

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>01/01/20</u> to <u>12/31/20</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>(Signed) _____ <u>05/26/2021</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td><i>* Subject to the attached Accountants' Consulting Report</i> (Date)</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u></td></tr><tr><td>and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u></td></tr><tr><td>& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>5/28/1998</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">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"><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><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>05/26/2021</u>	Paid Preparer	<i>* Subject to the attached Accountants' Consulting Report</i> (Date)	(Print Name <u>Steven N. Lavenda, CPA</u>	and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u>	& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>5/28/1998</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		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		<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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Facility Name & ID Number The Villa at Windsor Park

0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>240</u>	Skilled (SNF)	<u>240</u>	<u>87,840</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>240</u>	TOTALS	<u>240</u>	<u>87,840</u>	7

B. Census-For the entire report period.

	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			<u>6,221</u>	<u>6,221</u>	8
9	SNF/PED					9
10	ICF	<u>53,454</u>	<u>2,954</u>	<u>4,451</u>	<u>60,859</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>53,454</u>	<u>2,954</u>	<u>10,672</u>	<u>67,080</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.37%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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 6,221

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number The Villa at Windsor Park # 0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	503,806	99,174	37,145	640,125		640,125		640,125			1
2	Food Purchase		379,432		379,432		379,432	699	380,131			2
3	Housekeeping		28,674	443,418	472,092		472,092		472,092			3
4	Laundry			278,557	278,557		278,557		278,557			4
5	Heat and Other Utilities			323,448	323,448		323,448	(18,676)	304,772			5
6	Maintenance	87,341	80	240,030	327,451		327,451	3,370	330,821			6
7	Other (specify):*											7
8	TOTAL General Services	591,147	507,360	1,322,598	2,421,105		2,421,105	(14,608)	2,406,497			8
	B. Health Care and Programs											
9	Medical Director			40,115	40,115		40,115		40,115			9
10	Nursing and Medical Records	5,304,385	367,910	228,773	5,901,068		5,901,068	18,958	5,920,026			10
10a	Therapy		1,530	23,325	24,855		24,855		24,855			10a
11	Activities	255,050	9,670	1,122	265,842		265,842		265,842			11
12	Social Services	189,968	27		189,995		189,995		189,995			12
13	CNA Training											13
14	Program Transportation			22,101	22,101		22,101	(6,658)	15,443			14
15	Other (specify):*							2,364	2,364			15
16	TOTAL Health Care and Programs	5,749,403	379,137	315,436	6,443,976		6,443,976	14,663	6,458,639			16
	C. General Administration											
17	Administrative	139,438			139,438		139,438		139,438			17
18	Directors Fees											18
19	Professional Services			957,149	957,149	(400)	956,749	(842,104)	114,645			19
20	Dues, Fees, Subscriptions & Promotions			108,402	108,402		108,402	(32,384)	76,018			20
21	Clerical & General Office Expenses	417,353	952	847,980	1,266,285		1,266,285	(31,555)	1,234,730			21
22	Employee Benefits & Payroll Taxes			1,147,781	1,147,781		1,147,781	(2,682)	1,145,099			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,106	1,106		1,106	560	1,666			24
25	Other Admin. Staff Transportation			25,275	25,275		25,275	6,351	31,626			25
26	Insurance-Prop.Liab.Malpractice			306,350	306,350		306,350	39,797	346,147			26
27	Other (specify):*							66,794	66,794			27
28	TOTAL General Administration	556,791	952	3,394,043	3,951,786	(400)	3,951,386	(795,224)	3,156,162			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,897,341	887,449	5,032,077	12,816,867	(400)	12,816,467	(795,168)	12,021,299			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			150,963	150,963		150,963	606,277	757,240			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,497	21,497		21,497	831,266	852,763			32
33	Real Estate Taxes					400	400	441,914	442,314			33
34	Rent-Facility & Grounds			2,261,136	2,261,136		2,261,136	(2,261,136)				34
35	Rent-Equipment & Vehicles			19,042	19,042		19,042	1,304	20,346			35
36	Other (specify):*							145,759	145,759			36
37	TOTAL Ownership			2,452,638	2,452,638	400	2,453,038	(234,615)	2,218,423			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		544,173	755,439	1,299,612		1,299,612	(101)	1,299,511			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			501,173	501,173		501,173		501,173			42
43	Other (specify):*		1,884	33,960	35,844		35,844	(35,844)	(0)			43
44	TOTAL Special Cost Centers		546,057	1,290,572	1,836,629		1,836,629	(35,945)	1,800,684			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,897,341	1,433,506	8,775,287	17,106,134		17,106,134	(1,065,729)	16,040,405			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	(24,518)	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	(256,991)	30		9
10	Interest and Other Investment Income	(15,533)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(167)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,797)	21		18
19	Entertainment				19
20	Contributions	(3,391)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(498,047)	21		24
25	Fund Raising, Advertising and Promotional	(5,508)	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	(242,471)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,050,423)		\$	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)	(15,305)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,305)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,065,728)		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			Sch. V Line	
	Amount	Reference		
1	Miscellaneous Income	\$ (2,369)	21	1
2	Medical Records Income	(1,424)	10	2
3	Prior Year Seminar	(175)	24	3
4	Prior Year Employee Benefits	(2,682)	22	4
5	Sequestration Expense	(28,004)	21	5
6	Marketing Supplies	(1,884)	43	6
7	Locator/Promo/Gifts	(2,081)	43	7
8	Promo,Art/Design/Print	(235)	43	8
9	Marketing/Entertainment	(4,291)	43	9
10	Resident Retention	(13,317)	43	10
11	Bank Fees	(21,641)	21	11
12	Building Co. - Accounting Fees	(12,599)	19	12
13	Building Co. - Legal/Collection Fees	(742)	19	13
14	Building Co. - Bank Fees	(217)	21	14
15	Building Co. - Amortization	(6,039)	36	15
16	Additional R&M	24,270	06	16
17	Capitalized R&M	(27,385)	06	17
18	Prior Year Dues	(8,400)	20	18
19	PAC Dues	(18,480)	20	19
20	Non-Allowable Legal	(17,106)	19	20
21	Business Development	(8,650)	43	21
22	Marketing Expense	(5,385)	43	22
23	Collections	(83,635)	21	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(242,471)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Villa at Windsor Park

0051243

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(167)		866									699	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(24,518)		5,842									(18,676)	5
6	Maintenance	(3,115)		6,485									3,370	6
7	Other (specify):*													7
8	TOTAL General Services	(27,800)		13,192									(14,608)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,424)		20,382									18,958	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(6,658)							(6,658)	14
15	Other (specify):*			2,364									2,364	15
16	TOTAL Health Care and Programs	(1,424)		22,745		(6,658)							14,663	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(30,447)	13,341	(825,245)	247								(842,104)	19
20	Fees, Subscriptions & Promotions	(35,779)		3,389	5								(32,384)	20
21	Clerical & General Office Expenses	(637,710)	217	605,938									(31,555)	21
22	Employee Benefits & Payroll Taxes	(2,682)											(2,682)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(175)		735									560	24
25	Other Admin. Staff Transportation			6,351									6,351	25
26	Insurance-Prop.Liab.Malpractice		36,928	2,380	489								39,797	26
27	Other (specify):*			66,794									66,794	27
28	TOTAL General Administration	(706,793)	50,486	(139,658)	741								(795,224)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(736,017)	50,486	(103,721)	741	(6,658)							(795,168)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Villa at Windsor Park # 0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(256,991)	835,930	14,790	12,548								606,277	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15,533)	836,250	764	9,785								831,266	32
33	Real Estate Taxes		429,353		12,561								441,914	33
34	Rent-Facility & Grounds		(2,261,136)	37,833	(37,833)								(2,261,136)	34
35	Rent-Equipment & Vehicles			1,304									1,304	35
36	Other (specify):*	(6,039)	151,798										145,759	36
37	TOTAL Ownership	(278,563)	(7,805)	54,692	(2,939)								(234,615)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(101)						(101)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(35,844)											(35,844)	43
44	TOTAL Special Cost Centers	(35,844)					(101)						(35,945)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,050,424)	42,681	(49,029)	(2,198)	(6,658)	(101)						(1,065,729)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 2,261,136	Windsor Park Realty, LLC		\$	(2,261,136)	1
2	V	32	Interest	88	Windsor Park Realty, LLC		836,338	836,250	2
3	V	19	Accounting Fees		Windsor Park Realty, LLC		12,599	12,599	3
4	V	19	Legal/Collection Fees		Windsor Park Realty, LLC		742	742	4
5	V	21	Bank Fees		Windsor Park Realty, LLC		217	217	5
6	V	33	Real Estate Taxes		Windsor Park Realty, LLC		429,353	429,353	6
7	V	26	Insurance - Property/Flood		Windsor Park Realty, LLC		36,928	36,928	7
8	V	36	Insurance - Mortgage		Windsor Park Realty, LLC		145,759	145,759	8
9	V	30	Depreciation		Windsor Park Realty, LLC		835,930	835,930	9
10	V	36	Amortization		Windsor Park Realty, LLC		6,039	6,039	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,261,224			\$ 2,303,905	\$ * 42,681	14

* 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%	Park Villa	Palos Heights, IL	WINDSOR PARK REALTY	LINCOLNWOOD	BUILDING CO	1
2	MENACHEM SHABAT	10.00%	The Villa at Bradley Estates	Milwaukee, WI	VILLA FINANCIAL SERVICES	LINCOLNWOOD	MANAGEMENT CO	2
3	NMA HEALTHCARE LLC	15.76%	The Villa at Bryn Mawr	Minneapolis, MN	3701 LUNT LLC	LINCOLNWOOD	BUILDING CO	3
4	75TH AND EXCHANGE LLC	19.24%	The Villa at City Center	Warren, MI	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	4
5	AVIVA BERGER	42.00%	The Villa at Great Lakes Crossing	Detroit, MI	REMED SERVICES LLC	LINCOLNWOOD	DME SALES	5
6	YEHOShUA BAUMOL	3.00%	The Villa at Green Lake Estates	Orchard Lake, MI	INTEGRA HC EQUIP	ELMHURST	DME	6
7			The Villa at Lincoln Park	Racine, WI	INTEGRA RESP SERV	ELMHURST	RESPIRATORY SUPP.	7
8			The Villa at Middleton Village	Middleton, WI	YONA SOLUTIONS	SKOKIE	LAUNDRY	8
9			The Villa at Osseo	Osseo, MN	CONCERTO DIALYSIS, LLC	LINCOLNWOOD	DIALYSIS	9
10			The Villa at Parkridge	Ypsilanti, MI				10
11			The Villa at Rose City	Rose City, MI				11
12			The Villa at Silverbell Estates	Orion, MI				12
13			The Villa at South Holland	South Holland, IL				13
14			The Villa at St. Louis Park	St. Louis Park, MN				14
15			The Villa at The Bay	Petoskey, MI				15
16			The Villa at The Park	Highland Park, MI				16
17			The Villa at Traverse Point	Traverse City, MI				17
18			The Villa at West Branch	West Branch, MI				18
19			Ambassador, a Villa Center	Detroit, MI				19
20			Father Murray, a Villa Center	Center Line, MI				20
21			Imperial, a Villa Center	Dearborn Heights, MI				21
22			Regency, a Villa Center	Taylor, MI				22
23			St. Joseph, a Villa Center	Hamtramck, MI				23
24			Westland, a Villa Center	Westland, MI				24
25			Spring Meadows, a Villa Center	Holland, OH				25
26			Harbor House of Wheeling (Shelter Care)	Wheeling, IL				26
27								27
28								28
29								29
30			(CONTINUED ON NEXT PAGE)					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			Brookview a Villa Center	Golden Valley, MN				1
2			New Brighton a Villa Center	New Brighton, MN				2
3			Cedars at St. Louis Park, a Villa Center	St. Louis Park, MN				3
4			Park Health a Villa Center	St. Louis Park, MN				4
5			Richfield a Villa Center	Richfield, MN				5
6			Robbinsdale a Villa Center	Robbinsdale, MN				6
7			Rose of Sharon a Villa Center	Roseville, MN				7
8			Galtier a Villa Center	Saint Pual, MN				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)

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		\$ 866	\$ 866	15
16	V	5	Utilities		Villa Financial Services, LLC		5,842	5,842	16
17	V	6	Repairs & Maintenance		Villa Financial Services, LLC		6,485	6,485	17
18	V	10	Nursing		Villa Financial Services, LLC		20,382	20,382	18
19	V	15	Healthcare Benefits		Villa Financial Services, LLC		2,364	2,364	19
20	V	19	Professional Fees		Villa Financial Services, LLC		10,187	10,187	20
21	V	20	Fees, Subscriptions		Villa Financial Services, LLC		3,389	3,389	21
22	V	21	Clerical & General - Salaries		Villa Financial Services, LLC		569,235	569,235	22
23	V	21	Clerical & General - Other Expense		Villa Financial Services, LLC		36,703	36,703	23
24	V	24	Seminars & Education		Villa Financial Services, LLC		735	735	24
25	V	25	Admin. Staff Travel		Villa Financial Services, LLC		6,351	6,351	25
26	V	26	Insurance		Villa Financial Services, LLC		2,380	2,380	26
27	V	27	Employee Ben. - Gen. Admin.		Villa Financial Services, LLC		66,794	66,794	27
28	V	30	Depreciation		Villa Financial Services, LLC		14,790	14,790	28
29	V	32	Interest		Villa Financial Services, LLC		764	764	29
30	V	34	Rent		Villa Financial Services, LLC		37,833	37,833	30
31	V	35	Equipment Rental		Villa Financial Services, LLC		1,304	1,304	31
32	V								32
33	V	19	Home Office	835,432	Villa Financial Services, LLC			(835,432)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 835,432			\$ 786,403	\$ * (49,029)	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	19	Professional Fees		3701 Lunt, LLC		247	\$	247
16	V	19	Real Estate Tax Protest Fees		3701 Lunt, LLC				
17	V	20	Dues & Subscriptions		3701 Lunt, LLC		5		5
18	V	26	Insurance		3701 Lunt, LLC		489		489
19	V	30	Depreciation		3701 Lunt, LLC		12,548		12,548
20	V	32	Interest Expense		3701 Lunt, LLC		9,785		9,785
21	V	33	Real Estate Taxes		3701 Lunt, LLC		12,561		12,561
22	V								
23	V								
24	V	34	Rent	37,833	3701 Lunt, LLC				(37,833)
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 37,833			\$ 35,635	\$ *	(2,198)

* 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	\$ 35,225	Lifeline Ambulance		\$ 28,567	\$ (6,658)	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			\$ 35,225			\$ 28,567	\$ * (6,658)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Supplies	\$ 653	Integra Healthcare Equipment LLC		\$ 552	\$ (101)	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			\$ 653			\$ 552	\$ * (101)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Respiratory Services	\$ 21,357	Integra Respiratory Service, LLC		\$ 21,357	\$	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			\$ 21,357			\$ 21,357	\$ *	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)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 12/31/20

Facility Name & ID Number The Villa at Windsor Park# 0051243

Report Period Beginning:

01/01/20Ending: 12/31/20

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

3701 West Lunt Avenue

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 440-2660

Fax Number

(847) 430-3538

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Patient Days	1,292,465	35	\$ 16,679	\$	67,080	\$ 866	1
2	5	Utilities	Patient Days	1,292,465	35	112,553		67,080	5,842	2
3	6	Repairs & Maintenance	Patient Days	1,292,465	35	124,946		67,080	6,485	3
4	10	Nursing	Patient Days	1,292,465	35	392,704	374,881	67,080	20,382	4
5	15	Healthcare Benefits	Patient Days	1,292,465	35	45,545		67,080	2,364	5
6	19	Professional Fees	Patient Days	1,292,465	35	196,277		67,080	10,187	6
7	20	Fees, Subscriptions	Patient Days	1,292,465	35	65,302		67,080	3,389	7
8	21	Clerical & General - Salaries	Patient Days	1,292,465	35	10,967,738	10,967,738	67,080	569,235	8
9	21	Clerical & General - Other Expenses	Patient Days	1,292,465	35	707,177		67,080	36,703	9
10	24	Seminars & Education	Patient Days	1,292,465	35	14,159		67,080	735	10
11	25	Admin. Staff Travel	Patient Days	1,292,465	35	122,371		67,080	6,351	11
12	26	Insurance	Patient Days	1,292,465	35	45,856		67,080	2,380	12
13	27	Employee Ben. - Gen. Admin.	Patient Days	1,292,465	35	1,286,948		67,080	66,794	13
14	30	Depreciation	Patient Days	1,292,465	35	284,969		67,080	14,790	14
15	32	Interest	Patient Days	1,292,465	35	14,729		67,080	764	15
16	34	Rent	Patient Days	1,292,465	35	728,952		67,080	37,833	16
17	35	Equipment Rental	Patient Days	1,292,465	35	25,133		67,080	1,304	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 15,152,037	\$ 11,342,619		\$ 786,403	25

Facility Name & ID Number The Villa at Windsor Park # 0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Lifeline Ambulance
Street Address 2424 S. Wabash Avenue
City / State / Zip Code Chicago, IL 60616
Phone Number (312) 949-9595
Fax Number (312) 949-9262

	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	14	Ambulance	Direct Allocation			\$	\$		\$ 28,567	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					\$	\$		\$ 28,567	25

Ending: 12/31/20

(630) 834- 1500

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number The Villa at Windsor Park # 0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Windsor Park # 0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Windsor Park # 0051243 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 12/31/20

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			\$	22,230,015			\$	836,338	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Private Bank		X	Line of Credit								21,497	6
7													7
8													8
9	TOTAL Facility Related						\$	22,230,015			\$	857,835	9
	B. Non-Facility Related*												
10	Interest Income		X									(15,533)	10
11	Interest Income - Bldg Co.		X									(88)	11
12	Allocated - Villa Financial											764	12
13	Allocated - 3701 Lunt, LLC											9,785	13
14	TOTAL Non-Facility Related						\$				\$	(5,072)	14
15	TOTALS (line 9+line14)						\$	22,230,015			\$	852,763	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 145,759 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.)

FACILITY NAME	<u>The Villa at Windsor Park</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 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

Steven Lavenda

TELEPHONE ()

FAX #: ()

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)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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 from 3701 Lunt, LLC			23,161	2
3	TOTALS			\$ 261,870	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	240		2014	1998	\$ 18,828,721	\$ 835,930	39	\$ 482,788	\$ (353,142)	\$ 3,379,516
5										
6										
7										
8										
	Improvement Type**									
9	Various		2010		91,852		20	4,593	4,593	74,248
10	Various		2011		507,112		20	25,356	25,356	265,292
11	Various		2012		32,382		20	1,483	1,483	14,179
12	Various		2013		88,561		20	3,539	3,539	40,898
13	Various		2014		109,480		20	5,473	5,473	32,905
14	Various		2015		9,528		20	476	476	2,058
15	Various		2016		73,134		20	3,658	3,658	14,629
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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)		1,242,421			62,121	62,121	422,130	67
68	Related Party Allocations (Pages 12H & 12I)		448,344	9,418		8,131	(1,287)	10,591	68
69	Financial Statement Depreciation			150,963			(150,963)		69
70	TOTAL (lines 4 thru 69)		\$ 21,431,535	\$ 996,310		\$ 597,618	\$ (398,692)	\$ 4,256,447	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:

01/01/20

Ending:

12/31/20

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		\$ 21,431,535	\$ 996,310		\$ 597,618	\$ (398,692)	\$ 4,256,447	1
2	Parking Lot Renovation	2017	69,500		20	3,475	3,475	13,900	2
3	Install Fire Rated Doors In 1St Flr Spa, 3Rd Flr Lounge, Basemen	2017	5,296		20	265	265	1,059	3
4	Parking Lot - Sewer Repair	2017	11,640		20	582	582	2,328	4
5	Pneumatic Panel Repairs	2017	6,878		20	344	344	1,376	5
6	Fire Damper Repairs/Replacement	2017	2,834		20	142	142	567	6
7	Fire Damper Repairs/Replacement	2017	5,394		20	270	270	1,079	7
8	Elevator Pump Motor	2017	2,975		20	149	149	595	8
9	Repair 3Rd Floor Drain, Leak In Kitchen Coil	2017	4,281		20	214	214	856	9
10	Repair Leak - Chill Water Coil	2017	2,616		20	131	131	523	10
11	Boiler Repair	2018	5,600		20	280	280	840	11
12	Roof Repair - Apply Patch To Wall Flashings	2018	9,925		20	496	496	1,489	12
13	Laundry Rm/Kitchen Piping - Install Back Flow Preventors, Valve	2018	4,800		20	240	240	720	13
14	Common Area - Flooring	2018	3,879		20	194	194	582	14
15	Air Compressor Replacement	2018	12,075		20	604	604	1,812	15
16	Replace Pump Motor	2018	3,092		20	155	155	464	16
17	Plumbing Work - Kitchen, Elevator Pit, 2Nd Flr, Bsmnt, Jazz Roo	2018	17,050		20	853	853	2,558	17
18	Common Area - Vinyl Flooring	2018	3,900		20	195	195	585	18
19	Pump Replacement - Basement	2018	13,274		20	664	664	1,991	19
20	Generator Repairs	2018	12,824		20	641	641	1,923	20
21	Repaired Boiler Valves	2018	10,962		20	548	548	1,096	21
22	Wander Guard System Front Door Code Alert T70	2019	6,511		20	326	326	652	22
23	Repaired Fire Alarm System	2019	11,570		20	579	579	1,158	23
24	Repaired Egress Magnetic Lock	2019	8,513		20	426	426	852	24
25	Repaired Rear Exit Door	2019	3,641		20	182	182	364	25
26	Replaced Boiler	2019	86,750		20	4,338	4,338	8,676	26
27	Repaired Heat System	2019	9,797		20	490	490	980	27
28	Repaired Reduced Pressure Zone (Rpz) Valves W/Air Gap	2019	3,525		20	176	176	352	28
29	Installed Smoke Detectors In Elevator Shafts	2019	3,849		20	192	192	384	29
30	Installed Wood Pedestrian Fire Door	2019	2,569		20	128	128	256	30
31	Repaired Magnetic Lock Exit Door	2019	3,288		20	164	164	328	31
32	Installed And Programed Mapnet Card And Power Supply	2019	3,117		20	156	156	312	32
33	Repaired Chiller Compressor	2019	5,001		20	250	250	500	33
34	TOTAL (lines 1 thru 33)		\$ 21,788,461	\$ 996,310		\$ 615,467	\$ (380,843)	\$ 4,307,604	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:

01/01/20

Ending:

12/31/20

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		\$ 21,788,461	\$ 996,310		\$ 615,467	\$ (380,843)	\$ 4,307,604	1
2	Upgraded Door Alarm System (Tec70) With New Kits	2019	7,147		20	357	357	714	2
3	Repaired Chiller Fan Motors	2019	5,590		20	280	280	560	3
4	Repaired Boiler And Replaced Sensors	2019	2,912		20	146	146	292	4
5	Repaired Kitchen Boiler And Part Replacement	2019	2,887		20	144	144	288	5
6	Removed And Replaced Blower On Boiler	2019	2,975		20	149	149	298	6
7	Repaired Alert System	2019	9,568		20	478	478	956	7
8	Replaced Boiler Room	2019	14,400		20	720	720	1,440	8
9	Replace Pump In Kitchen	2019	4,556		20	228	228	684	9
10	Repaired Generator	2019	2,796		20	140	140	280	10
11	Temperature Kiosk	2020	3,000		20	150	150	150	11
12	Replaced Pump Behind Hot Water Tank	2020	4,203		20	210	210	210	12
13	Replaced Air Compressor Pump	2020	4,402		20	220	220	220	13
14	Sealcoat The Parking Lots	2020	7,394		20	370	370	370	14
15	Heating Unit-Repair Cracks And Coils, Installed Freezestat	2020	10,571		20	529	529	529	15
16	Chiller Repair - Leaking Circuit	2020	14,478		20	724	724	724	16
17	Resident Rm Reno 107-111 - Install Nurse Call Unit, Painting	2020	12,526		20	626	626	626	17
18	Elevator - Furnish & Install New Door	2020	2,850		20	143	143	143	18
19	Elevator - Install New Clutch	2020	2,850		20	143	143	143	19
20	Repair Broken Water Pipe	2020	4,276		20	214	214	214	20
21	Hvac Repair	2020	8,705		20	435	435	435	21
22	Light Fixture Upgrades	2020	4,966		20	248	248	248	22
23	Repair Air Leaks In Compressor System	2020	3,738		20	187	187	187	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)		\$ 21,925,249	\$ 996,310		\$ 622,307	\$ (374,003)	\$ 4,317,313	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:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 21,925,249	\$ 996,310		\$ 622,307	\$ (374,003)	\$ 4,317,313	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
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18									18
19									19
20									20
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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)		\$ 21,925,249	\$ 996,310		\$ 622,307	\$ (374,003)	\$ 4,317,313	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:

01/01/20

Ending:

12/31/20

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		\$ 21,925,249	\$ 996,310		\$ 622,307	\$ (374,003)	\$ 4,317,313	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)		\$ 21,925,249	\$ 996,310		\$ 622,307	\$ (374,003)	\$ 4,317,313	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:

01/01/20

Ending:

12/31/20

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	40,667	9
10	Magnetic Locks Installed W/Push Button And Keypads	2012	25,853		20	1,293	1,293	11,634	10
11	New Camera System, Wiring And Labor	2012	3,224		20	161	161	1,451	11
12	Installation Of New Model 30Rbx Series 460 Volt Chiller	2012	199,579		20	9,979	9,979	89,811	12
13	2Nd Floor Corridor Remodel: Millwork/Handrails, Wallcoverings	2012	112,889		20	5,644	5,644	50,800	13
14	Granite For 2Nd Floor Built In Nurses Station	2012	4,857		20	243	243	2,186	14
15	2Nd Floor Dining Room Remodel: Flooring, Wallcovering And Li	2012	37,869		20	1,893	1,893	17,041	15
16	2Nd Flr Resident Room Remodel: Windsow Treatments, Cubicle C	2012	59,934		20	2,997	2,997	26,970	16
17	3Rd Flr Dining Room Remodel: Flooring And Wallcoverings	2012	28,325		20	1,416	1,416	12,746	17
18	Built-In Work Station For Physicians Office	2012	3,330		20	167	167	1,499	18
19	3Rd Floor Corridor: Millwork, Wallcoverings Flooring And Signa	2012	115,885		20	5,794	5,794	52,148	19
20	Granite For 3Rd Floor Built In Nurses Station	2012	4,867		20	243	243	2,190	20
21	3Rd Floor Dining Room Remodel: Cornices And Light Fixtures	2012	9,081		20	454	454	4,086	21
22	3Rd Flr Resident Room Remodel: Built-In Furniture, Window Tr	2012	55,540		20	2,777	2,777	24,993	22
23	Granite Installation For Built-In Transacaion Areas	2012	5,380		20	269	269	2,421	23
24	Special order steel door, Rim Exit device aluminum, universal arm	2012	4,752		20	238	238	2,138	24
25	Convection Pallet Heater	2012	3,851		20	193	193	1,733	25
26	Weatherproof Camera, Dome Camera, Pigtail Connector, dvr, Po	2012	11,805		20	590	590	5,312	26
27	Install 76 power outlets and TV Cables in the 2nd and 3rd floors	2012	8,500		20	425	425	3,825	27
28	Elevator Modernization	2018	456,530		20	22,826	22,826	68,479	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,242,421	\$		\$ 62,121	\$ 62,121	\$ 422,130	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 12F, Carried Forward		\$ 1,242,421	\$		\$ 62,121	\$ 62,121	\$ 422,130	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,242,421	\$		\$ 62,121	\$ 62,121	\$ 422,130	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:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 3701 Lunt, LLC	2019	131,244	3,365	20	3,750	385	5,625	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Villa Financial Services, LLC	2015	825	165	20	41	(124)	219	9
10	Allocated from Villa Financial Services, LLC	2017	182	36	20	9	(27)	36	10
11	Allocated from Villa Financial Services, LLC	2018	2,295	459	20	115	(344)	243	11
12	Allocated from Villa Financial Services, LLC	2019	7,839	1,568	20	392	(1,176)	645	12
13									13
14	Allocated from 3701 Lunt, LLC	2020	305,958	3,824	20	3,824		3,824	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)		\$ 448,344	\$ 9,418		\$ 8,131	\$ (1,287)	\$ 10,591	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:

01/01/20

Ending:

12/31/20

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		\$ 448,344	\$ 9,418		\$ 8,131	\$ (1,287)	\$ 10,591	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)		\$ 448,344	\$ 9,418		\$ 8,131	\$ (1,287)	\$ 10,591	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	\$ 1,364,702	\$ 11,633	\$ 128,951	\$ 117,318	10	\$ 931,177	71
72	Current Year Purchases	140,199	6,287	5,982	(305)	10	5,982	72
73	Fully Depreciated Assets	336,347				10	336,347	73
74								74
75	TOTALS	\$ 1,841,249	\$ 17,920	\$ 134,933	\$ 117,013		\$ 1,273,507	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	24,028,368
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	1,014,231
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	757,240
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(256,991)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	5,590,820

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Roofing Repairs	\$ 126,474
93		
94		
95		\$ 126,474

* 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?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			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 ☐ NO
16. Rental Amount for movable equipment: \$ 20,346 Description: See Attached

(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. /2021 \$
13. /2022 \$
14. /2023 \$

* 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)	\$			

(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.

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	

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	\$		\$ 366,448	\$		\$ 366,448	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			66,783			66,783	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			321,463			321,463	4
5	Physician Care	39 - 03	visits			745			745	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				107,966		107,966	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached						436,207		436,207	13
14	TOTAL			\$		\$ 755,439	\$ 544,173		\$ 1,299,612	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	\$	113,677	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,315,698	5,501,035	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	454,487	499,769	6
7	Other Prepaid Expenses	186,974	243,133	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		844,713	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,957,159	\$ 7,202,327	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		22,338,721	14
15	Leasehold Improvements, at Historical Cost	1,522,059	2,017,298	15
16	Equipment, at Historical Cost	2,109,443	2,932,013	16
17	Accumulated Depreciation (book methods)	(3,276,853)	(9,222,851)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	63,237	301,596	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 417,886	\$ 18,566,777	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,375,045	\$ 25,769,104	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,274,141	\$ 4,274,140	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		431,703	29
30	Accrued Salaries Payable	484,269	484,269	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		511,790	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	4,946,665	4,025,875	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,705,075	\$ 9,727,777	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		21,798,313	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)	\$	\$ 21,798,313	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,705,075	\$ 31,526,090	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,330,030)	\$ (5,756,986)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,375,045	\$ 25,769,104	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,892,688)	1
2	Restatements (describe):		2
3	Equity Restatement	176,333	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,716,355)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(433,675)	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	(180,000)	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)	\$ (613,675)	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)	\$ (3,330,030)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Villa at Windsor Park

0051243

Report Period Beginning: 01/01/20

Ending: 12/31/20

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	\$ 13,438,573	1
2	Discounts and Allowances for all Levels	1,926,954	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,365,527	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,237,288	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,237,288	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	12,958	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,199	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,157	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,533	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,533	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	38,954	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,954	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,672,459	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,421,105	31
32	Health Care	6,443,976	32
33	General Administration	3,951,786	33
	B. Capital Expense		
34	Ownership	2,452,638	34
	C. Ancillary Expense		
35	Special Cost Centers	1,335,456	35
36	Provider Participation Fee	501,173	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,106,134	40
41	Income before Income Taxes (line 30 minus line 40)**	(433,675)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (433,675)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 10,120,150	44
45	Private Pay - Net Inpatient Revenue	541,806	45
46	Medicare - Net Inpatient Revenue	3,393,192	46
47	Other-(specify) Hospice	570,435	47
48	Other-(specify) Managed Care	739,944	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,365,527	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	1,335	1,435	\$ 88,282	\$ 61.52	1
2	Assistant Director of Nursing	1,866	2,006	114,140	56.90	2
3	Registered Nurses	17,056	18,339	740,787	40.39	3
4	Licensed Practical Nurses	61,657	66,298	2,131,478	32.15	4
5	CNAs & Orderlies	117,356	126,189	2,147,817	17.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,056	2,211	41,512	18.78	9
10	Activity Assistants	12,141	13,055	213,538	16.36	10
11	Social Service Workers	7,973	8,573	189,968	22.16	11
12	Dietician					12
13	Food Service Supervisor	1,635	1,758	38,343	21.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,352	28,335	465,463	16.43	15
16	Dishwashers					16
17	Maintenance Workers	3,981	4,280	87,341	20.41	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,376	1,479	82,312	55.65	20
21	Assistant Administrator	1,215	1,306	57,126	43.74	21
22	Other Administrative					22
23	Office Manager	791	851	23,221	27.29	23
24	Clerical	17,824	19,166	394,132	20.56	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	2,081	2,238	43,645	19.50	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,027	2,179	38,236	17.55	33
34	TOTAL (lines 1 - 33)	278,722	299,698	\$ 6,897,341 *	\$ 23.01	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	808	\$ 37,145	01-03	35
36	Medical Director	Monthly	40,115	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	24,236	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	23,325	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,122	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	831	\$ 125,943		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	678	\$ 59,460	10-03	50
51	Licensed Practical Nurses	147	9,376	10-03	51
52	Certified Nurse Assistants/Aides	2,969	135,701	10-03	52
53	TOTAL (lines 50 - 52)	3,794	\$ 204,537		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

The Villa at Windsor Park

0051243

Report Period Beginning:

01/01/20

Ending:

12/31/20

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Levi Israel		Administrator	0	\$ 47,838	Workers' Compensation Insurance		\$ 139,782	IDPH License Fee		\$ 3,980	
Shlomo Schultz		Administrator	0	34,474	Unemployment Compensation Insurance		44,279	Advertising: Employee Recruitment		14,787	
Shlomo Schultz		Assistant Admin	0	57,126	FICA Taxes		527,647	Health Care Worker Background Check			
					Employee Health Insurance		322,079	(Indicate # of checks performed 125)		1,251	
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		48,725	
					401k Employer Contribution		55,563	Licenses & Fees		3,880	
					Dental/Vision/Life Insurance		10,451				
					Employee Retention		45,298				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 139,438							
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,145,099	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 76,017
(Attach a copy of any management service agreement)					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
C. Professional Services		Type	Amount	Description		Line #	Amount	Description		Amount	
Villa Financial Services		Bookkeeping	\$ 835,432				\$	Out-of-State Travel		\$	
Crowe LLP		Accounting	1,070								
Marcum LLP		Accounting	18,526								
Prospect Resources		Energy Procurement	1,887					In-State Travel			
Personnel Planner		Unemployment Consulting	2,214								
Alliance for Strategic Advantage		Revenue Cycle Consulting	506								
Widlak and Petriches		Tax Consulting	1,758								
Kronos		Workforce Management	23,115					Seminar Expense		931	
Improvisation Inc		Open Enrollment	1,583								
Maestro Health		Compliance	1,166								
See Attached		Legal	37,882					See Supplemental Schedule		735	
See Supplemental Schedule			32,010					Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		(agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)			\$ 957,149					TOTAL		\$ 1,666	

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>The Villa at Windsor Park</u>	STATE OF ILLINOIS # <u>0051243</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
XX. GENERAL INFORMATION:			
(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>HCCI - \$36,960</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 Years</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>3,019</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>501,173</u> 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? <u>No</u> 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? <u>No</u> (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? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____ (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u> d. Have vehicle usage logs been maintained? <u>N/A</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>No</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u> (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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees		