

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0052340

Facility Name: The Villa at South Holland

Address: 16300 Wausau Street South Holland 60473
Number City Zip Code

County: Cook

Telephone Number: (708) 596-5500 Fax # (708) 596-5527

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2013

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

#	0052340	Report Period Beginning:	01/01/16	Ending:	12/31/16
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 05/01/2013

YES ☒ Date 05/01/2013 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 171 and days of care provided 16,978

IV. ACCOUNTING BASIS

ACCRUAL	X
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CASH*	
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CASH* ☐

YES ☒ NO ☐

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

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			16,978	16,978	8
9	SNF/PED					9
10	ICF	15,895	1,955	6,867	24,717	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,895	1,955	23,845	41,695	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	66.62%
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Facility Name & ID Number The Villa at South Holland # 0052340 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	1,009	36,353	660,475	697,837		697,837	(710)	697,127			1
2	Food Purchase							1,018	1,018			2
3	Housekeeping		1,859	303,245	305,104		305,104		305,104			3
4	Laundry		19,808	202,153	221,961		221,961		221,961			4
5	Heat and Other Utilities			252,271	252,271		252,271	(15,162)	237,109			5
6	Maintenance	161,124	2,478	119,513	283,115		283,115	24,904	308,019			6
7	Other (specify):*											7
8	TOTAL General Services	162,133	60,498	1,537,657	1,760,288		1,760,288	10,050	1,770,338			8
	B. Health Care and Programs											
9	Medical Director			58,500	58,500		58,500		58,500			9
10	Nursing and Medical Records	3,086,941	244,525	21,576	3,353,042		3,353,042	(13,886)	3,339,156			10
10a	Therapy	18,336	10,617	5,880	34,833		34,833		34,833			10a
11	Activities	141,101	12,316		153,417		153,417		153,417			11
12	Social Services	454,524	7,960		462,484		462,484		462,484			12
13	CNA Training											13
14	Program Transportation			20,214	20,214		20,214	(239)	19,975			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,700,902	275,418	106,170	4,082,490		4,082,490	(14,125)	4,068,365			16
	C. General Administration											
17	Administrative	175,077			175,077		175,077		175,077			17
18	Directors Fees											18
19	Professional Services			983,951	983,951	(4,944)	979,007	(791,258)	187,749			19
20	Dues, Fees, Subscriptions & Promotions			108,174	108,174		108,174	(13,442)	94,732			20
21	Clerical & General Office Expenses	168,678	1,623	480,266	650,567		650,567	43,068	693,635			21
22	Employee Benefits & Payroll Taxes			736,332	736,332		736,332	(1,460)	734,872			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,378	1,378		1,378	3,720	5,098			24
25	Other Admin. Staff Transportation			23,407	23,407		23,407	2,449	25,856			25
26	Insurance-Prop.Liab.Malpractice			276,926	276,926		276,926	1,233	278,159			26
27	Other (specify):*							57,711	57,711			27
28	TOTAL General Administration	343,755	1,623	2,610,434	2,955,812	(4,944)	2,950,868	(697,979)	2,252,889			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,206,790	337,539	4,254,261	8,798,590	(4,944)	8,793,646	(702,053)	8,091,592			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			583,611	583,611		583,611	(402,129)	181,482			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,220	155,220		155,220	8,712	163,932			32
33	Real Estate Taxes			102,000	102,000	4,944	106,944	(94,360)	12,584			33
34	Rent-Facility & Grounds			1,822,256	1,822,256		1,822,256	0	1,822,256			34
35	Rent-Equipment & Vehicles			16,063	16,063		16,063	922	16,985			35
36	Other (specify):*			28,369	28,369		28,369	(28,369)	0			36
37	TOTAL Ownership			2,707,519	2,707,519	4,944	2,712,463	(515,223)	2,197,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,003,354	2,001,066	3,004,420		3,004,420		3,004,420			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,912	243,912		243,912		243,912			42
43	Other (specify):*			60,325	60,325		60,325	(60,325)	(0)			43
44	TOTAL Special Cost Centers		1,003,354	2,305,303	3,308,657		3,308,657	(60,325)	3,248,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,206,790	1,340,893	9,267,083	14,814,766		14,814,766	(1,277,601)	13,537,165			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,667)	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	(463,190)	30		9
10	Interest and Other Investment Income	(1,010)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(1,180)	21		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	(309,629)	21		24
25	Fund Raising, Advertising and Promotional	(8,647)	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	(230,107)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,031,430)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(246,172)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (246,172)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,277,602)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (432)	21	1
2	Vending Income	(710)	01	2
3	Medical Records Income	(6,765)	10	3
4	Prior Period Expenses	(1,626)	21	4
5	Settlement	(16,964)	36	5
6	Employee Benefits - 2015	(1,460)	22	6
7	Prior Year Real Estate Taxes	(102,000)	33	7
8	Non-allowable Travel	(4,168)	25	8
9	Veterans - Pharmacy	(7,121)	10	9
10	Internet Advertising	(4,858)	43	10
11	Promotional Materials	(5,126)	43	11
12	Resident Retention	(10,209)	43	12
13	Locator/Promo/Gifts	(14,390)	43	13
14	Marketing Entertainment	(13,025)	43	14
15	Marketing Supplies	(1,380)	43	15
16	Newspaper Advertising	(1,368)	43	16
17	Bank Fees	(6,518)	21	17
18	Donations	(3,051)	20	18
19	Mortgage Costs	(8,810)	36	19
20	Acquisition Costs	(2,595)	36	20
21	PAC Dues	(7,470)	20	21
22	Non-allowable Dues	(150)	20	22
23	Marketing Expense - Professional	(480)	43	23
24	Marketing Expense - Consultants	(9,488)	43	24
25	Non-allowable Legal	(18,276)	19	25
26	Additional R&M	18,334	06	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	(230,107)		49

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

Summary A

12/31/16

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Villa at South Holland # 0052340 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(463,190)		13,468	47,593								(402,129)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,010)		1,051	8,671								8,712	32
33	Real Estate Taxes	(102,000)			7,640								(94,360)	33
34	Rent-Facility & Grounds			20,497	(20,497)								0	34
35	Rent-Equipment & Vehicles			922									922	35
36	Other (specify):*	(28,369)											(28,369)	36
37	TOTAL Ownership	(594,569)		35,939	43,407								(515,223)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,325)											(60,325)	43
44	TOTAL Special Cost Centers	(60,325)											(60,325)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,031,430)		(292,587)	46,654	(239)							(1,277,601)	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			\$			\$	\$	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	100.00%	\$ 1,018	\$ 1,018	15
16	V	5	UTILITIES		VILLA FINANCIAL SERVICES, LLC	100.00%	2,505	2,505	16
17	V	6	REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	4,517	4,517	17
18	V	19	PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC	100.00%	427	427	18
19	V	20	FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC	100.00%	5,859	5,859	19
20	V	21	CLERICAL & GENERAL		VILLA FINANCIAL SERVICES, LLC	100.00%	362,453	362,453	20
21	V	24	SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC	100.00%	3,720	3,720	21
22	V	25	ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC	100.00%	6,617	6,617	22
23	V	26	INSURANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	719	719	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC	100.00%	57,711	57,711	24
25	V	30	DEPRECIATION		VILLA FINANCIAL SERVICES, LLC	100.00%	13,468	13,468	25
26	V	32	INTEREST		VILLA FINANCIAL SERVICES, LLC	100.00%	1,051	1,051	26
27	V	34	RENT		VILLA FINANCIAL SERVICES, LLC	100.00%	20,497	20,497	27
28	V	35	EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC	100.00%	922	922	28
29	V								29
30	V								30
31	V	19	HOME OFFICE	774,072				(774,072)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 774,072			\$ 481,485	\$ * (292,587)	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.

☒ X

 YES

☐ NO

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

1		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%	2,054	\$	2,054
16	V	19	PROFESSIONAL FEES		3737 Chase, LLC	100.00%	219		219
17	V	19	REAL ESTATE TAX PROTEST FEES		3737 Chase, LLC	100.00%	444		444
18	V	20	DUES & SUBSCRIPTIONS		3737 Chase, LLC	100.00%	17		17
19	V	26	INSURANCE		3737 Chase, LLC	100.00%	513		513
20	V	30	DEPRECIATION		3737 Chase, LLC	100.00%	47,593		47,593
21	V	32	INTEREST EXPENSE		3737 Chase, LLC	100.00%	8,671		8,671
22	V	33	REAL ESTATE TAXES		3737 Chase, LLC	100.00%	7,640		7,640
23	V								
24	V								
25	V	34	RENT	20,497	3737 Chase, LLC	100.00%			(20,497)
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			\$ 20,497			\$ 67,151	\$ *	46,654

* 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	14	AMBULANCE	\$ 1,809	LIFELINE AMBULANCE	100.00%	\$ 1,570	\$ (239)	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			\$ 1,809			\$ 1,570	\$ * (239)	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.

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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	AVIVA GREEN	1.00%	Holland Home	South Holland, IL	VILLA FINANCIAL SERVICES, I	SKOKIE	MANAGEMENT	1
2	TZVI SCHNELL	1.00%	Park Villa	Palos Heights, IL	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	2
3	ORA AARON	2.00%	The Villa at Bradley Estates	Milwaukee, WI	DISTINCT LLC		APARTMENTS	3
4	ILANA AARON	4.00%	The Villa at Bryn Mawr	Minneapolis, MN	THE PINNACLE APARTMENTS		APARTMENTS	4
5	JONATHAN AARON	4.00%	The Villa at City Center	Warren, MI	3737 CHASE, LLC	SKOKIE	BUILDING COMPANY	5
6	DAVID SCHNELL	4.00%	The Villa at Evergreen	Evergreen Park, IL	SEASONS HOSPICE	DES PLAINES	HOSPICE	6
7	BATSHEVA SCHNELL	4.00%	The Villa at Great Lakes Crossing	Detroit, MI				7
8	ABM LIMITED PARTNERSHIP	14.90%	The Villa at Green Lake Estates	Orchard Lake, MI				8
9	RAPHAELA STERN	16.10%	The Villa at Lincoln Park	Racine, WI				9
10	MENACHEM BERGER	28.00%	The Villa at Middleton Village	Middleton, WI				10
11	BENJAMIN ISRAEL	21.00%	The Villa at Osseo	Osseo, MN				11
12			The Villa at PA Peterson	Rockford, IL				12
13			The Villa at Parkridge	Ypsilanti, MI				13
14			The Villa at River Parkway	Milwaukee, WI				14
15			The Villa at Rose City	Rose City, MI				15
16			The Villa at Silverbell Estates	Orion, MI				16
17			The Villa at South Holland	South Holland, IL				17
18			The Villa at St. Louis Park	St. Louis Park, MN				18
19			The Villa at The Bay	Petoskey, MI				19
20			The Villa at The Park	Highland Park, MI				20
21			The Villa at Traverse Point	Traverse City, MI				21
22			The Villa at West Branch	West Branch, MI				22
23			The Villa at Windsor Park	Chicago, IL				23
24			Trinity Senior Community	Madison, WI				24
25			Trinity Senior Community II	Madison, WI				25
26			Add Place II	East Lansing, MI				26
27			Addington Place	Northville, MI				27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number The Villa at South Holland # 0052340 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 The Villa at South Holland # 0052340 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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	The Villa at South Holland
---------------------------	----------------------------

0052340

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	2	FOOD	FINCL. CONSLT. REV.	11,549,901	25	\$ 15,191	\$	774,044	\$ 1,018	1
2	5	UTILITIES	FINCL. CONSLT. REV.	11,549,901	25	37,375		774,044	2,505	2
3	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	11,549,901	25	67,393		774,044	4,517	3
4	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	11,549,901	25	6,368		774,044	427	4
5	20	FEES SUBSCRIPTIONS	FINCL. CONSLT. REV.	11,549,901	25	87,429		774,044	5,859	5
6	21	CLERICAL & GENERAL	FINCL. CONSLT. REV.	11,549,901	25	5,408,336	5,366,442	774,044	362,453	6
7	24	SEMINARS AND EDUCATION	FINCL. CONSLT. REV.	11,549,901	25	55,513		774,044	3,720	7
8	25	ADMIN. STAFF TRAVEL	FINCL. CONSLT. REV.	11,549,901	25	98,738		774,044	6,617	8
9	26	INSURANCE	FINCL. CONSLT. REV.	11,549,901	25	10,735		774,044	719	9
10	27	EMPLOYEE BEN. GEN. ADMIN	FINCL. CONSLT. REV.	11,549,901	25	861,135		774,044	57,711	10
11	30	DEPRECIATION	FINCL. CONSLT. REV.	11,549,901	25	200,966		774,044	13,468	11
12	32	INTEREST	FINCL. CONSLT. REV.	11,549,901	25	15,683		774,044	1,051	12
13	34	RENT	FINCL. CONSLT. REV.	11,549,901	25	305,851		774,044	20,497	13
14	35	EQUIPMENT RENTAL	FINCL. CONSLT. REV.	11,549,901	25	13,760		774,044	922	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,184,473	\$ 5,366,442		\$ 481,485	25

Ending: 12/31/16

(847) 430-3538

Ending: 12/31/16

(312) 949-9262

IL478-2471

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

Fax Number

Ending: 12/31/16

Facility Name & ID Number The Villa at South Holland # 0052340 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X	Line of Credit				1,563,000		0.0500	148,544		6
7	The Private Bank		X	Construction Loan							6,676		7
8					-								8
9	TOTAL Facility Related						\$	1,563,000			\$ 155,220		9
	B. Non-Facility Related*												
10	Interest Income		X								(1,010)		10
11	Allocated - Villa Financial	X									1,051		11
12	Allocated - 3737 Chase, LLC	X									8,671		12
13					-								13
14	TOTAL Non-Facility Related						\$				\$ 8,712		14
15	TOTALS (line 9+line14)						\$	1,563,000			\$ 163,932		15

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Villa at South Holland

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0052340

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	241,648		\$	1
2	Allocated - 3737 Chase, LLC			17,241	2
3	TOTALS	241,648		\$ 17,241	3

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										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Villa at South Holland

0052340

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		205,984	41,152		7,926	(33,226)	19,169	68
69	Financial Statement Depreciation			583,611			(583,611)		69
70	TOTAL (lines 4 thru 69)		\$ 205,984	\$ 624,763		\$ 7,926	\$ (616,837)	\$ 19,169	70

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

Facility Name & ID Number The Villa at South Holland

0052340

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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		\$ 205,984	\$ 624,763		\$ 7,926	\$ (616,837)	\$ 19,169	1
2	Security System, Cables, Annunciator	2013	25,264		20	1,263	1,263	4,211	2
3	Lionheart Hvac Fuel Injectors	2013	8,397		20	700	700	2,274	3
4	Generator Repairs	2013	2,810		20	141	141	468	4
5	Physical Therapy Addition / Remodel, Architecture & Construction	2014	10,000		20	286	286	643	5
6	Repiped & Replaced 20 Heads In Boiler Room	2014	3,575		20	102	102	221	6
7	Installed Rebuilt Pump For Sewage Ejector System In Basement	2014	5,076		20	145	145	302	7
8	Pulled Data Cables To Move Nursing Station, Install New Data Cables	2014	4,217		20	211	211	474	8
9	Exterior Renovation Design For Therapy Wing	2014	4,630		20	232	232	232	9
10	Topographic Survey	2014	3,700		20	185	185	185	10
11	Installed Condensor For Basement A/c	2015	9,250		20	463	463	578	11
12	Piped Sprinkler Head Into Freight Elevator Pit	2015	8,500		20	425	425	815	12
13	Installed New Damper	2015	5,907		20	295	295	591	13
14	Elevator Work-Wall Panels, Handrails, Stainless Steel Ceiling	2015	27,970		20	1,399	1,399	2,797	14
15	Repaired 2"-3/4" Piping & Fittings	2015	2,982		20	149	149	174	15
16	Structural Engineering - Design Work	2015	2,900		20	145	145	145	16
17	Ran Cables For Phones In New Offices On 1St, 2Nd & 3Rd Floor	2015	4,345		20	217	217	217	17
18	Installed 2 - 5" Storz Connections For Fire Sprinkler System	2016	3,900		20	195	195	195	18
19	Installed Hot Water Circulator Pump	2016	3,146		20	157	157	157	19
20	Furnish And Install New Face Panel Overlay And Paint Existing S	2016	6,232		20	312	312	312	20
21	Lower Level Rtu - Heat Exchanger, Blower Motor And Blower Motor	2016	5,278		20	264	264	264	21
22	Rtu Control Conversion - Remove Add-On Board And Installed 8	2016	3,613		20	181	181	181	22
23	North Hallway A/c - Replaced Both Compressors	2016	4,175		20	209	209	209	23
24	North Hallway - Replaced Evaporator Coil From Ductwork	2016	10,500		20	525	525	525	24
25	South Hallway A/c - New Custom Evaporator Coil	2016	16,865		20	843	843	843	25
26	New 48Tc-3-15 Carrier 5 Ton Rooftop Unit	2016	6,190		20	310	310	310	26
27	Installed New Phone System	2016	31,818		20	1,591	1,591	1,591	27
28	Installed Alarm Door And Delayed Egress For Therapy Room (Ex	2016	2,795		20	140	140	140	28
29	Therapy Room Renovation - Paint, Fire Protection, Electrical,	2016			20				29
30	Hvac, Carpentry, Concrete, Drywall, Insulation, Milwork,	2016			20				30
31	Flooring, Plumbing, Lockers, Roofing	2016	1,199,857		20	59,993	59,993	59,993	31
32	3Rd Floor Corridor - Handrail, Bumper, Corner Guards	2016	15,862		20	793	793	793	32
33	3Rd Floor Corridor And Lounge - Install Drywall, Nurses Stations	2016	37,434		20	1,872	1,872	1,872	33
34	TOTAL (lines 1 thru 33)		\$ 1,683,172	\$ 624,763		\$ 81,666	\$ (543,097)	\$ 100,879	34

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

Facility Name & ID Number The Villa at South Holland

0052340

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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		\$ 1,683,172	\$ 624,763		\$ 81,666	\$ (543,097)	\$ 100,879	1
2	3Rd Floor Dining Room - Build Wing Walls And Soffits, Install Le	2016	36,572		20	1,829	1,829	1,829	2
3	3Rd Floor Resident Room - Corner And Bumper Guards, Cubicle	2016	47,460		20	2,373	2,373	2,373	3
4	3Rd Floor Resident Bathroom - Vinyl Flooring, Vanity Light, Mir	2016	62,765		20	3,138	3,138	3,138	4
5	3Rd Floor Shower Room - Install Plumbing, Light Fixtures, Mirro	2016	62,936		20	3,147	3,147	3,147	5
6	3Rd Floor Nurses Station - Install Pure Vinyl Tile And Millwork F	2016	3,654		20	183	183	183	6
7	Lounge Bistro - Furnish And Install Ceiling Feature	2016	14,265		20	713	713	713	7
8	2Nd Floor Corridor - Wall Scones	2016	3,569		20	178	178	178	8
9	2Nd Floor Resident Room - Electric Work, Installed Corner And I	2016	11,824		20	591	591	591	9
10	2Nd Floor Resident Bathroom - Mirror, Vanity Lights, And Faucet	2016	7,102		20	355	355	355	10
11	3Rd Floor Signage And Light Fixtures	2016	3,625		20	181	181	181	11
12	3Rd Floor Dining Room - Installed New Recessed Lighting	2016	13,976		20	699	699	699	12
13	1St, 2Nd, And 3Rd Floor Corridor Wallcovering (Final Billing)	2016	127,510		20	6,375	6,375	6,375	13
14	Furnish And Install Belbien/Senstar On 1St, 2Nd, And 3Rd Floor	2016	4,499		20	225	225	225	14
15	Custom Signage	2016	2,818		20	141	141	141	15
16	New Flooring - 2 Elevators/Wallcovering And Flooring In Various	2016	5,782		20	289	289	289	16
17	Idph Plan Review Costs	2016	8,356		20	418	418	418	17
18	Electrical Work For Therapy Room - Light And Power Cables	2016	2,971		20	149	149	149	18
19	Installation Of Roller Shades In Therapy Gym	2016	18,850		20	942	942	942	19
20	Therapy Ceiling Lift	2016	13,605		20	680	680	680	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)		\$ 2,135,310	\$ 624,763		\$ 104,273	\$ (520,490)	\$ 123,486	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 Totals from Page 12C, Carried Forward		\$ 2,135,310	\$ 624,763		\$ 104,273	\$ (520,490)	\$ 123,486	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)		\$ 2,135,310	\$ 624,763		\$ 104,273	\$ (520,490)	\$ 123,486	34

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

Facility Name & ID Number The Villa at South Holland

0052340

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,135,310	\$ 624,763		\$ 104,273	\$ (520,490)	\$ 123,486	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)		\$ 2,135,310	\$ 624,763		\$ 104,273	\$ (520,490)	\$ 123,486	34

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

Facility Name & ID Number The Villa at South Holland

0052340

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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)		\$	\$		\$	\$	\$	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	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
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)		\$	\$		\$	\$	\$	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 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated - 3737 Chase, LLC	2013	97,700	4,780	39	2,791	(1,989)	8,956	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated - Villa Financial Services	2015	1,066	213	20	53	(160)	69	9
10								10
11 Allocated - 3737 Chase, LLC	2014	61,987	28,542	20	3,099	(25,443)	7,878	11
12 Allocated - 3737 Chase, LLC	2015	34,070	6,814	20	1,704	(5,110)	1,987	12
13 Allocated - 3737 Chase, LLC	2016	11,161	803	20	279	(524)	279	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)		\$ 205,984	\$ 41,152		\$ 7,926	\$ (33,226)	\$ 19,169	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	Totals from Page 12H, Carried Forward		\$ 205,984	\$ 41,152		\$ 7,926	\$ (33,226)	\$ 19,169	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)		\$ 205,984	\$ 41,152		\$ 7,926	\$ (33,226)	\$ 19,169	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	\$358,488	\$6,968	\$55,316	\$48,348	10	\$155,484	71
72	Current Year Purchases	274,062	12,941	21,893	8,952	10	21,893	72
73	Fully Depreciated Assets	4,374				10	4,374	73
74								74
75	TOTALS	\$636,924	\$19,909	\$77,209	\$57,300		\$181,751	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)	\$2,789,474	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$644,672	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$181,482	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(463,190)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$305,238	85

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

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

G. Construction-in-Progress

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

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

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

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?

YES

X

NO
- If NO, see instructions.

		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:	1977	171		\$ 1,822,256			3
4	Additions							4
5								5
6								6
7	TOTAL		171		\$ 1,822,256			7

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

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

9. Option to Buy:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment: \$ 16,985Description: 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

10. Effective dates of current rental agreement:

Beginning 04/17/2013

Ending 04/17/2018

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	2017	\$
13.	2018	\$
14.	2019	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 918,102	\$		\$ 918,102	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			169,019			169,019	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			913,945			913,945	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				763,638		763,638	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						239,716		239,716	13
14	TOTAL			\$		\$ 2,001,066	\$ 1,003,354		\$ 3,004,420	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.

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	\$ 223	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,621,620		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,423		6
7	Other Prepaid Expenses	16,826		7
8	Accounts Receivable (owners or related parties)	990,638		8
9	Other(specify): <u>See Attached Schedule</u>	152,097		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,813,827	\$	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	3,343,088		15
16	Equipment, at Historical Cost	430,178		16
17	Accumulated Depreciation (book methods)	(719,553)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,053,713	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,867,540	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,874,848	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,563,000		29
30	Accrued Salaries Payable	304,117		30
31	Accrued Taxes Payable (excluding real estate taxes)	67,006		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>	2,802,227		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,611,198	\$	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)	\$ 6,611,198	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,256,342	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,867,540	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,118,022	1
2	Restatements (describe):		2
3	Distributions	(1,200,000)	3
4	Rent Expense	72,000	4
5	Miscellaneous Expense	259,638	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,249,660	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	666,682	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	340,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	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)	\$ 1,006,682	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)	\$ 2,256,342	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **The Villa at South Holland**# **0052340**Report Period Beginning: **01/01/16**Ending: **12/31/16**

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,855,802	1
2	Discounts and Allowances for all Levels	(798,586)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,057,216	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,437,136	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,437,136	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	874,220	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,059	19
20	Radiology and X-Ray	34,312	20
21	Other Medical Services	31,588	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 978,179	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,010	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,010	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,907	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,907	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,481,448	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,760,288	31
32	Health Care	4,082,490	32
33	General Administration	2,955,812	33
	B. Capital Expense		
34	Ownership	2,707,519	34
	C. Ancillary Expense		
35	Special Cost Centers	3,064,745	35
36	Provider Participation Fee	243,912	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,814,766	40
41	Income before Income Taxes (line 30 minus line 40)**	666,682	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 666,682	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,068,526	44
45	Private Pay - Net Inpatient Revenue	522,387	45
46	Medicare - Net Inpatient Revenue	4,856,753	46
47	Other-(specify) Hospice, Insurance	190,688	47
48	Other-(specify) Various Managed Care	1,418,862	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,057,216	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.

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	1,566	1,669	\$ 85,149	\$ 51.02	1
2	Assistant Director of Nursing	909	968	31,571	32.61	2
3	Registered Nurses	9,788	10,530	311,362	29.57	3
4	Licensed Practical Nurses	54,477	58,363	1,549,548	26.55	4
5	CNAs & Orderlies	88,434	94,025	1,038,032	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,253	1,376	18,336	13.33	8
9	Activity Director	1,940	2,061	44,024	21.36	9
10	Activity Assistants	6,848	7,620	97,077	12.74	10
11	Social Service Workers	22,747	24,716	454,524	18.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	96	100	1,009	10.09	15
16	Dishwashers					16
17	Maintenance Workers	6,984	7,519	161,124	21.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,037	2,110	175,077	82.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,798	1,893	42,054	22.22	23
24	Clerical	8,548	9,025	126,624	14.03	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	1,972	2,132	34,584	16.22	31
32	Other Health Care(specify)					32
33	Other(specify)	2,240	2,324	36,695	15.79	33
34	TOTAL (lines 1 - 33)	211,637	226,431	\$ 4,206,790 *	\$ 18.58	34

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	58,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,576	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	5,880	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dietary Contract Services		660,475	01-03	47
48	Psychologist	Monthly	5,000	10-03	48
49	TOTAL (lines 35 - 48)		\$ 746,431		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>The Villa at South Holland</u>	STATE OF ILLINOIS # <u>0052340</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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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. ICLTC \$22,635

(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. \$ 27,589 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 243,912
 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 benefit 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 1
 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