FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0050260

Facility Name: St James Manor & Villa

Address: 1251 East Richton Rd (Number) Crete (City) 60417 (Zip Code)

County: Will

Telephone Number: (708) 672-6700 **Fax #** (708) 672-4939

HFS ID Number:

Date of Initial License for Current Owners: 03/01/09

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: :Boris Kushnir **Telephone Number:** (614) 849-3000
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Plante & Moran, PLLC, 65 E. State Street, Suite 600 Columbus, Ohio 43215
(Telephone) (614) 849-3000 Fax # (614) 221-3535

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	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	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,310	9,528	11,776	31,614	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,310	9,528	11,776	31,614	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.74%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 03/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/09 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 110 and days of care provided 11,398

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	379,810	78,995	917	459,722		459,722	(140,687)	319,035			1
2	Food Purchase		408,664		408,664		408,664	(151,044)	257,620			2
3	Housekeeping	232,931	77,321		310,252		310,252	(109,488)	200,764			3
4	Laundry		6,859		6,859		6,859	(2,487)	4,372			4
5	Heat and Other Utilities			252,421	252,421		252,421	(89,080)	163,341			5
6	Maintenance	111,253	39,939	215,892	367,084		367,084	(116,500)	250,584			6
7	Other (specify):* See Supplemental							5,750	5,750			7
8	TOTAL General Services	723,994	611,778	469,230	1,805,002		1,805,002	(603,536)	1,201,466			8
	B. Health Care and Programs											
9	Medical Director			28,000	28,000		28,000		28,000			9
10	Nursing and Medical Records	2,545,010	46,841	10,803	2,602,654		2,602,654	(480,051)	2,122,603			10
10a	Therapy											10a
11	Activities	151,091	25,851		176,942		176,942	(64,170)	112,772			11
12	Social Services	182,781			182,781		182,781	(66,287)	116,494			12
13	CNA Training											13
14	Program Transportation			13,961	13,961		13,961	(5,063)	8,898			14
15	Other (specify):* See Supplemental							5,525	5,525			15
16	TOTAL Health Care and Programs	2,878,882	72,692	52,764	3,004,338		3,004,338	(610,046)	2,394,292			16
	C. General Administration											
17	Administrative	139,301		578,155	717,456		717,456	(306,896)	410,560			17
18	Directors Fees											18
19	Professional Services			50,116	50,116		50,116	(39,564)	10,552			19
20	Dues, Fees, Subscriptions & Promotions			67,940	67,940		67,940	(52,779)	15,161			20
21	Clerical & General Office Expenses	181,743	35,999	195,633	413,375		413,375	(233,109)	180,266			21
22	Employee Benefits & Payroll Taxes			925,929	925,929		925,929	(236,435)	689,494			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,150	1,150		1,150	(417)	733			24
25	Other Admin. Staff Transportation			18,245	18,245		18,245	(18,245)				25
26	Insurance-Prop.Liab.Malpractice			77,621	77,621		77,621	(27,393)	50,228			26
27	Other (specify):* See Supplemental							26,630	26,630			27
28	TOTAL General Administration	321,044	35,999	1,914,789	2,271,832		2,271,832	(888,207)	1,383,625			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,923,920	720,469	2,436,783	7,081,172		7,081,172	(2,101,789)	4,979,383			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

St James Manor & Villa
Medicaid Cost Report
01/01/13 - 12/31/13

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Alloc. Trilogy Health Services, LLC - Emp. Ben.			8,978
Non-Allowable - Alloc. Assisted Living			(3,228)
Total	-	-	5,750
Line 15 Detailed			
Alloc. Trilogy Health Services, LLC - Emp. Ben.			6,894
Non-Allowable - Alloc. Assisted Living			(1,369)
Total	-	-	5,525
Line 27 Detailed			
Alloc. Trilogy Health Services, LLC - Emp. Ben.			41,783
Non-Allowable - Alloc. Assisted Living			(15,153)
Total	-	-	26,630

Facility Name & ID Number St James Manor & Villa #0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			354,985	354,985		354,985	(125,275)	229,710			30
31	Amortization of Pre-Op. & Org.			23,450	23,450		23,450	(8,276)	15,174			31
32	Interest			539,386	539,386		539,386	(181,674)	357,712			32
33	Real Estate Taxes			222,594	222,594		222,594	(78,554)	144,040			33
34	Rent-Facility & Grounds			2,377	2,377		2,377	33,159	35,536			34
35	Rent-Equipment & Vehicles			6,005	6,005		6,005	16,507	22,512			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			1,148,797	1,148,797		1,148,797	(344,113)	804,684			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		715,000	1,013,090	1,728,090		1,728,090		1,728,090			39
40	Barber and Beauty Shops			25,037	25,037		25,037		25,037			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,973	182,973		182,973		182,973			42
43	Other (specify):* See Supplemental											43
44	**TOTAL Special Cost Centers**		715,000	1,221,100	1,936,100		1,936,100		1,936,100			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,923,920	1,435,469	4,806,680	10,166,069		10,166,069	(2,445,902)	7,720,167			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

St James Manor & Villa
Medicaid Cost Report
01/01/13 - 12/31/13

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Alloc. Trilogy Health Services, LLC - Per. Prop. Tax			319
Non-Allowable Expense			(319)
Total	-	-	-
Line 43 Detailed			
Total	-	-	-

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(4,453)	02		4
5	Telephone, TV & Radio in Resident Rooms	(25,068)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,443)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(2,275)	21		18
19	Entertainment				19
20	Contributions	(750)	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	(94,664)	21		24
25	Fund Raising, Advertising and Promotional	(43,402)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(694)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(2,459,817)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,634,566)		$	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)	188,664		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 188,664		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,445,902)		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

SEE ACCOUNTANTS' COMPILATION REPORT

St James Manor & Villa

ID# 0050260

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Staff Admin. Transportation	$ (18,245)	25	1
2	Revenue - Miscellaneous	(913)	21	2
3	Bank Charges	(6,110)	21	3
4	Trilogy Health Services - Pers. Prop. Tax	(319)	36	4
5	Revenue - Admin Fees	(810)	21	5
6	Revenue - Rental	(59)	06	6
7	Non-Allowable Legal	(27,547)	19	7
8	Non-Allowable Other Professional	(6,012)	19	8
9	Capitalized R&M < $2,500	1,526	06	9
10				10
11				11
12				12
13				13
14				14
15	Assisted Living Costs - Allocated			15
16	Dietary	(181,538)	01	16
17	Food	(146,591)	02	17
18	Housekeeping	(109,488)	03	18
19	Laundry	(2,487)	04	19
20	Heat and Other Utilities	(89,080)	05	20
21	Maintenance	(136,659)	06	21
22	Other	(3,228)	07	22
23	Nursing and Medical Records	(525,772)	10	23
24	Activities	(64,170)	11	24
25	Social Services	(66,287)	12	25
26	Program Transportation	(5,063)	14	26
27	Other	(1,369)	15	27
28	Administrative	(233,617)	17	28
29	Professional	(6,005)	19	29
30	Dues, Fees, Subscriptions & Promotions	(8,627)	20	30
31	Clerical and General Office	(102,575)	21	31
32	Employee Benefits	(236,435)	22	32
33	Travel and Seminar	(417)	24	33
34	Other Admin. Staff Transportation	0	25	34
35	Insurance - Property and Liability	(27,393)	26	35
36	Other	(15,153)	27	36
37	Depreciation	(125,275)	30	37
38	Amortization	(8,276)	31	38
39	Interest	(195,081)	32	39
40	Real Estate Taxes	(78,554)	33	40
41	Rent - Facility and Grounds	(19,380)	34	41
42	Rent - Equipment	(12,809)	35	42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,459,817)		49

St. James Manor & Villa
Medicaid Cost Report
01/01/13 - 12/31/13

Page 5A Assisted Living Allocation

Cost Center	Adjusted Cost Before Allocation	Allocation Basis	Nursing Facility Units	Total Units	Nursing Home Cost	Assisted Living Cost
Dietary - Salary	379,810	Patient Days	31,614	49,603	242,068	137,742
Dietary - Supplies & Other	79,912	Patient Days	31,614	49,603	50,931	28,981
Dietary - Trilogy Health Care, LLC	40,851	Patient Days	31,614	49,603	26,036	14,815
Food	404,211	Patient Days	31,614	49,603	257,620	146,591
Housekeeping - Salary	232,931	Square Feet	41,193	63,658	150,729	82,202
Housekeeping - Supplies & Other	77,321	Square Feet	41,193	63,658	50,034	27,287
Laundry	6,859	Patient Days	31,614	49,603	4,372	2,487
Heat and Other Utilities	252,421	Square Feet	41,193	63,658	163,341	89,080
Maintenance - Salary	111,253	Square Feet	41,193	63,658	71,992	39,261
Maintenance - Supplies & Other	257,298	Square Feet	41,193	63,658	166,497	90,801
Maintenance - Trilogy Health Care, LLC	18,692	Square Feet	41,193	63,658	12,096	6,596
Other - Trilogy Health Care, LLC	8,978	Pro-Rata	38,132	59,543	5,750	3,228
Medical Director	28,000	Direct Cost	27,000	27,000	28,000	-
Nursing and Medical Records - Salary (Direct)	2,251,111	Direct Cost	1,804,206	2,251,111	1,804,206	446,905
Nursing and Medical Records - Salary (Administration)	293,900	Pro-Rata	1,804,206	2,251,111	235,553	58,347
Nursing and Medical Records - Supplies & Other	57,643	Pro-Rata	1,804,206	2,251,111	46,199	11,444
Nursing and Medical Records - Trilogy Health Care, LLC	45,721	Pro-Rata	1,804,206	2,251,111	36,644	9,077
Activities - Salary	151,091	Patient Days	31,614	49,603	96,296	54,795
Activities - Supplies & Other	25,851	Patient Days	31,614	49,603	16,476	9,375
Social Services - Salary	182,781	Patient Days	31,614	49,603	116,494	66,287
Program Transportation	13,961	Patient Days	31,614	49,603	8,898	5,063
Other - Trilogy Health Care, LLC	6,894	Pro-Rata	36,644	45,721	5,525	1,369
Administrative - Salary	139,301	Patient Days	31,614	49,603	88,782	50,519
Administrative - Supplies & Other	-	Patient Days	31,614	49,603	-	-
Administrative - Trilogy Health Care, LLC	504,876	Patient Days	31,614	49,603	321,778	183,098
Professional Services	16,557	Patient Days	31,614	49,603	10,552	6,005
Dues, Fees, Subscriptions & Promotions	23,788	Patient Days	31,614	49,603	15,161	8,627
Clerical & General Office Expenses - Salary	181,743	Patient Days	31,614	49,603	115,832	65,911
Clerical & General Office Expenses - Supplies & Other	101,098	Patient Days	31,614	49,603	64,434	36,664
Employee Benefits	925,929	Pro-Rata	2,921,953	3,923,921	689,494	236,435
Travel and Seminar	1,150	Patient Days	31,614	49,603	733	417
Other Admin. Staff Transportation	-	Patient Days	31,614	49,603	-	-
Insurance - Property, Liability	77,621	Square Feet	41,193	63,658	50,228	27,393
Other - Trilogy Health Care, LLC	41,783	Patient Days	31,614	49,603	26,630	15,153
Depreciation	354,985	Square Feet	41,193	63,658	229,710	125,275
Amortization	23,450	Square Feet	41,193	63,658	15,174	8,276
Interest	552,793	Square Feet	41,193	63,658	357,712	195,081
Real Estate Taxes	222,594	Square Feet	41,193	63,658	144,040	78,554
Rent - Facility & Grouns	54,916	Square Feet	41,193	63,658	35,536	19,380
Rent - Equipment & Vehicles	35,321	Patient Days	31,614	49,603	22,512	12,809
	8,185,395				5,784,067	2,401,328

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St James Manor & Villa # 0050260 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(181,538)	40,851	0	0	0	0	0	0	0	0	0	(140,687)	1
2	Food Purchase	(151,044)	0	0	0	0	0	0	0	0	0	0	(151,044)	2
3	Housekeeping	(109,488)	0	0	0	0	0	0	0	0	0	0	(109,488)	3
4	Laundry	(2,487)	0	0	0	0	0	0	0	0	0	0	(2,487)	4
5	Heat and Other Utilities	(89,080)	0	0	0	0	0	0	0	0	0	0	(89,080)	5
6	Maintenance	(135,192)	18,692	0	0	0	0	0	0	0	0	0	(116,500)	6
7	Other (specify):*	(3,228)	8,978	0	0	0	0	0	0	0	0	0	5,750	7
8	**TOTAL General Services**	(672,057)	68,521	0	0	0	0	0	0	0	0	0	(603,536)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(525,772)	45,721	0	0	0	0	0	0	0	0	0	(480,051)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(64,170)	0	0	0	0	0	0	0	0	0	0	(64,170)	11
12	Social Services	(66,287)	0	0	0	0	0	0	0	0	0	0	(66,287)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(5,063)	0	0	0	0	0	0	0	0	0	0	(5,063)	14
15	Other (specify):*	(1,369)	6,894	0	0	0	0	0	0	0	0	0	5,525	15
16	**TOTAL Health Care and Programs**	(662,661)	52,615	0	0	0	0	0	0	0	0	0	(610,046)	16
	C. General Administration													
17	Administrative	(233,617)	(73,279)	0	0	0	0	0	0	0	0	0	(306,896)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(39,564)	0	0	0	0	0	0	0	0	0	0	(39,564)	19
20	Fees, Subscriptions & Promotions	(52,779)	0	0	0	0	0	0	0	0	0	0	(52,779)	20
21	Clerical & General Office Expenses	(233,109)	0	0	0	0	0	0	0	0	0	0	(233,109)	21
22	Employee Benefits & Payroll Taxes	(236,435)	0	0	0	0	0	0	0	0	0	0	(236,435)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(417)	0	0	0	0	0	0	0	0	0	0	(417)	24
25	Other Admin. Staff Transportation	(18,245)	0	0	0	0	0	0	0	0	0	0	(18,245)	25
26	Insurance-Prop.Liab.Malpractice	(27,393)	0	0	0	0	0	0	0	0	0	0	(27,393)	26
27	Other (specify):*	(15,153)	41,783	0	0	0	0	0	0	0	0	0	26,630	27
28	**TOTAL General Administration**	(856,711)	(31,496)	0	0	0	0	0	0	0	0	0	(888,207)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,191,429)	89,640	0	0	0	0	0	0	0	0	0	(2,101,789)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St James Manor & Villa **#** 0050260 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	(125,275)	0	0	0	0	0	0	0	0	0	0	(125,275)	30
31	Amortization of Pre-Op. & Org.	(8,276)	0	0	0	0	0	0	0	0	0	0	(8,276)	31
32	Interest	(198,524)	16,850	0	0	0	0	0	0	0	0	0	(181,674)	32
33	Real Estate Taxes	(78,554)	0	0	0	0	0	0	0	0	0	0	(78,554)	33
34	Rent-Facility & Grounds	(19,380)	52,539	0	0	0	0	0	0	0	0	0	33,159	34
35	Rent-Equipment & Vehicles	(12,809)	29,316	0	0	0	0	0	0	0	0	0	16,507	35
36	Other (specify):*	(319)	319	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(443,137)	99,024	0	0	0	0	0	0	0	0	0	(344,113)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,634,566)	188,664	0	0	0	0	0	0	0	0	0	(2,445,902)	45

