,437	\$ (11,259)	\$ 17,316	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)	\$ 138,117	\$ 16,696		\$ 5,437	\$ (11,259)	\$ 17,316	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:

01/01/17

Ending:

12/31/17

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	\$ 256,971	\$ 26,528	\$ 35,454	\$ 8,926	10	\$ 138,963	71
72	Current Year Purchases	13,198	2,147	1,123	(1,024)	10	1,123	72
73	Fully Depreciated Assets	35,619				10	35,619	73
74								74
75	TOTALS	\$ 305,788	\$ 28,675	\$ 36,577	\$ 7,902		\$ 175,705	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)	\$ 2,062,862	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 141,666	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,971	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,695)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 732,006	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	\$ 201,671	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Park Villa Nrsg & Rehab Center

0051417

Report Period Beginning: 01/01/17

Ending: 12/31/17

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.

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:		<u>101</u>		\$ <u>979,698</u>			<u>3</u>
4	Additions							<u>4</u>
5	<u>Church Parking Lot Rental</u>				<u>6,000</u>			<u>5</u>
6								<u>6</u>
7	TOTAL		101		\$ 985,698			7

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.	<u> /2018</u>	\$ <u> </u>
13.	<u> /2019</u>	\$ <u> </u>
14.	<u> /2020</u>	\$ <u> </u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 11,743 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	<u>Facility</u>	<u>Chrysler</u>	\$ <u>629</u>	\$ <u>3,774</u>	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$ 629	\$ 3,774	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 347,326		\$			\$ 347,326	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	73,311					73,311	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	572,175					572,175	4
5	Physician Care	39 - 03	visits			29,029			29,029	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				317,176		317,176	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____						131,033		131,033	13
14	TOTAL			\$ 992,812		\$ 29,029	\$ 448,209		\$ 1,470,050	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,470	\$ 4,307	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,329,094	1,329,094	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,075	23,075	6
7	Other Prepaid Expenses	17,092	17,092	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)	\$ 1,370,731	\$ 1,979,568	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	1,106,210	1,106,210	15
16	Equipment, at Historical Cost	1,086,741	1,086,741	16
17	Accumulated Depreciation (book methods)	(2,040,209)	(2,040,209)	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	201,671	201,671	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 354,413	\$ 354,413	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,725,144	\$ 2,333,981	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 277,569	\$ 277,570	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	705,000	918,984	29
30	Accrued Salaries Payable	365,574	365,574	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,348,143	\$ 1,562,128	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	1,117,275	1,378,480	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,117,275	\$ 1,378,480	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,465,418	\$ 2,940,608	46
47	TOTAL EQUITY(page 18, line 24)	\$ (740,274)	\$ (606,627)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,725,144	\$ 2,333,981	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 90,538	1
2	Restatements (describe):		2
3	Equity Adjustment	(341,394)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (250,856)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(324,418)	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)	\$ (489,418)	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)	\$ (740,274)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Villa Nrsg & Rehab Center

0051417

Report Period Beginning: 01/01/17

Ending:

12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,484,282	1
2	Discounts and Allowances for all Levels	(3,176,952)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,307,330	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,392,933	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,392,933	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	336,948	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,491	19
20	Radiology and X-Ray	28,750	20
21	Other Medical Services	20,092	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 462,281	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,047	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,047	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,291	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,291	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,172,882	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,148,014	31
32	Health Care	2,932,211	32
33	General Administration	2,542,627	33
B. Capital Expense			
34	Ownership	1,202,602	34
C. Ancillary Expense			
35	Special Cost Centers	1,514,787	35
36	Provider Participation Fee	157,059	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,497,300	40
41	Income before Income Taxes (line 30 minus line 40)**	(324,418)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (324,418)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 643,923	44
45	Private Pay - Net Inpatient Revenue	591,014	45
46	Medicare - Net Inpatient Revenue	454,898	46
47	Other-(specify) Hospice	440,623	47
48	Other-(specify) Managed Care	1,176,872	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,307,330	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: 01/01/17

Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,736	1,980	\$ 98,401	\$ 49.70	1
2	Assistant Director of Nursing	1,928	2,056	77,155	37.53	2
3	Registered Nurses	15,847	16,681	532,635	31.93	3
4	Licensed Practical Nurses	26,337	27,889	787,136	28.22	4
5	CNAs & Orderlies	41,411	43,058	513,839	11.93	5
6	CNA Trainees					6
7	Licensed Therapist	22,650	24,214	992,812	41.00	7
8	Rehab/Therapy Aides	2,567	2,829	75,183	26.58	8
9	Activity Director	2,062	2,188	31,805	14.54	9
10	Activity Assistants	3,279	3,572	41,345	11.57	10
11	Social Service Workers	8,496	9,016	195,238	21.65	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,088	47,380	22.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,937	18,382	266,108	14.48	15
16	Dishwashers					16
17	Maintenance Workers	2,362	2,596	68,112	26.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,024	2,080	154,330	74.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,744	1,872	49,972	26.69	23
24	Clerical	9,862	10,604	140,819	13.28	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	1,880	2,080	33,800	16.25	31
32	Other Health Care(specify)					32
33	Other(specify)	376	400	15,023	37.56	33
34	TOTAL (lines 1 - 33)	162,466	173,585	\$ 4,121,093 *	\$ 23.74	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	239	\$ 13,163	01-03	35
36	Medical Director	Monthly	30,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,286	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	170	10,197	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Therapy Consulting	Monthly	3,091	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	409	\$ 66,987		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	10,134	304,030	10-03	52
53	TOTAL (lines 50 - 52)	10,134	\$ 304,030		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Elaina Mejia	Administrator	0	\$ 154,330	Workers' Compensation Insurance	\$ 231,843	IDPH License Fee	\$		
				Unemployment Compensation Insurance	29,257	Advertising: Employee Recruitment	7,987		
				FICA Taxes	284,239	Health Care Worker Background Check			
				Employee Health Insurance	218,137	(Indicate # of checks performed <u>788</u>)	7,884		
				Employee Meals	26,463	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,657		
				401K Expense	13,664	Licenses & Permits	8,928		
				Dental	528	Allocated from Villa Financial Services	5,604		
				Vision	221	Allocated from 3737 Chase, LLC	10		
				Life Insurance	5,317				
				Employee Retention	13,740	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 154,330	TOTAL (agree to Schedule V, line 22, col.8)		\$ 823,410	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 47,069
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	2,602	
							Allocated from Villa Financial Services	478	
C. Professional Services									
Vendor/Payee	Type		Amount						
Villa Financial Services	Financial Consulting Fees		\$ 454,293				Entertainment Expense	()	
Proclaim Partners, LLC	Reimbursement Consultant		64				(agree to Sch. V, line 24, col. 8)		
Marcum LLP	Accounting		29,555						
See Attached	Legal		30,874						
Achieve Accreditation LLC	Accreditation		8,830						
BDO Consulting	Reimbursement Consulting		1,163						
Betco LTC Consulting, LLC	Clinical Consulting		2,066						
Documentation Solutions, Inc.	Clinical Documentation		1,584						
Illinois Rytes Corp.	Liability Management		9,595						
MTS Consulting LLC	Tax Consulting		1,262						
See Supplemental Schedule			92,924						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 632,212	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Villa Nrsng & Rehab Center# 0051417

Report Period Beginning:

01/01/17

Ending:

12/31/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$11,312
- (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. \$ 1,191 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 157,059
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 26,463 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees