

		FOR BHF USE					

LL1

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: <u>0051243</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																	
Facility Name: <u>The Villa at Windsor Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																																																																																	
Address: <u>2649 East 75th St</u> <u>Chicago</u> <u>60649</u>																																																																																			
Number City Zip Code																																																																																			
County: <u>Cook</u>																																																																																			
Telephone Number: <u>(773) 356-9300</u> Fax # <u>(773) 356-9384</u>																																																																																			
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>5/28/1998</u></td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____		Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Date of Initial License for Current Owners: <u>5/28/1998</u>		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		Type of Ownership:		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____							In the event there are further questions about this report, please contact:		Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>		Email Address: _____	
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#	0051243	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.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

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 11/01/2010

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 240 and days of care provided

Medicare Intermediary National Government Services

MODIFIED

ACCRUAL	X
---------	---

CASH*	
-------	--

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/16 **Fiscal Year:** 12/31/16

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

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			11,098	11,098	8
9	SNF/PED					9
10	ICF	48,152	1,269	5,712	55,133	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,152	1,269	16,810	66,231	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.40%

Facility Name & ID Number The Villa at Windsor Park # 0051243 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	414,616	85,777	22,795	523,188		523,188		523,188			1
2	Food Purchase		350,053		350,053	(47,287)	302,766	1,034	303,800			2
3	Housekeeping		23,146	348,584	371,730		371,730		371,730			3
4	Laundry		29,471	232,390	261,861		261,861		261,861			4
5	Heat and Other Utilities			296,187	296,187		296,187	(7,609)	288,578			5
6	Maintenance	146,078	6,993	237,401	390,472		390,472	29,174	419,646			6
7	Other (specify):*											7
8	TOTAL General Services	560,694	495,440	1,137,357	2,193,491	(47,287)	2,146,204	22,599	2,168,803			8
	B. Health Care and Programs											
9	Medical Director			96,000	96,000		96,000		96,000			9
10	Nursing and Medical Records	4,441,109	275,908	24,200	4,741,217		4,741,217	(6,622)	4,734,595			10
10a	Therapy	279,140	17,933	20,910	317,983		317,983		317,983			10a
11	Activities	199,970	19,360	1,344	220,674		220,674		220,674			11
12	Social Services	214,533	9,836		224,369		224,369		224,369			12
13	CNA Training											13
14	Program Transportation			38,749	38,749		38,749	(10,723)	28,026			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,134,752	323,037	181,203	5,638,992		5,638,992	(17,345)	5,621,647			16
	C. General Administration											
17	Administrative	149,899			149,899		149,899		149,899			17
18	Directors Fees											18
19	Professional Services			939,885	939,885	(9,919)	929,966	(778,474)	151,492			19
20	Dues, Fees, Subscriptions & Promotions			126,109	126,109		126,109	(22,422)	103,687			20
21	Clerical & General Office Expenses	519,598	782	528,873	1,049,253		1,049,253	19,864	1,069,117			21
22	Employee Benefits & Payroll Taxes			1,062,574	1,062,574	47,287	1,109,861	(2,629)	1,107,232			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,626	5,626		5,626	2,760	8,386			24
25	Other Admin. Staff Transportation			43,368	43,368		43,368	(7,776)	35,592			25
26	Insurance-Prop.Liab.Malpractice			714,333	714,333		714,333	19,574	733,907			26
27	Other (specify):*							62,424	62,424			27
28	TOTAL General Administration	669,497	782	3,420,768	4,091,047	37,369	4,128,416	(706,678)	3,421,737			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,364,943	819,259	4,739,328	11,923,530	(9,919)	11,913,611	(701,424)	11,212,187			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			730,796	730,796		730,796	48,796	779,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99,482	99,482		99,482	899,108	998,590			32
33	Real Estate Taxes					9,919	9,919	575,906	585,825			33
34	Rent-Facility & Grounds			2,100,000	2,100,000		2,100,000	(2,100,000)	0			34
35	Rent-Equipment & Vehicles			13,475	13,475		13,475	997	14,472			35
36	Other (specify):*							163,726	163,726			36
37	TOTAL Ownership			2,943,753	2,943,753	9,919	2,953,672	(411,466)	2,542,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	331,631	718,630	812,448	1,862,709		1,862,709	(408)	1,862,301			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			466,417	466,417		466,417		466,417			42
43	Other (specify):*	6,625		48,031	54,656		54,656	(54,656)	(0)			43
44	TOTAL Special Cost Centers	338,256	718,630	1,326,896	2,383,782		2,383,782	(55,064)	2,328,718			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,703,199	1,537,889	9,009,977	17,251,065	0	17,251,065	(1,167,954)	16,083,111			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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	(10,318)	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	(1,459,917)	30		9
10	Interest and Other Investment Income	(5,490)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	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	(17,451)	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	(334,906)	21		24
25	Fund Raising, Advertising and Promotional	(11,906)	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	(143,840)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,983,895)		\$	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)	815,941		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 815,941		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,167,954)		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

ID#

0051243

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Miscellaneous Income	\$ (2,062)	21	1
2	Ancillary - Insurance Premiums	(408)	39	2
3	Medical Records Income	(6,345)	10	3
4	Marketing Charges	(2,109)	43	4
5	IRS Penalty	(588)	21	5
6	401K Contribution - 2015	(2,629)	22	6
7	Patient Care/Doctor Visits - 2015	(277)	10	7
8	Non-allowable Auto Leases	(14,933)	25	8
9	Marketing Salaries	(6,625)	43	9
10	Promo/Marketing	(4,874)	43	10
11	Resident Retention	(7,727)	43	11
12	Marketing/Advertising	(5,038)	43	12
13	Marketing/Entertainment	(10,725)	43	13
14	Marketing Supplies	(5,978)	43	14
15	Bank Fees	(17,027)	21	15
16	Donations	(6,443)	20	16
17	Building Company - Amortization	(6,039)	36	17
18	Building Company - Accounting Fees	(19,650)	19	18
19	Building Company - Professional Fees	(12,000)	19	19
20	Building Company - Bank Fees	(335)	21	20
21	Additional R&M	22,067	06	21
22	Convenience Fee	(36)	33	22
23	PAC Dues	(9,929)	20	23
24	Annual Report	(500)	20	24
25	Non-allowable Seminar	(1,074)	24	25
26	2017 Seminar Expense	(190)	24	26
27	Marketing - Professional Fees	(976)	43	27
28	Marketing - Consulting	(10,604)	43	28
29	Non-allowable Legal	(10,786)	19	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	(143,840)		49

ID#

0051243

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Summary B

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
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)
30	Depreciation	(1,459,917)	1,442,665	14,568	51,480								48,796 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(5,490)	894,082	1,137	9,379								899,108 32
33	Real Estate Taxes	(36)	567,678		8,264								575,906 33
34	Rent-Facility & Grounds		(2,100,000)	22,171	(22,171)								(2,100,000) 34
35	Rent-Equipment & Vehicles			997									997 35
36	Other (specify):*	(6,039)	169,765										163,726 36
37	TOTAL Ownership	(1,471,482)	974,190	38,874	46,952								(411,466) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers	(408)											(408) 39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(54,656)											(54,656) 43
44	TOTAL Special Cost Centers	(55,064)											(55,064) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,983,895)	1,024,258	(248,059)	50,465	(10,723)							(1,167,954) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 2,100,000	Windsor Park Realty, LLC	100.00%	\$	\$ (2,100,000)	1
2	V	21	Miscellaneous Income	157	Windsor Park Realty, LLC	100.00%		(157)	2
3	V	36	Amortization		Windsor Park Realty, LLC	100.00%	6,039	6,039	3
4	V	19	Accounting Fees		Windsor Park Realty, LLC	100.00%	19,650	19,650	4
5	V	19	Professional Fees		Windsor Park Realty, LLC	100.00%	12,000	12,000	5
6	V	21	Bank Fees		Windsor Park Realty, LLC	100.00%	335	335	6
7	V	33	Real Estate Taxes		Windsor Park Realty, LLC	100.00%	567,678	567,678	7
8	V	26	Insurance-Property/Flood		Windsor Park Realty, LLC	100.00%	18,240	18,240	8
9	V	32	Interest Expense		Windsor Park Realty, LLC	100.00%	894,082	894,082	9
10	V	36	Mortgage Insurance Premium		Windsor Park Realty, LLC	100.00%	163,726	163,726	10
11	V	30	Depreciation Expense		Windsor Park Realty, LLC	100.00%	1,442,665	1,442,665	11
12	V								12
13	V								13
14	Total			\$ 2,100,157			\$ 3,124,415	\$ * 1,024,258	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%	\$ 1,101	\$ 1,101	15
16	V	5	UTILITIES		VILLA FINANCIAL SERVICES, LLC	100.00%	2,709	2,709	16
17	V	6	REPAIRS AND MAINTENANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	4,885	4,885	17
18	V	19	PROFESSIONAL FEES		VILLA FINANCIAL SERVICES, LLC	100.00%	462	462	18
19	V	20	FEES SUBSCRIPTIONS		VILLA FINANCIAL SERVICES, LLC	100.00%	6,338	6,338	19
20	V	21	CLERICAL & GENERAL		VILLA FINANCIAL SERVICES, LLC	100.00%	392,055	392,055	20
21	V	24	SEMINARS AND EDUCATION		VILLA FINANCIAL SERVICES, LLC	100.00%	4,024	4,024	21
22	V	25	ADMIN. STAFF TRAVEL		VILLA FINANCIAL SERVICES, LLC	100.00%	7,158	7,158	22
23	V	26	INSURANCE		VILLA FINANCIAL SERVICES, LLC	100.00%	778	778	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		VILLA FINANCIAL SERVICES, LLC	100.00%	62,424	62,424	24
25	V	30	DEPRECIATION		VILLA FINANCIAL SERVICES, LLC	100.00%	14,568	14,568	25
26	V	32	INTEREST		VILLA FINANCIAL SERVICES, LLC	100.00%	1,137	1,137	26
27	V	34	RENT		VILLA FINANCIAL SERVICES, LLC	100.00%	22,171	22,171	27
28	V	35	EQUIPMENT RENTAL		VILLA FINANCIAL SERVICES, LLC	100.00%	997	997	28
29	V								29
30	V								30
31	V	19	HOME OFFICE	768,867	VILLA FINANCIAL SERVICES, LLC			(768,867)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 768,867			\$ 520,808	\$ * (248,059)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINTENANCE		3737 Chase, LLC	100.00%	2,221	\$	2,221
16	V	19	PROFESSIONAL FEES		3737 Chase, LLC	100.00%	237		237
17	V	19	REAL ESTATE TAX PROTEST FEES		3737 Chase, LLC	100.00%	480		480
18	V	20	DUES & SUBSCRIPTIONS		3737 Chase, LLC	100.00%	18		18
19	V	26	INSURANCE		3737 Chase, LLC	100.00%	555		555
20	V	30	DEPRECIATION		3737 Chase, LLC	100.00%	51,480		51,480
21	V	32	INTEREST EXPENSE		3737 Chase, LLC	100.00%	9,379		9,379
22	V	33	REAL ESTATE TAXES		3737 Chase, LLC	100.00%	8,264		8,264
23	V								23
24	V								24
25	V	34	RENT	22,171	3737 Chase, LLC	100.00%			(22,171)
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			\$ 22,171			\$ 72,636	\$ *	50,465

* 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	\$ 81,297	Lifeline Ambulance	100.00%	\$ 70,574	\$ (10,723)	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			\$ 81,297			\$ 70,574	\$ * (10,723)	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	CHAIM RAJCHENBACH	10.00%	Holland Home	South Holland, IL	3737 CHASE, LLC	SKOKIE	BUILDING CO	1
2	MENACHEM SHABAT	10.00%	Park Villa	Palos Heights, IL	VILLA FINANCIAL SERVICES	SKOKIE	MANAGEMENT CO	2
3	NMA HEALTHCARE LLC	15.76%	The Villa at Bradley Estates	Milwaukee, WI	WINDSOR PARK REALTY	CHICAGO	BUILDING CO	3
4	75TH AND EXCHANGE LLC	19.24%	The Villa at Bryn Mawr	Minneapolis, MN	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	4
5	AVIVA BERGER	42.00%	The Villa at City Center	Warren, MI	THE PINNACLE APARTMENTS		APARTMENTS	5
6	YEHOSHUA BAUMOL	3.00%	The Villa at Evergreen	Evergreen Park, IL	DISTINCT LLC		APARTMENTS	6
7			The Villa at Great Lakes Crossing	Detroit, MI	REMED SERVICES LLC	LINCOLNWOOD	DME SALES	7
8			The Villa at Green Lake Estates	Orchard Lake, MI	SEASONS HOSPICE	DES PLAINES	HOSPICE	8
9			The Villa at Lincoln Park	Racine, WI				9
10			The Villa at Middleton Village	Middleton, WI				10
11			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

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

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16

(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	\$	837,262	\$ 1,101	1
2	5	UTILITIES	FINCL. CONSLT. REV.	11,549,901	25	37,375		837,262	2,709	2
3	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	11,549,901	25	67,393		837,262	4,885	3
4	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	11,549,901	25	6,368		837,262	462	4
5	20	FEES SUBSCRIPTIONS	FINCL. CONSLT. REV.	11,549,901	25	87,429		837,262	6,338	5
6	21	CLERICAL & GENERAL	FINCL. CONSLT. REV.	11,549,901	25	5,408,336	5,366,442	837,262	392,055	6
7	24	SEMINARS AND EDUCATION	FINCL. CONSLT. REV.	11,549,901	25	55,513		837,262	4,024	7
8	25	ADMIN. STAFF TRAVEL	FINCL. CONSLT. REV.	11,549,901	25	98,738		837,262	7,158	8
9	26	INSURANCE	FINCL. CONSLT. REV.	11,549,901	25	10,735		837,262	778	9
10	27	EMPLOYEE BEN. GEN. ADMIN	FINCL. CONSLT. REV.	11,549,901	25	861,135		837,262	62,424	10
11	30	DEPRECIATION	FINCL. CONSLT. REV.	11,549,901	25	200,966		837,262	14,568	11
12	32	INTEREST	FINCL. CONSLT. REV.	11,549,901	25	15,683		837,262	1,137	12
13	34	RENT	FINCL. CONSLT. REV.	11,549,901	25	305,851		837,262	22,171	13
14	35	EQUIPMENT RENTAL	FINCL. CONSLT. REV.	11,549,901	25	13,760		837,262	997	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		\$ 520,808	25

Ending: 12/31/16

(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	6	REPAIRS AND MAINTENANCE	FINCL. CONSLT. REV.	11,549,901	25	30,644	837,262	2,221	1
2	19	PROFESSIONAL FEES	FINCL. CONSLT. REV.	11,549,901	25	3,275	837,262	237	2
3	19	REAL ESTATE TAX PROTEST	FINCL. CONSLT. REV.	11,549,901	25	6,626	837,262	480	3
4	20	DUES & SUBSCRIPTIONS	FINCL. CONSLT. REV.	11,549,901	25	250	837,262	18	4
5	26	INSURANCE	FINCL. CONSLT. REV.	11,549,901	25	7,662	837,262	555	5
6	30	DEPRECIATION	FINCL. CONSLT. REV.	11,549,901	25	710,163	837,262	51,480	6
7	32	INTEREST EXPENSE	FINCL. CONSLT. REV.	11,549,901	25	129,383	837,262	9,379	7
8	33	REAL ESTATE TAXES	FINCL. CONSLT. REV.	11,549,901	25	114,000	837,262	8,264	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,002,003	\$	\$ 72,636	25

Ending: 12/31/16

(312) 949-9262

	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	14	Ambulance	Direct Allocation			\$	\$		\$ 70,574	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					\$	\$		\$ 70,574	25

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16

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

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 Windsor Park # 0051243 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

Fax Number

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

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	Private Bank		X	Mortgage			\$	23,804,672			\$	894,082	1	
2													2	
3													3	
4													4	
5					-								5	
	Working Capital													
6	Private Bank		X	Line of Credit				2,187,000				99,482	6	
7													7	
8					-								8	
9	TOTAL Facility Related						\$	25,991,672				\$	993,564	9
	B. Non-Facility Related*													
10	Interest Income		X									(5,490)	10	
11	Allocated - Villa Financial	X										1,137	11	
12	Allocated - 3737 Chase, LLC	X										9,379	12	
13					-								13	
14	TOTAL Non-Facility Related						\$					\$	5,026	14
15	TOTALS (line 9+line14)						\$	25,991,672				\$	998,590	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 163,726 Line # 36

* 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.)

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 2015 report.	\$	453,400		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.)	\$	513,706		2
3. Under or (over) accrual (line 2 minus line 1).	\$	60,306		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	515,600		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.)	\$	9,919		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.	\$	585,825		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	326,469	8	
	2012	419,614	9	
	2013	424,872	10	
	2014	433,176	11	
	2015	505,442	12	
2016 Accrual = \$505,442 X 1.02 = \$515,600 (Rounded)				
Allocated - 3737 Chase, LLC - \$8,264				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Villa at Windsor Park

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0051243

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. <u>21-30-200-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>415,944.90</u>	\$ <u>415,944.90</u>
2. <u>21-30-200-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,610.71</u>	\$ <u>5,610.71</u>
3. <u>21-30-200-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>79,158.58</u>	\$ <u>79,158.58</u>
4. <u>21-30-121-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,569.30</u>	\$ <u>1,569.30</u>
5. <u>21-30-121-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,158.83</u>	\$ <u>3,158.83</u>
6. <u>10-26-318-023-0000</u>	<u>Allocated - 3737 Chase, LLC</u>	\$ <u>112,632.76</u>	\$ <u>8,164.84</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>618,075.08</u>	\$ <u>513,607.16</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

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

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

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

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

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.

FACILITY NAME The Villa at Windsor Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051243

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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.

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?

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.)

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:

96,000

B. General Construction Type:

Exterior

Brick

Frame

Steel & Masonry

Number of Stories

3

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		2014	\$ 238,709	1
2	Allocated - 3737 Chase, LLC			18,649	2
3	TOTALS			\$ 257,358	3

Facility Name & ID Number The Villa at Windsor Park

0051243

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	240		2014	1998	\$ 18,828,721	\$ 1,442,665	39	\$ 482,788	\$ (959,877)	\$ 1,448,364	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	91,852		20	9,185	9,185	55,877	9
10	Various			2011	507,113		20	30,833	30,833	183,746	10
11	Various			2012	32,382		20	2,029	2,029	9,320	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	785,891			46,450	46,450	232,250	67
68	Related Party Allocations (Pages 12H & 12I)	222,807	44,514		8,574	(35,940)	20,735	68
69	Financial Statement Depreciation		730,796			(730,796)		69
70	TOTAL (lines 4 thru 69)	\$ 20,468,766	\$ 2,217,974		\$ 579,859	\$ (1,638,116)	\$ 1,950,291	70

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

Facility Name & ID Number The Villa at Windsor Park

0051243

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		\$ 20,468,766	\$ 2,217,974		\$ 579,859	\$ (1,638,116)	\$ 1,950,291	1
2	<u>Pump</u>	2013	2,834		20	567	567	2,267	2
3	<u>Air Conditioner</u>	2013	4,104		20	205	205	804	3
4	<u>Schindler Elevator</u>	2013	14,934		20	2,987	2,987	11,201	4
5	<u>Coil</u>	2013	12,613		20	631	631	2,260	5
6	<u>Parking Lot Repair</u>	2013	7,201		20	360	360	1,230	6
7	<u>Wall Mounted Lights, 175, 200, 400 Watts</u>	2013	2,982		20	149	149	485	7
8	<u>Fire Safety System</u>	2013	3,973		20	199	199	662	8
9	<u>Corridors, Elevators, Basement - Wallcovering, Doors</u>	2013	3,184		20	159	159	491	9
10	<u>Resident Bathrooms - Flooring, Tile, Wallcovering, Light Fixtures</u>	2013	32,608		20	1,630	1,630	5,842	10
11	<u>Repaired Fire Smoke Dampers</u>	2013	4,128		20	206	206	740	11
12	<u>Installed 2 New Submersible Sewer Pumps & Motors</u>	2014	13,808		20	690	690	1,956	12
13	<u>New Pumps & Valves For Sump Pump System In Basement</u>	2014	15,646		20	782	782	2,217	13
14	<u>Dialysis Room-Plumbing For 8 Dialysis Stations, 2 Sinks, Data Wi</u>	2014	26,000		20	1,300	1,300	3,358	14
15	<u>New Circulating Pump For Hot Water Heater</u>	2014	6,444		20	322	322	940	15
16	<u>Replaced Motor/Repiped And Installed Water Valve</u>	2014	2,500		20	125	125	354	16
17	<u>Replace Chiller Contactors</u>	2014	4,499		20	225	225	544	17
18	<u>Emergency Switch To Generator Panel, Floor Around Nsg Station</u>	2014	14,585		20	729	729	1,823	18
19	<u>Ejector Pump</u>	2014	16,602		20	830	830	2,214	19
20	<u>Installed Alarm Remote Panel</u>	2014	5,202		20	743	743	2,106	20
21	<u>Bad Water Valve. Install Motor, Mounts, Water Valves, And Repi</u>	2014	4,194		20	210	210	489	21
22	<u>Install 2 New Flex Connections On 4" Heating Water Lines</u>	2015	6,828		20	341	341	370	22
23	<u>Replaced Fuse & Body Gasket For Return Pump For Hot Water</u>	2015	2,700		20	135	135	259	23
24	<u>Replaced City Tie Assembly</u>	2016	2,930		20	147	147	147	24
25	<u>Installed Sewage Ejector System</u>	2016	7,700		20	385	385	385	25
26	<u>Plumbing Rough-In For Dialysis Stations</u>	2016	5,000		20	250	250	250	26
27	<u>Installed Water Stations For Dialysis And Framed Walls In Storag</u>	2016	5,035		20	252	252	252	27
28	<u>Installed Diaphragm In Outside Air Damper And Mixed Air Tran</u>	2016	4,000		20	200	200	200	28
29	<u>Installed Fish Tank Cabinet</u>	2016	18,125		20	906	906	906	29
30	<u>Installed Purified Water Loop In Dialysis Center</u>	2016	3,853		20	193	193	193	30
31	<u>Installed Branch Circuit For Dialysis Center</u>	2016	2,500		20	125	125	125	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	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 12B, Carried Forward		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	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		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	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 12D, Carried Forward		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	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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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)		\$ 20,725,480	\$ 2,217,974		\$ 595,843	\$ (1,622,132)	\$ 1,995,358	34

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

Facility Name & ID Number The Villa at Windsor Park

0051243

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Painting 2Nd & 3Rd Floor Resident Rooms/Corridor	2012	90,370		20	4,519	4,519	22,595	9
10	Magnetic Locks Installed W/Push Button And Keypads	2012	25,853		20	1,293	1,293	6,465	10
11	New Camera System, Wiring And Labor	2012	3,224		20	161	161	805	11
12	Installation Of New Model 30Rbx Series 460 Volt Chiller	2012	199,579		20	9,979	9,979	49,895	12
13	2Nd Floor Corridor Remodel: Millwork/Handrails, Wallcoverings	2012	112,889		20	5,644	5,644	28,220	13
14	Granite For 2Nd Floor Built In Nurses Station	2012	4,857		20	243	243	1,215	14
15	2Nd Floor Dining Room Remodel: Flooring, Wallcovering And Li	2012	37,869		20	1,893	1,893	9,465	15
16	2Nd Flr Resident Room Remodel: Windsow Treatments, Cubicle C	2012	59,934		20	6,571	6,571	32,855	16
17	3Rd Flr Dining Room Remodel: Flooring And Wallcvoerings	2012	28,325		20	1,416	1,416	7,080	17
18	Built-In Work Station For Physicians Office	2012	3,330		20	167	167	835	18
19	3Rd Floor Corridor: Millwork, Wallcoverings Flooring And Signa	2012	115,885		20	5,794	5,794	28,970	19
20	Granite For 3Rd Floor Built In Nurses Station	2012	4,867		20	243	243	1,215	20
21	3Rd Floor Dining Room Remodel: Cornices And Light Fixtures	2012	9,081		20	454	454	2,270	21
22	3Rd Flr Resident Room Remodel: Built-In Furniture, Window Tr	2012	55,540		20	6,358	6,358	31,790	22
23	Granite Installation For Built-In Transacaion Areas	2012	5,380		20	269	269	1,345	23
24	Special order steel door, Rim Exit device aluminum, universal arm	2012	4,752		20	238	238	1,190	24
25	Convection Pallet Heater	2012	3,851		20	193	193	965	25
26	Weatherproof Camera, Dome Camera, Pigtail Connector, dvr, Po	2012	11,805		20	590	590	2,950	26
27	Install 76 power outlets and TV Cables in the 2nd and 3rd floors	2012	8,500		20	425	425	2,125	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 785,891	\$		\$ 46,450	\$ 46,450	\$ 232,250	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		\$ 785,891	\$		\$ 46,450	\$ 46,450	\$ 232,250	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 785,891	\$		\$ 46,450	\$ 46,450	\$ 232,250	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 - 3737 Chase, LLC	2013	105,679	5,170	39	3,019	(2,151)	9,687	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Villa Financial Services	2015	1,153	231	20	58	(173)	75	9
10									10
11									11
12	Allocated - 3737 Chase, LLC	2014	67,050	30,873	20	3,352	(27,521)	8,521	12
13	Allocated - 3737 Chase, LLC	2015	36,853	7,371	20	1,843	(5,528)	2,150	13
14	Allocated - 3737 Chase, LLC	2016	12,072	869	20	302	(567)	302	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 222,807	\$ 44,514		\$ 8,574	\$ (35,940)	\$ 20,735	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		\$ 222,807	\$ 44,514		\$ 8,574	\$ (35,940)	\$ 20,735	1
2									2
3									3
4									4
5									5
6									6
7									7
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10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 222,807	\$ 44,514		\$ 8,574	\$ (35,940)	\$ 20,735	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	\$1,532,386	\$7,537	\$175,440	\$167,903	10	\$718,891	71
72	Current Year Purchases	142,736	13,998	8,310	(5,688)	10	8,310	72
73	Fully Depreciated Assets	22,660				10	22,660	73
74								74
75	TOTALS	\$1,697,782	\$21,535	\$183,750	\$162,215		\$749,861	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	2	
	Reference	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)	\$22,680,621	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,239,509	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$779,593	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(1,459,917)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,745,219	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	Four Seasons	\$5,364	92
93	Suburban Electric Company	41,700	93
94			94
95		\$47,064	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy:

YES

NO

 Terms: *

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: \$ 14,472 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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* 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
		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)	\$			

- (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.

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	

- (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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 96,697		\$ 284,517	\$		\$ 381,214	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	73,432		186,609			260,041	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	161,502		341,322			502,824	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				448,817		448,817	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						269,813		269,813	13
14	TOTAL			\$ 331,631		\$ 812,448	\$ 718,630		\$ 1,862,709	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	244,280	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,353,948	7,353,948	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,205	61,173	6
7	Other Prepaid Expenses	150,473	150,473	7
8	Accounts Receivable (owners or related parties)	185,601	185,601	8
9	Other(specify): <u>See Attached Schedule</u>	582,924	1,138,766	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,321,151	\$ 9,134,241	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		238,709	13
14	Buildings, at Historical Cost		22,338,721	14
15	Leasehold Improvements, at Historical Cost	1,037,264	1,037,264	15
16	Equipment, at Historical Cost	1,984,141	2,806,711	16
17	Accumulated Depreciation (book methods)	(2,571,534)	(5,223,469)	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>	47,064	246,341	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 496,935	\$ 21,444,277	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,818,086	\$ 30,578,518	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,705,944	\$ 1,779,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,187,000	2,187,000	29
30	Accrued Salaries Payable	658,189	658,189	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		515,600	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>	3,102,433	2,027,167	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,653,566	\$ 7,167,894	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,804,672	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)	\$	\$ 23,804,672	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,653,566	\$ 30,972,566	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,164,520	\$ (394,048)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,818,086	\$ 30,578,518	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,383,418	1
2	Restatements (describe):		2
3	Depreciation	475,491	3
4	Rent	38,955	4
5	Equity Restatement	826,855	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,724,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(510,199)	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	(2,050,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,560,199)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,164,520	24 *

* This must agree with page 17, line 47.

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	\$ 12,762,134	1
2	Discounts and Allowances for all Levels	528,620	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,290,754	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,896,249	6
7	Oxygen	113	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,896,362	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	389,556	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,883	19
20	Radiology and X-Ray	61,485	20
21	Other Medical Services	12,521	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 539,445	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,490	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,490	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,815	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,815	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,740,866	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,193,491	31
32	Health Care	5,638,992	32
33	General Administration	4,091,047	33
	B. Capital Expense		
34	Ownership	2,943,753	34
	C. Ancillary Expense		
35	Special Cost Centers	1,917,365	35
36	Provider Participation Fee	466,417	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,251,065	40
41	Income before Income Taxes (line 30 minus line 40)**	(510,199)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (510,199)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,526,932	44
45	Private Pay - Net Inpatient Revenue	242,955	45
46	Medicare - Net Inpatient Revenue	3,316,548	46
47	Other-(specify) Hospice	718,278	47
48	Other-(specify) Managed Care	486,041	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,290,754	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	1,912	2,057	\$ 133,305	\$ 64.81	1
2	Assistant Director of Nursing	2,163	2,461	110,027	44.71	2
3	Registered Nurses	18,390	21,131	713,607	33.77	3
4	Licensed Practical Nurses	55,548	62,725	1,708,005	27.23	4
5	CNAs & Orderlies	137,370	150,415	1,707,209	11.35	5
6	CNA Trainees					6
7	Licensed Therapist	7,391	8,034	331,631	41.28	7
8	Rehab/Therapy Aides	12,381	13,446	279,140	20.76	8
9	Activity Director	1,954	2,100	43,834	20.87	9
10	Activity Assistants	12,034	13,708	156,136	11.39	10
11	Social Service Workers	10,479	11,226	214,533	19.11	11
12	Dietician					12
13	Food Service Supervisor	1,925	2,033	38,258	18.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,721	33,014	376,358	11.40	15
16	Dishwashers					16
17	Maintenance Workers	6,772	7,487	146,078	19.51	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,005	2,085	132,292	63.45	20
21	Assistant Administrator	327	371	17,607	47.46	21
22	Other Administrative					22
23	Office Manager	1,743	2,100	57,864	27.55	23
24	Clerical	21,686	26,028	461,734	17.74	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	2,039	2,274	39,698	17.46	31
32	Other Health Care(specify)					32
33	Other(specify)	1,985	2,479	35,883	14.47	33
34	TOTAL (lines 1 - 33)	327,825	365,174	\$ 6,703,199 *	\$ 18.36	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	491	\$ 22,795	01-03	35
36	Medical Director	Monthly	96,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	24,200	10-03	39
40	Physical Therapy Consultant	Visit	1,430	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	19,480	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,344	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	519	\$ 165,249		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.

Facility Name & ID Number		The Villa at Windsor Park		STATE OF ILLINOIS	#	0051243	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
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 \$30,087							
(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.			\$		40,548		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.			\$		466,417					
	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?			No							
(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.			\$		47,287		Has any meal income been offset against related costs?		No	
						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		\$ 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?			Yes		See page 39 of the instructions for details.					
	Attach invoices and a summary of services for all architect and appraisal fees										