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
Trilogy Health Services, LLC	100%	See Page 6 - Supp		See Page 6 - Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Trilogy Health Services, LLC	100.00%	$ 40,851	$ 40,851	1
2	V	6	Maintenance		Trilogy Health Services, LLC	100.00%	18,692	18,692	2
3	V	7	Employee Benefits		Trilogy Health Services, LLC	100.00%	8,978	8,978	3
4	V	10	Nursing		Trilogy Health Services, LLC	100.00%	45,721	45,721	4
5	V	15	Employee Benefits		Trilogy Health Services, LLC	100.00%	6,894	6,894	5
6	V	17	Administrative		Trilogy Health Services, LLC	100.00%	277,097	277,097	6
7	V	17	Administrative	578,155	Trilogy Health Services, LLC	100.00%	227,779	(350,376)	7
8	V	27	Employee Benefits		Trilogy Health Services, LLC	100.00%	41,783	41,783	8
9	V	30	Depreciation		Trilogy Health Services, LLC	100.00%	0		9
10	V	32	Interest		Trilogy Health Services, LLC	100.00%	16,850	16,850	10
11	V	34	Building Rent		Trilogy Health Services, LLC	100.00%	52,539	52,539	11
12	V	35	Equipment Rent		Trilogy Health Services, LLC	100.00%	29,316	29,316	12
13	V	36	Personal Property Tax		Trilogy Health Services, LLC	100.00%	319	319	13
14	Total			$ 578,155			$ 766,819	$ * 188,664	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			Owen Valley Health Campus	Spencer, IN				1
2			Oakwood Health Campus	Tell City, IN				2
3			Homewood Health Campus	Lebanon, IN				3
4			Autumn Woods Health Campus	New Albany, IN				4
5			Waterford Place Health Campus	Kokomo, IN				5
6			Silver Oaks Health Campus	Columbus, IN				6
7			St. Charles Health Campus	Jasper, IN				7
8			Covered Bridge Health Campus	Seymour, IN				8
9			Woodmont Health Campus	Boonville, IN				9
10			River Pointe Health Campus	Evansville, IN				10
11			Bethany Pointe Health Campus	Anderson, IN				11
12			Cedar Ridge Health Campus	Cynthiana, KY				12
13			StoneBridge Health Campus	Bedford, IN				13
14			Thornton Terrace Health Campus	Hanover, IN				14
15			RiverOaks Health Campus	Princeton, IN				15
16			Ashford Place Health Campus	Shelbyville, IN				16
17			Mill Pond Health Campus	Greencastle, IN				17
18			St. Andrews Health Campus	Batesville, IN				18
19			Hampton Oaks Health Campus	Scottsburg, IN				19
20			Spring Mill Health Campus	Merrillville, IN				20
21			Forest Park Health Campus	Richmond, IN				21
22			The Maples at Waterford Crossing	Goshen, IN				22
23			Springhurst Health Campus	Greenfield, IN				23
24			Glen Ridge Health Campus	Louisville, KY				24
25			Park Terrace at Norton Southwest	Louisville, KY				25
26			Morrison Woods Health Campus	Muncie, IN				26
27			Cobble Stone Crossing	Terre Haute, IN				27
28			WoodBridge Health Campus	Logansport, IN				28
29			BridgePointe Health Campus	Vincennes, IN				29
30			Greenleaf Living Center	Elkhart, IN				30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			Creasy Springs Health Campus	Lafayette, IN				1
2			St. Elizabeth Healthcare	Delphi, IN				2
3			Cumberland Pointe Health	West Lafayette, IN				3
4			St. Mary Healthcare	Lafayette, IN				4
5			Franciscan Healthcare Center	Louisville, KY				5
6			White Oak Health Campus	Monticello, IN				6
7			Prairie Lakes Health Campus	Noblesville, IN				7
8			West River Health Campus	Evansville,				8
9			Ridgewood Health Campus	Lawrenceburg, IN				9
10			Blair Ridge Health Campus	Peru, IN				10
11			Westport Place Health Campus	Louisville, KY				11
12			Glen Oaks - Senior Living	New Castle, IN				12
13			Glen Oaks Health Campus	New Castle, IN				13
14			The Arbors at Michigan City	Michigan, IN				14
15			Lakeland Rehabilitation	Milford, IN				15
16			Scenic Hills Care Center	Ferdinand, IN				16
17			Amber Manor Care Center	Petersburg, IN				17
18			Forest Glen Health Campus	Springfield, OH				18
19			Valley View Healthcare Center	Fremont, OH				19
20			Willard Healthcare Center	Willard, OH				20
21			The Meadows of Ottawa-Glandorf	Ottawa, OH				21
22			Meadows of Kalida Health Campus	Kalida, OH				22
23			Richland Manor	Bluffton, OH				23
24			The Heritage	Findlay, OH				24
25			Meadows of Leipsic Health Campus	Leipsic, OH				25
26			Springview Manor	Lima, OH				26
27			Genoa Retirement Village	Genoa, OH				27
28			Triple Creek Retirement Community	Colerain, OH				28
29			The Willows at Bellevue	Bellevue, OH				29
30			Briar Hill Health Campus	North Baltimore, OH				30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			Cypress Pointe Health Campus	Englewood, OH				1
2			Highland Oaks Health Center	McConnellsville, OH				2
3			Forest View Health Campus	Zanesville, OH				3
4			The Oaks at North Pointe Woods	Battle Creek, MI				4
5			Ridgecrest Health Campus	Jackson, MI				5
6			West Winds Health Campus	Commerce, MI				6
7			West Lake Health Campus	Commerce, MI				7
8			Village Green Healthcare Center	Greenville, OH				8
9			The Willows at Hamburg	Lexington, KY				9
10			Aspen Place Health Campus	Greensburg, IN				10
11			Avalon Springs Health Campus	Valparaiso, IN				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: Trilogy Health Services, LLC
Street Address: 1650 Lyndon Farm Court, Suite 201
City / State / Zip Code: Louisville, Kentucky 40223
Phone Number: (502) 412-5847
Fax Number: (502) 412-0407

	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	Dietary	Patient Days	2,381,909	80	$ 1,961,643	$ 1,961,643	49,603	$ 40,851	1
2	6	Maintenance	Patient Days	2,381,909	80	897,580	897,580	49,603	18,692	2
3	7	Employee Benefits	Patient Days	2,381,909	80	431,141		49,603	8,978	3
4	10	Nursing	Patient Days	2,381,909	80	2,195,497	2,195,497	49,603	45,721	4
5	15	Employee Benefits	Patient Days	2,381,909	80	331,058		49,603	6,894	5
6	17	Administrative	Patient Days	2,381,909	80	13,306,047	13,306,047	49,603	277,097	6
7	17	Administrative	Patient Days	2,381,909	80	10,937,823		49,603	227,779	7
8	27	Employee Benefits	Patient Days	2,381,909	80	2,006,412		49,603	41,783	8
9	30	Depreciation	Patient Days	2,381,909	80	0		49,603	0	9
10	32	Interest	Patient Days	2,381,909	80	809,128		49,603	16,850	10
11	34	Building Rent	Patient Days	2,381,909	80	2,522,894		49,603	52,539	11
12	35	Equipment Rent	Patient Days	2,381,909	80	1,407,738		49,603	29,316	12
13	36	Personal Property Tax	Patient Days	2,381,909	80	15,318		49,603	319	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 36,822,278	$ 18,360,767		$ 766,819	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$			$ 491,505	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit							46,671	6
7	Other		X	Equipment Financing							1,211	7
8												8
9	TOTAL Facility Related						$	$			$ 539,387	9
	B. Non-Facility Related*											
10	Interest Income										(3,443)	10
11	Trilogy Health Services, LLC	X		Interest Allocation							16,850	11
12												12
13	Assisted Living Allocation			See Page 6 Supplemental							(195,081)	13
14	TOTAL Non-Facility Related						$	$			$ (181,674)	14
15	TOTALS (line 9+line14)						$	$			$ 357,712	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

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

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.)

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 176,651	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.)		$ 194,754	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,103	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 204,491	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.)**		$	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.		$ 222,594	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009	105,447	9
2010	155,500	10
2011	171,506	11
2012	194,754	12

2013 Real Estate Tax Accrual = $194,754 * 1.05 =$204,491
Nursing Home Real Estate Tax Expense = $144,040
Nursing Home Real Estate Tax Bill = $126,025

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Manor & Villa COUNTY Will

FACILITY IDPH LICENSE NUMBER 0050260

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-15-02-400-015-0000	Long Term Care Facility	$ 170,480.20	$ 110,317.74
2.	23-15-02-400-023-0000	Long Term Care Facility	$ 24,273.46	$ 15,707.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 194,753.66	$ 126,025.09

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 X 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,658 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

Assisted Living - 60 Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		2009	$ 558,396	1
2					2
3	TOTALS			$ 558,396	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		2009	1979	$ 3,448,377	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	1,229,139						9
10	Container for Storage During Construction			2010	326						10
11	Handrail Installation & Paint			2010	423						11
12	Storage Unit for Construction			2010	1,240						12
13	Sprinkler Work for State Survey			2010	3,385						13
14	Container for Storage During Construction			2010	1,059						14
15	Contractor Payment (Electrical, Drywall, Plumbing, Flooring)			2010	262,395						15
16	Paint			2010	1,170						16
17	Alarm			2010	1,141						17
18	Contractor Payment (Electrical, Drywall, Plumbing, Flooring)			2010	100,155						18
19	Design Fees			2010	969						19
20	Doors			2010	5,959						20
21	Paint			2010	561						21
22	Water Heater Replacement			2010	2,097						22
23	Light Fixture			2010	3,357						23
24	Container for Storage During Construction			2010	1,184						24
25	Dupster			2010	3,321						25
26	Carpet Storage			2010	800						26
27	Service Safe & Change Com			2010	832						27
28	Electric Fireplace			2010	1,800						28
29	Circuit			2010	661						29
30	Container for Storage During Construction			2010	506						30
31	Security Doors			2010	3,911						31
32	Pad			2010	377						32
33	Water Heater Replacement			2010	1,714						33
34	Relocate Smoke Detectors			2010	1,221						34
35	Hot Water Heater			2010	26,757						35
36	Handrails			2010	14,980						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flooring	2010	$ 33,332	$		$	$	$	37
38	Autocad & Design Time	2010	600						38
39	Contractor Payment (Electrical, Drywall, Plumbing, Flooring)	2010	23,129						39
40	Locks	2010	600						40
41	Flooring	2010	2,180						41
42	Hardware Installation	2010	434						42
43	Garden Fountain	2010	1,018						43
44	2nd Floor Room Conversion (Electrical, Drywall, Plumbing)	2011	3,500						44
45	Wallcoverings	2011	190						45
46	Install Nurse Call Station Light	2011	1,681						46
47	2nd Floor Room Conversion (Electrical, Drywall, Plumbing)	2011	7,800						47
48	Lobby and Dining Room Drafting	2011	143						48
49	Flooring	2011	767						49
50	Hot Water Heater	2011	21,285						50
51	Floorcovering	2011	20,285						51
52	Paint and Wallcoverings	2011	10,032						52
53	Hot Water Pump	2011	2,218						53
54	Hot Water Motor	2011	2,208						54
55	Lavatory Faucets	2011	1,514						55
56	Lavatory Faucets	2011	2,271						56
57	Lavatory Faucets	2011	1,009						57
58	Lavatory Faucets	2011	2,081						58
59	Parking Lot Seal Coat	2011	3,837						59
60	Audio Communication - Hallway	2012	2,096						60
61	Carpet - Hallway	2012	12,039						61
62	Design and Printing Fees - Laundry Room *****	2012	1,042						62
63	Autocad Design - Hallways *****	2012	650						63
64	Design Fees and Expenses - Laundry Room	2012	5,606						64
65	Wallpaper - Hallway *****	2012	2,102						65
66	Vinyl Floor - Hallway *****	2012	865						66
67	Carpet - Hallway *****	2012	1,319						67
68	Vinyl Floor - Hallway *****	2012	2,025						68
69	Plank Flooring - Hallway *****	2012	3,557						69
70	TOTAL (lines 4 thru 69)		$ 5,293,231	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 12A, Carried Forward		$ 5,293,231	$		$	$	$	1
2	Autocad Design - Hallways *****	2012	800						2
3	Carpet - Hallway *****	2012	1,869						3
4	Carpet - Hallway *****	2012	22,205						4
5	Carpet - Hallway *****	2012	34,466						5
6	Design Fees - Laundry Room *****	2012	249						6
7	Laundry Room Construction - Walls, Electric, Piping	2012	24,323						7
8	Relocate Nurse Call System	2012	3,245						8
9	Window Replacements	2012	11,881						9
10	Laundry Room Construction - Walls, Electric, Piping	2012	54,687						10
11	Vinyl Floor - Hallway *****	2012	333						11
12	Parking Lot	2012	8,450						12
13	Carpet - Hallway *****	2013	1,359						13
14	Laundry Room Construction - Walls, Electric, Piping	2013	25,390						14
15	Flooring - Pergola	2013	3,200						15
16	Flooring - Pergola	2013	3,200						16
17	Contract Planks	2013	2,514						17
18	Paint	2013	2,699						18
19	New Antennas and Key Pad	2013	8,027						19
20	New Antennas and Key Pad - Installation	2013	1,285						20
21	Code Alert System	2013	6,925						21
22	Wireless project ****	2013	477						22
23	Painting ****	2013	598						23
24	Painting ****	2013	160						24
25	Materials / Frabrication	2013	14,850						25
26	40' Premium TRI Doors	2013	170						26
27	40' Premium TRI Doors	2013	1,485						27
28	Dining Activities	2013	2,749						28
29	Flooring	2013	27,628						29
30	Wall Coverings and Painting	2013	37,917						30
31	Flooring and Installation	2013	5,955						31
32	Plumbing	2013	1,583						32
33	Chapel Interior Remodel - Walls, Electric, Paiting	2013	37,400						33
34	TOTAL (lines 1 thru 33)		$ 5,641,308	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 12B, Carried Forward		$ 5,641,308	$		$	$	$	1
2	Interior Remodel - Walls, Electric, Paiting, Etc.	2013	68,500						2
3	Flooring - Office and Conference Room	2013	2,365						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	***** - Costs were reported separately to be consistent with								16
17	the client depreciation schedules even if individual line								17
18	items were less than $2,500. These line items should be								18
19	accumulated with other line items for complete project costs.								19
20									20
21									21
22	Financial Statement Depreciation			189,723		189,723		785,323	22
23									23
24									24
25	Assisted Living Allocations - See Non-Care Assets								25
26	Building	2009	(1,216,932)						26
27	Leasehold Improvements	2009	(433,763)						27
28	Leasehold Improvements	2010	(177,718)						28
29	Leasehold Improvements	2011	(28,521)						29
30	Leasehold Improvements	2012	(68,396)						30
31	Leasehold Improvements	2013	(90,496)						31
32	Financial Statement Depreciation			(66,953)		(66,953)		(277,140)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,696,347	$ 122,770		$ 122,770	$	$ 508,183	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 2,164,277	$ 161,350	$ 161,350	$		$ 756,397	71
72	Current Year Purchases	41,208	2,444	2,444			2,444	72
73	Fully Depreciated Assets							73
74	Non-Care Assisted Living	(778,316)	(56,854)	(56,854)			(267,795)	74
75	TOTALS	$ 1,427,169	$ 106,940	$ 106,940	$		$ 491,046	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,681,912	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,710	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,710	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 999,229	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	AL - Land	$ 304,524	$	$	86
87	AL - Building	1,216,932	31,105	150,583	87
88	AL - Leasehold Improvements	798,894	35,848	126,557	88
89	AL - Equipment	778,316	56,854	267,795	89
90					90
91	TOTALS	$ 3,098,666	$ 123,807	$ 544,935	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	See							5
6	Supplement				35,536			6
7	TOTAL				$ 35,536 **			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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 22,512 Description: See Supplemental Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

St James Manor & Villa
Medicaid Cost Report
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Eagle Nest Storage	2,377
Alloc. Trilogy Health Services, LLC	52,539
Non-Allowable Alloc. Assisted Living	(19,380)
Total	35,536

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
GE Capital / CO Ricoh Ikon Financial Services	4,175
Pitney Bowes	1,830
Alloc. Trilogy Health Services, LLC	29,316
Non-Allowable Alloc. Assisted Living	(12,809)
Total	22,512

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 449,474	$		$ 449,474	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			126,449			126,449	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			332,625			332,625	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				687,930		687,930	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					27,070		27,070	12
13	Other (specify): See Supplemental	39 - 03				104,542			104,542	13
14	TOTAL			$		$ 1,013,090	$ 715,000		$ 1,728,090	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.

SEE ACCOUNTANTS' COMPILATION REPORT

St James Manor & Villa
Medicaid Cost Report
01/01/13 - 12/31/13

Page 16 Supplemental Schedule

Description	Supplies	Other
Oxygen	27,070	
Medical Equipment		87,795
Radiology		15,529
Ambulance		489
Other		729
Total	27,070	104,542

STATE OF ILLINOIS

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (last day of reporting year)

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	$ 21,827,179	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 39,178)	2,374,344		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	23,420		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,241		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 24,231,184	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	859,848		13
14	Buildings, at Historical Cost	4,273,941		14
15	Leasehold Improvements, at Historical Cost	1,404,704		15
16	Equipment, at Historical Cost	2,254,698		16
17	Accumulated Depreciation (book methods)	(1,544,164)		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 Supplemental Schedule	79,548		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,328,575	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 31,559,759	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 923,338	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,961		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,993		31
32	Accrued Real Estate Taxes(Sch.IX-B)	204,492		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,366,784	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	29,976,823		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 29,976,823	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 31,343,607	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 216,152	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 31,559,759	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

St James Manor & Villa
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Total	-	-
Line 23 - Other Long Term Assets		
Financing Costs (Net of Amortization)	45,835	
Tax Benefit	33,713	
Total	79,548	-
Line 36 - Other Current Liabilities		
		-
Total	-	-
Line 43 - Other Long Term Liabilities		
Intercompany Payable - Trilogy Health Services	29,976,823	
Total	29,976,823	-

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,370,634)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,370,634)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,586,786	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	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,586,786	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)**	$ 216,152	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,367,544	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,367,544	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,695	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 82,695	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	26,023	13
14	Non-Patient Meals	4,453	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,476	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,443	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,443	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,268,697	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,268,697	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,752,855	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,805,002	31
32	Health Care	3,004,338	32
33	General Administration	2,271,832	33
	B. Capital Expense		
34	Ownership	1,148,797	34
	C. Ancillary Expense		
35	Special Cost Centers	1,753,127	35
36	Provider Participation Fee	182,973	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,166,069	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,586,786	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,586,786	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,212,863	44
45	Private Pay - Net Inpatient Revenue	2,907,133	45
46	Medicare - Net Inpatient Revenue	5,760,516	46
47	Other-(specify) Hospice - Net Inpatient Revenue	267,780	47
48	Other-(specify) Insurance - Net Inpatient Revenue	219,252	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,367,544	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished 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.

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Description	Total	Adjustment
Line 28 - Other Revenue		
Assisted Living	1,266,753	
Lease / Rental Services	59	59
Vending Commissions	161	
Admin Fees	810	810
Miscellaneous Revenue	914	914
Total	1,268,697	1,783

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,183	$ 86,451	$ 39.60	1
2	Assistant Director of Nursing	2,000	5,075	142,772	28.13	2
3	Registered Nurses	7,681	8,206	242,488	29.55	3
4	Licensed Practical Nurses	26,766	29,100	682,375	23.45	4
5	CNAs & Orderlies	95,893	103,767	1,326,248	12.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	44,210	21.25	9
10	Activity Assistants	8,276	8,997	106,881	11.88	10
11	Social Service Workers	6,913	7,621	182,781	23.98	11
12	Dietician					12
13	Food Service Supervisor	2,766	2,989	64,421	21.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,356	27,395	315,389	11.51	15
16	Dishwashers					16
17	Maintenance Workers	4,750	5,195	111,253	21.42	17
18	Housekeepers	20,140	22,031	232,931	10.57	18
19	Laundry					19
20	Administrator	2,000	2,080	139,301	66.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,863	10,614	181,742	17.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,968	2,217	64,677	29.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,372	239,550	$ 3,923,920 *	$ 16.38	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 917	01 - 03	35
36	Medical Director		28,000	09 - 03	36
37	Medical Records Consultant		975	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,828	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,720		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janet Breed	Administrator	0	$ 73,249
Tina Strimbu	Administrator	0	17,995
Cindy Zolper	Administrator	0	34,615
Michael Hunter	Administrator	0	13,442
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 139,301

B. Administrative - Other

Description	Amount
Management Fees - Trilogy Health Services, LLC	$ 578,155
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 578,155

C. Professional Services

Vendor/Payee	Type	Amount
Plante & Moran, PLLC	Accounting	$ 6,600
ADP	Payroll Processing	9,957
Foote, Meyers, Mielke & Flowers, LLC	Legal	10,844
Frank J. Koprcina & Assoc. PC	Legal	3,530
Harrison & Moberly, LLP	Legal	13,173
Other	Legal	6,012
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 50,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,168
Unemployment Compensation Insurance	142,851
FICA Taxes	286,912
Employee Health Insurance	336,947
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,859
401K Match	
Employee Recognition	21,501
Scholarship Funding	2,090
Other Employee Benefits	51,601
Non-Allowable - Assisted Living	(236,435)
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,494

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,590
Advertising: Employee Recruitment	2,146
Health Care Worker Background Check (Indicate # of checks performed)	3,585
Patient Background Checks	4,594
Dues and Subscriptions	6,466
Licenses	3,407
Advertising and Promotion	43,402
Non-Allowable - Assisted Living	(8,627)
Less: Public Relations Expense	( )
Non-allowable advertising	(43,402)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,161

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,150
Non-Allowable - Assisted Living	(417)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 733

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Page 21 Supplemental Schedule - Legal Details

Vendor	Invoice Date	Amount	Allowable
Harrison & Moberly, LLP	02/06/13	7,867	
Harrison & Moberly, LLP	06/10/13	3,799	
Frank J. Koprcina & Associates, PC	07/22/13	3,530	
Harrison & Moberly, LLP	07/09/13	1,506	
Meyers & Flowers, LLC	02/05/13	10,844	
Total		27,547	-
Non-Allowable			27,547

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St James Manor & Villa # 0050260 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. **Life Services Network - $5,714**

(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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,435** Line **10 - 02**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **182,973**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln. 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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? **Yes**
Firm Name: **Crowe Horwath - Not Finalized**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees