

Facility Name & ID Number Villa At South Holland

0052340 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 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	171	Skilled (SNF)	171	62,415	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	171	TOTALS	171	62,415	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			10,124	10,124	8
9	SNF/PED					9
10	ICF	12,742	1,514	14,206	28,462	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,742	1,514	24,330	38,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.82%

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 05/01/2013

J. Was the facility purchased or leased after January 1, 1978? YES Date 05/01/2013 NO

K. Was the facility certified for Medicare during the reporting year? YES NO If YES, enter number of beds certified 171 and days of care provided 10,124

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Villa At South Holland # 0052340 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 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		28,939	634,625	663,564		663,564		663,564		1
2	Food Purchase		1,744		1,744		1,744	810	2,554		2
3	Housekeeping		24,447	274,098	298,545		298,545		298,545		3
4	Laundry			182,732	182,732		182,732		182,732		4
5	Heat and Other Utilities			227,480	227,480		227,480	(10,749)	216,731		5
6	Maintenance	97,600	241	125,054	222,895		222,895	13,870	236,765		6
7	Other (specify):*										7
8	TOTAL General Services	97,600	55,371	1,443,989	1,596,960		1,596,960	3,931	1,600,891		8
	B. Health Care and Programs										
9	Medical Director			73,500	73,500		73,500		73,500		9
10	Nursing and Medical Records	3,196,478	156,307	22,717	3,375,502		3,375,502		3,375,502		10
10a	Therapy	46,374	7,459	10,047	63,880		63,880		63,880		10a
11	Activities	127,874	6,558		134,432		134,432		134,432		11
12	Social Services	172,351	4,292		176,643		176,643		176,643		12
13	CNA Training										13
14	Program Transportation			3,702	3,702		3,702		3,702		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,543,077	174,616	109,966	3,827,659		3,827,659		3,827,659		16
	C. General Administration										
17	Administrative	149,103			149,103		149,103		149,103		17
18	Directors Fees										18
19	Professional Services			769,010	769,010	(20,060)	748,950	(621,319)	127,631		19
20	Dues, Fees, Subscriptions & Promotions			77,061	77,061		77,061	(17,486)	59,575		20
21	Clerical & General Office Expenses	170,571	906	616,493	787,970		787,970	(103,724)	684,246		21
22	Employee Benefits & Payroll Taxes			674,896	674,896		674,896	(7,002)	667,894		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,182	3,182		3,182	(567)	2,615		24
25	Other Admin. Staff Transportation			26,104	26,104		26,104	6,973	33,077		25
26	Insurance-Prop.Liab.Malpractice			443,085	443,085		443,085	1,408	444,493		26
27	Other (specify):*							42,706	42,706		27
28	TOTAL General Administration	319,674	906	2,609,831	2,930,411	(20,060)	2,910,351	(699,012)	2,211,339		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,960,351	230,893	4,163,786	8,355,030	(20,060)	8,334,970	(695,081)	7,639,889		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			740,451	740,451		740,451	(550,228)	190,223			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,517	72,517		72,517	(8,887)	63,630			32
33	Real Estate Taxes					20,060	20,060	5,619	25,679			33
34	Rent-Facility & Grounds			1,962,000	1,962,000		1,962,000	0	1,962,000			34
35	Rent-Equipment & Vehicles			12,155	12,155		12,155	678	12,833			35
36	Other (specify):*											36
37	TOTAL Ownership			2,787,123	2,787,123	20,060	2,807,183	(552,818)	2,254,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		364,040	1,305,069	1,669,109		1,669,109	(7,017)	1,662,092			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,388	266,388		266,388		266,388			42
43	Other (specify):*		1,708	35,346	37,054		37,054	(37,054)	0			43
44	TOTAL Special Cost Centers		365,748	1,606,803	1,972,551		1,972,551	(44,071)	1,928,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,960,351	596,641	8,557,712	13,114,704		13,114,704	(1,291,969)	11,822,735			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 Villa At South Holland

0052340

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(13,522)	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	(585,504)	30		9
10	Interest and Other Investment Income	(16,741)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(367,243)	21		24
25	Fund Raising, Advertising and Promotional	(9,945)	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	(193,427)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,186,383)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(105,586)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (105,586)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,291,969)		37

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

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

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

Villa At South Holland

ID# 0052340
 Report Period Beginning: 01/01/18
 Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Sequestration Reduction	\$ (99,667)	21	1
2	Miscellaneous Income	(1,890)	21	2
3	Rebates/Refunds	(1,051)	21	3
4	Vending Income	(346)	02	4
5	Marketing Supplies	(1,708)	43	5
6	Locoater/Promo/Gifts	(4,516)	43	6
7	Promo/Art/Design/Print	(3,371)	43	7
8	Marketing/Entertainment	(16,875)	43	8
9	Resident Retention	(10,584)	43	9
10	Bank Fees	(21,677)	21	10
11	Donations	(3,740)	20	11
12	Employee Benefits - 2017	(7,002)	22	12
13	X-Ray Expense - 2016	(225)	39	13
14	Additional R&M	17,706	06	14
15	Capitalized R&M	(7,746)	06	15
16	Non-Allowable Seminar	(1,405)	24	16
17	Prior Year Dues	(5,804)	20	17
18	PAC Dues	(7,695)	20	18
19	Annual Report	(75)	20	19
20	Non-Allowable Legal Fees	(15,758)	19	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(193,427)		49

Villa At South Holland

Report Period Beginning: ID# 0052340
 Ending: 01/01/18
 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 Villa At South Holland

0052340

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	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	(347)		1,157									810	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,522)		2,773									(10,749)	5
6	Maintenance	9,960		3,910									13,870	6
7	Other (specify):*													7
8	TOTAL General Services	(3,909)		7,840									3,931	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(15,758)		(605,630)	69								(621,319)	19
20	Fees, Subscriptions & Promotions	(27,259)		9,769	3								(17,486)	20
21	Clerical & General Office Expenses	(491,528)		387,804									(103,724)	21
22	Employee Benefits & Payroll Taxes	(7,002)											(7,002)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,405)		837									(567)	24
25	Other Admin. Staff Transportation			6,973									6,973	25
26	Insurance-Prop.Liab.Malpractice			922	485								1,408	26
27	Other (specify):*			42,706									42,706	27
28	TOTAL General Administration	(542,951)		(156,619)	558								(699,012)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(546,860)		(148,779)	558								(695,081)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa At South Holland

0052340

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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(585,504)		25,641	9,635								(550,228)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,741)		693	7,161								(8,887)	32
33	Real Estate Taxes				5,619								5,619	33
34	Rent-Facility & Grounds			8,837	(8,837)								0	34
35	Rent-Equipment & Vehicles			678									678	35
36	Other (specify):*													36
37	TOTAL Ownership	(602,245)		35,849	13,578								(552,818)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(225)				(6,792)							(7,017)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(37,054)											(37,054)	43
44	TOTAL Special Cost Centers	(37,279)				(6,792)							(44,071)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,186,383)		(112,930)	14,136	(6,792)							(1,291,969)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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		\$ 1,157	\$ 1,157	15
16	V	5 UTILITIES		VILLA FINANCIAL SERVICES, LLC		2,773	2,773	16
17	V	6 REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC		3,910	3,910	17
18	V	19 PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC		6,442	6,442	18
19	V	20 FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC		9,769	9,769	19
20	V	21 CLERICAL & GENERAL - SALARIES		VILLA FINANCIAL SERVICES, LLC		389,107	389,107	20
21	V	21 CLERICAL & GENERAL - OTHER EXPENSE		VILLA FINANCIAL SERVICES, LLC		(1,302)	(1,302)	21
22	V	24 SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC		837	837	22
23	V	25 ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC		6,973	6,973	23
24	V	26 INSURANCE		VILLA FINANCIAL SERVICES, LLC		922	922	24
25	V	27 EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC		42,706	42,706	25
26	V	30 DEPRECIATION		VILLA FINANCIAL SERVICES, LLC		25,641	25,641	26
27	V	32 INTEREST		VILLA FINANCIAL SERVICES, LLC		693	693	27
28	V	34 RENT		VILLA FINANCIAL SERVICES, LLC		8,837	8,837	28
29	V	35 EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC		678	678	29
30	V							30
31	V	19 HOME OFFICE	612,072				(612,072)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 612,072			\$ 499,142	\$ * (112,930)	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						\$	15
16	V	19 PROFESSIONAL FEES		3737 Chase, LLC		69	69	16
17	V	20 DUES & SUBSCRIPTIONS		3737 Chase, LLC		3	3	17
18	V	26 INSURANCE		3737 Chase, LLC		485	485	18
19	V	30 DEPRECIATION		3737 Chase, LLC		9,635	9,635	19
20	V	32 INTEREST EXPENSE		3737 Chase, LLC		7,161	7,161	20
21	V	33 REAL ESTATE TAXES		3737 Chase, LLC		5,619	5,619	21
22	V							22
23	V							23
24	V	34 RENT	8,837	3737 Chase, LLC			(8,837)	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		\$ 8,837			\$ 22,973	\$ * 14,136	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	\$ 43,734	Integra Healthcare Equipment LLC		\$ 36,942	\$ (6,792)	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			\$ 43,734			\$ 36,942	\$ * (6,792)	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	10A	Respiratory Services	\$ 11,127	Integra Respiratory Service, LLC		\$ 11,127	\$	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			\$ 11,127			\$ 11,127	\$ *	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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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 Villa At South Holland # 0052340 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 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											11
12											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 Villa At South Holland

0052340

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	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 Villa At South Holland

0052340

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 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 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	2	FOOD	FINCL. CONSLT. REV.	13,724,750	32	\$ 25,934	\$ 612,072	\$ 1,157	1
2	5	UTILITIES	FINCL. CONSLT. REV.	13,724,750	32	62,183	612,072	2,773	2
3	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	13,724,750	32	87,685	612,072	3,910	3
4	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	13,724,750	32	144,447	612,072	6,442	4
5	20	FEES SUBSCRIPTIONS	FINCL. CONSLT. REV.	13,724,750	32	219,061	612,072	9,769	5
6	21	CLERICAL & GENERAL - SAL	FINCL. CONSLT. REV.	13,724,750	32	8,725,104	8,725,104	389,107	6
7	21	CLERICAL & GENERAL - OTH	FINCL. CONSLT. REV.	13,724,750	32	(29,206)	612,072	(1,302)	7
8	24	SEMINARS AND EDUCATION	FINCL. CONSLT. REV.	13,724,750	32	18,770	612,072	837	8
9	25	ADMIN. STAFF TRAVEL	FINCL. CONSLT. REV.	13,724,750	32	156,350	612,072	6,973	9
10	26	INSURANCE	FINCL. CONSLT. REV.	13,724,750	32	20,680	612,072	922	10
11	27	EMPLOYEE BEN. GEN. ADMIN	FINCL. CONSLT. REV.	13,724,750	32	957,610	612,072	42,706	11
12	30	DEPRECIATION	FINCL. CONSLT. REV.	13,724,750	32	574,948	612,072	25,641	12
13	32	INTEREST	FINCL. CONSLT. REV.	13,724,750	32	15,547	612,072	693	13
14	34	RENT	FINCL. CONSLT. REV.	13,724,750	32	198,162	612,072	8,837	14
15	35	EQUIPMENT RENTAL	FINCL. CONSLT. REV.	13,724,750	32	15,206	612,072	678	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	\$ 499,142	25

Facility Name & ID Number Villa At South Holland

0052340

Report Period Beginning:

01/01/18

Ending: 12/31/18

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									1
2	19	PROFESSIONAL FEES	FINCL. CONSLT. REV. 13,724,750	32	1,545		612,072	69	2
3	20	DUES & SUBSCRIPTIONS	FINCL. CONSLT. REV. 13,724,750	32	75		612,072	3	3
4	26	INSURANCE	FINCL. CONSLT. REV. 13,724,750	32	10,882		612,072	485	4
5	30	DEPRECIATION	FINCL. CONSLT. REV. 13,724,750	32	216,050		612,072	9,635	5
6	32	INTEREST EXPENSE	FINCL. CONSLT. REV. 13,724,750	32	160,582		612,072	7,161	6
7	33	REAL ESTATE TAXES	FINCL. CONSLT. REV. 13,724,750	32	126,000		612,072	5,619	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	\$		\$ 22,973	25

Facility Name & ID Number Villa At South Holland

0052340

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 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 Allocation		\$	\$		\$ 36,942	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				\$	\$		\$ 36,942	25

Facility Name & ID Number Villa At South Holland

0052340

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

Integra Respiratory Service 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	10A	Respiratory Services	Direct Allocation		\$	\$		11,127	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				\$	\$		11,127	25

Facility Name & ID Number Villa At South Holland

0052340 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	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 Villa At South Holland

0052340 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	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 Villa At South Holland

0052340 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	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 Villa At South Holland

0052340 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	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 Villa At South Holland

0052340

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	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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 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.)

\$ 5,619 2

3. Under or (over) accrual (line 2 minus line 1).

\$ 5,619 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.)

\$ 20,060 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.

\$ 25,679 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u> </u>	8
	2014	<u> </u>	9
	2015	<u> </u>	10
	2016	<u> </u>	11
	2017	<u> </u>	12

Real estate taxes are included in the building rental on page 14

Allocated - 3737 Chase, LLC - \$5,619

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	\$	<u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$	<u> </u>	14
15	LESS REFUND FROM LINE 6	\$	<u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	<u> 25,679 </u>	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 Villa At South Holland COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052340

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>10-26-318-023-0000</u>	<u>Allocated - 3737 Chase, LLC</u>	\$ <u>128,381.74</u>	\$ <u>5,725.34</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>128,381.74</u>	\$ <u>5,725.34</u>

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 Villa At South Holland COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0052340
 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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
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 Villa At South Holland

0052340

Report Period Beginning:

01/01/18

Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,515 B. General Construction Type: Exterior 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
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>241,648</u>		\$	<u>1</u>
2	<u>Allocated - 3737 Chase, LLC</u>			<u>11,473</u>	<u>2</u>
3	TOTALS			\$ <u>11,473</u>	3

Facility Name & ID Number Villa At South Holland

0052340

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	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		2013	36,471		20	2,104	2,104	4,849	9
10	Various		2014	31,198		20	1,161	1,161	2,147	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
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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 Villa At South Holland

0052340

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		150,060	9,822		6,023	(3,799)	24,588	68
69			740,451			(740,451)		69
70		\$ 217,729	\$ 750,273		\$ 9,287	\$ (740,986)	\$ 31,583	70

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

Facility Name & ID Number Villa At South Holland

0052340

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	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		\$ 217,729	\$ 750,273		\$ 9,287	\$ (740,986)	\$ 31,583	1
2	Installed Condensor For Basement Ac	2015	9,250		20	116	116	116	2
3	Piped Sprinkler Head Into Freight Elevator Pit	2015	8,500		20	390	390	390	3
4	Installed New Damper	2015	5,907		20	295	295	295	4
5	Elevator Work-Wall Panels, Handrails, Stainless Steel Ceiling	2015	27,970		20	1,399	1,399	1,399	5
6	Repaired 2"-3/4" Piping & Fittings	2015	2,982		20	25	25	25	6
7	3Rd Floor Corridor - Handrail, Bumper, Corner Guards	2015	15,862		20	793	793	2,379	7
8	3Rd Floor Corridor And Lounge - Install Drywall, Nurses Stations	2015	37,434		20	1,872	1,872	5,615	8
9	3Rd Floor Dining Room - Build Wing Walls And Soffits, Install Lc	2015	36,572		20	1,829	1,829	5,486	9
10	3Rd Floor Resident Room - Corner And Bumper Guards, Cubicle	2015	47,460		20	2,373	2,373	7,119	10
11	3Rd Floor Resident Bathroom - Vinyl Flooring, Vanity Light, Mir	2015	62,765		20	3,138	3,138	9,415	11
12	3Rd Floor Shower Room - Install Plumbing, Light Fixtures, Mirro	2015	62,936		20	3,147	3,147	9,440	12
13	Structural Engineering - Design Work	2015	2,900		20	145	145	435	13
14	Ran Cables For Phones In New Offices On 1St, 2Nd & 3Rd Floor	2015	4,345		20	217	217	652	14
15	Installed 2 - 5" Storz Connections For Fire Sprinkler System	2016	3,900		20	195	195	585	15
16	Installed Hot Water Circulator Pump	2016	3,146		20	157	157	472	16
17	Furnish And Install New Face Panel Overlay And Paint Existing S	2016	6,232		20	312	312	935	17
18	Lower Level Rtu - Heat Exchanger, Blower Motor And Blower M	2016	5,278		20	264	264	792	18
19	Rtu Control Conversion - Remove Add-On Board And Installed 8	2016	3,613		20	181	181	542	19
20	North Hallway Ac - Replaced Both Compressors	2016	4,175		20	209	209	626	20
21	North Hallway - Replaced Evaporator Coil From Ductwork	2016	10,500		20	525	525	1,575	21
22	South Hallway Ac - New Custom Evaporator Coil	2016	16,865		20	843	843	2,530	22
23	New 48Tc-3-15 Carrier 5 Ton Rooftop Unit	2016	6,190		20	310	310	929	23
24	Installed New Phone System	2016	31,818		20	1,591	1,591	4,773	24
25	Installed Alarm Door And Delayed Egress For Therapy Room (Ex	2016	2,795		20	140	140	419	25
26	Therapy Room Renovation - Paint, Fire Protection, Electrical,	2016			20				26
27	Hvac, Carpentry, Concrete, Drywall, Insulation, Milwork,	2016			20				27
28	Flooring, Plumbing, Lockers, Roofing	2016	1,199,857		20	59,993	59,993	179,979	28
29	3Rd Floor Nurses Station - Install Pure Vinyl Tile And Millwork B	2016	3,654		20	183	183	548	29
30	Lounge Bistro - Furnish And Install Ceiling Feature	2016	14,265		20	713	713	2,140	30
31	2Nd Floor Corridor - Wall Scones	2016	3,569		20	178	178	535	31
32	2Nd Floor Resident Room - Electric Work, Installed Corner And I	2016	11,824		20	591	591	1,774	32
33	2Nd Floor Resident Bathroom - Mirror, Vanity Lights, And Fauce	2016	7,102		20	355	355	1,065	33
34	TOTAL (lines 1 thru 33)		\$ 1,877,394	\$ 750,273		\$ 91,765	\$ (658,508)	\$ 274,566	34

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

Facility Name & ID Number Villa At South Holland

0052340

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	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 12B, Carried Forward		\$ 1,877,394	\$ 750,273		\$ 91,765	\$ (658,508)	\$ 274,566	1
2	3Rd Floor Signage And Light Fixtures	2016	3,625		20	181	181	544	2
3	3Rd Floor Dining Room - Installed New Recessed Lighting	2016	13,976		20	699	699	2,096	3
4	1St, 2Nd, And 3Rd Floor Corridor Wallcovering (Final Billing)	2016	127,510		20	6,375	6,375	19,126	4
5	Furnish And Install Belbien/Senstar On 1St, 2Nd, And 3Rd Floor	2016	4,499		20	225	225	675	5
6	Custom Signage	2016	2,818		20	141	141	423	6
7	New Flooring - 2 Elevators/Wallcovering And Flooring In Various	2016	5,782		20	289	289	867	7
8	Idph Plan Review Costs	2016	8,356		20	418	418	1,253	8
9	Electrical Work For Therapy Room - Light And Power Cables	2016	2,971		20	149	149	446	9
10	Installation Of Roller Shades In Therapy Gym	2016	18,850		20	942	942	2,827	10
11	Therapy Ceiling Lift	2016	13,605		20	680	680	2,041	11
12	Hollow Metal Doors And Labor	2017	5,630		20	282	282	563	12
13	Water Heater	2017	14,009		20	700	700	1,401	13
14	Elevator Pit Ladders	2017	7,869		20	393	393	787	14
15	Fire Damper Installation	2017	3,250		20	163	163	325	15
16	Pipe Replacement Repairs	2017	16,171		20	809	809	1,617	16
17	Repair Drain Line In Kitchen	2017	4,362		20	218	218	436	17
18	Pipe Repairs And Removal Of Mold Insulation	2017	36,148		20	1,807	1,807	3,615	18
19	Repair And Relamp Parking Lot Lights	2017	2,818		20	141	141	282	19
20	Elavator Repair - Breaker Units, Volt Motors	2017	7,000		20	350	350	350	20
21	Rooftop Unit - 10 Ton Trane, Hail Gaurds,Electrical Connections,	2018	16,714		20	836	836	836	21
22	Rooftop Unit Installation	2018	41,854		20	2,093	2,093	2,093	22
23	Kitchen - Pipe Replacement	2018	4,607		20	230	230	230	23
24	Piping/Temperature Control - Hall	2018	8,520		20	426	426	426	24
25	Excavate & Replace P-Trap In Floor - Women'S Washroom	2018	2,610		20	131	131	131	25
26	Rooftop Unit Repairs	2018	4,477		20	224	224	224	26
27	Replace 4" Cast Iron Line In Lobby Ceiling	2018	3,269		20	163	163	163	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,258,693	\$ 750,273		\$ 110,830	\$ (639,443)	\$ 318,343	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		\$ 2,258,693	\$ 750,273		\$ 110,830	\$ (639,443)	\$ 318,343	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)	\$ 2,258,693	\$ 750,273		\$ 110,830	\$ (639,443)	\$ 318,343	34

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

Facility Name & ID Number Villa At South Holland

0052340

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	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		\$ 2,258,693	\$ 750,273		\$ 110,830	\$ (639,443)	\$ 318,343	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)	\$ 2,258,693	\$ 750,273		\$ 110,830	\$ (639,443)	\$ 318,343	34

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

Facility Name & ID Number Villa At South Holland

0052340

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									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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	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 12F, Carried Forward		\$	\$		\$	\$	\$	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
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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	65,014	2,167	20	1,858	(310)	9,675	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Villa Financial Services, LLC	2015	709	142	20	35	(106)	117	9
10	Allocated from Villa Financial Services, LLC	2017	156	31	20	8	(23)	15	10
11	Allocated from Villa Financial Services, LLC	2018	1,972	14	20	12	(2)	12	11
12	Allocated from 3737 Chase, LLC	2014	41,249		20	2,062	2,062	9,367	12
13	Allocated from 3737 Chase, LLC	2015	22,672	4,534	20	1,134	(3,401)	3,590	13
14	Allocated from 3737 Chase, LLC	2016	7,427	1,485	20	371	(1,114)	907	14
15	Allocated from 3737 Chase, LLC	2017	10,862	1,448	20	543	(905)	905	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)		\$ 150,060	\$ 9,822		\$ 6,023	\$ (3,799)	\$ 24,588	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		\$ 150,060	\$ 9,822		\$ 6,023	\$ (3,799)	\$ 24,588	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)	\$ 150,060	\$ 9,822		\$ 6,023	\$ (3,799)	\$ 24,588	34

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

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	\$ 614,729	\$ 24,976	\$ 77,485	\$ 52,509	10	\$ 184,588	71
72	Current Year Purchases	27,866	478	1,908	1,430	10	1,908	72
73	Fully Depreciated Assets	4,374				10	4,374	73
74								74
75	TOTALS	\$ 646,969	\$ 25,454	\$ 79,393	\$ 53,939		\$ 190,870	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)	\$ 2,917,135	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 775,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 190,223	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (585,504)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 509,214	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	Dialysis Room Design	\$ 78,120	92
93			93
94			94
95		\$ 78,120	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FNR South Holland, 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>1977</u>	<u>171</u>		\$ <u>1,962,000</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>171</u>		\$ <u>1,962,000</u>			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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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: \$ 12,833

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	593,441	\$		\$	593,441	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				79,057				79,057	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				632,571				632,571	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					251,598			251,598	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):							112,442			112,442	13
14	TOTAL			\$		\$	1,305,069	\$	364,040	\$	1,669,109	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Villa At South Holland

0052340

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,239,224		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,657		6
7	Other Prepaid Expenses	10,663		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	141,160		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,394,704	\$	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	3,552,612		15
16	Equipment, at Historical Cost	487,980		16
17	Accumulated Depreciation (book methods)	(2,226,713)		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): <u>See Attached Schedule</u>	78,120		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,891,999	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,286,703	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 929,508	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	619,000		29
30	Accrued Salaries Payable	371,376		30
31	Accrued Taxes Payable (excluding real estate taxes)	528		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	<u>See Attached Schedule</u>	5,930,245		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,850,657	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,850,657	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (563,954)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,286,703	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 92,941	1
2	Restatements (describe):		2
3	Equity Adjustment	979,695	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,072,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(778,965)	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	(857,625)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,636,590)	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)	\$ (563,954)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Villa At South Holland

0052340

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,612,202	1
2	Discounts and Allowances for all Levels	(4,927,653)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,684,549	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,245,847	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,245,847	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	360,779	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,161	19
20	Radiology and X-Ray	13,375	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 385,315	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,741	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,741	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,287	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,287	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,335,739	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,596,960	31
32	Health Care	3,827,659	32
33	General Administration	2,930,411	33
B. Capital Expense			
34	Ownership	2,787,123	34
C. Ancillary Expense			
35	Special Cost Centers	1,706,163	35
36	Provider Participation Fee	266,388	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,114,704	40
41	Income before Income Taxes (line 30 minus line 40)**	(778,965)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (778,965)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,634,271	44
45	Private Pay - Net Inpatient Revenue	254,422	45
46	Medicare - Net Inpatient Revenue	644,152	46
47	Other-(specify) <u>Hospice</u>	302,915	47
48	Other-(specify) <u>Various Managed Care</u>	1,848,789	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,684,549	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 Villa At South Holland

0052340

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,871	2,041	\$ 97,180	\$ 47.61	1
2	Assistant Director of Nursing	1,320	1,344	51,567	38.37	2
3	Registered Nurses	8,808	9,157	309,243	33.77	3
4	Licensed Practical Nurses	56,135	55,771	1,622,158	29.09	4
5	CNAs & Orderlies	76,535	77,831	1,059,878	13.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,204	3,455	46,374	13.42	8
9	Activity Director	1,929	2,086	44,156	21.17	9
10	Activity Assistants	6,338	6,873	83,718	12.18	10
11	Social Service Workers	7,958	8,497	172,351	20.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,981	4,174	97,600	23.38	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,977	2,086	149,103	71.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,650	1,808	42,474	23.49	23
24	Clerical	7,655	8,114	128,097	15.79	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	1,954	2,127	34,477	16.21	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,570	1,573	21,975	13.97	33
34	TOTAL (lines 1 - 33)	182,885	186,937	\$ 3,960,351 *	\$ 21.19	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	\$		35	
36	Medical Director	Monthly	73,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,717	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	10,047	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Dietary Contract Services</u>	Monthly	634,625	01-03	47
48	<u>Psychiatrist</u>	Monthly	6,000	10-03	48
49	TOTAL (lines 35 - 48)		\$ 740,889		49

C. CONTRACT NURSES

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

Facility Name & ID Number Villa At South Holland

0052340

Report Period Beginning: 01/01/18

Ending: 12/31/18

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		
Sue Ahlgren	Administrator	0	\$ 68,040	Workers' Compensation Insurance	\$ 175,424	IDPH License Fee	\$		
Lucille Hoffman	Administrator	0	81,063	Unemployment Compensation Insurance	47,209	Advertising: Employee Recruitment	12,282		
				FICA Taxes	291,281	Health Care Worker Background Check (Indicate # of checks performed <u>293</u>)	2,933		
				Employee Health Insurance	134,884	Patient Background Checks			
				Employee Meals		Licensing & Permitting	3,900		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	30,687		
				Dental/Vision/Life Insurance	6,607	Allocated - Villa Financial Services	9,769		
				Employee Retention	12,489	Allocated - 3737 Chase, LLC	3		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 149,103			Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	()		
Description			Amount			Yellow page advertising	()		
			\$			TOTAL (agree to Sch. V, line 20, col. 8)			
					\$ 667,894		\$ 59,574		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount		Line #	Amount		Amount	
Villa Financial Services	Bookkeeping		\$ 612,072			\$	Out-of-State Travel	\$	
LeadingWave Consulting	Leadership Development		306						
Kronos	Workforce Management		21,710				In-State Travel		
Personnel Planners	Unemployment Consulting		1,850						
Prospect Resources	Energy Procurement		1,200						
Skidelsky & Associates	RE Tax Assessment		14,560				Seminar Expense	1,778	
Achieve Accreditation	Accreditation Assistance		10,799				Allocated - Villa Financial Services	837	
Illinois Rytes Corporation	Liability Management		9,569						
Alliance for Strategic Advantage	Revenue Cycle Consulting		324				Entertainment Expense	()	
JPS Consulting Partners	Site and Structural Consulting		5,165				(agree to Sch. V, line 24, col. 8)		
Med-Rec Systems	Health Information Consulting		2,768				TOTAL	\$ 2,615	
See Supplemental Schedule			88,687						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 769,010	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Villa At South Holland

0052340

Report Period Beginning:

01/01/18

Ending:

12/31/18

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$15,390
- (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. \$ None Line N/A
- (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. \$ 266,388
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. \$ No 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.