FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0052779

Facility Name: St James Wellness Reh Villas

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: 4/1/2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 04/01/14 to 12/31/14 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) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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	30,250	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	30,250	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	10,679	5,545	7,842	24,066	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,679	5,545	7,842	24,066	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.56%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 04/01/14

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/14 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 7,089

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 **Report Period Beginning:** 04/01/14 **Ending:** 12/31/14

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	190,500	25,125	9,655	225,280		225,280	2,481	227,761			1
2	Food Purchase		183,488		183,488		183,488	(1,078)	182,410			2
3	Housekeeping	82,315	30,481	1,218	114,014		114,014	310	114,324			3
4	Laundry	46,442	19,178	228	65,848		65,848		65,848			4
5	Heat and Other Utilities			99,911	99,911		99,911	679	100,590			5
6	Maintenance	84,363		166,354	250,717		250,717	(77,112)	173,605			6
7	Other (specify):*							910	910			7
8	**TOTAL General Services**	403,620	258,272	277,366	939,258		939,258	(73,810)	865,448			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	1,572,520	180,819	6,079	1,759,418		1,759,418	21,123	1,780,541			10
10a	Therapy	53,865			53,865		53,865		53,865			10a
11	Activities	88,842	27,394		116,236		116,236		116,236			11
12	Social Services	118,439			118,439		118,439	10,030	128,469			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,672	3,672			15
16	**TOTAL Health Care and Programs**	1,833,666	208,213	28,079	2,069,958		2,069,958	34,825	2,104,783			16
	C. General Administration											
17	Administrative	71,048			71,048		71,048	45,383	116,431			17
18	Directors Fees											18
19	Professional Services			325,336	325,336		325,336	(288,014)	37,322			19
20	Dues, Fees, Subscriptions & Promotions			12,135	12,135		12,135	(4,254)	7,881			20
21	Clerical & General Office Expenses	90,197	17,226	367,320	474,743		474,743	(243,526)	231,217			21
22	Employee Benefits & Payroll Taxes			483,264	483,264		483,264	(3,632)	479,632			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,910	1,910		1,910	805	2,715			24
25	Other Admin. Staff Transportation			2,385	2,385		2,385	660	3,045			25
26	Insurance-Prop.Liab.Malpractice			46,892	46,892		46,892	977	47,869			26
27	Other (specify):*							18,473	18,473			27
28	**TOTAL General Administration**	161,245	17,226	1,239,242	1,417,713		1,417,713	(473,128)	944,585			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,398,531	483,711	1,544,687	4,426,929		4,426,929	(512,113)	3,914,816			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.

Facility Name & ID Number St James Wellness Reh Villas #0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,435	7,435		7,435	483,768	491,203			30
31	Amortization of Pre-Op. & Org.			347	347		347	(347)				31
32	Interest			5,891	5,891		5,891	759,257	765,148			32
33	Real Estate Taxes			128,250	128,250		128,250	212,023	340,273			33
34	Rent-Facility & Grounds			871,053	871,053		871,053	(710,000)	161,053			34
35	Rent-Equipment & Vehicles			8,023	8,023		8,023	388	8,411			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,020,999	1,020,999		1,020,999	745,089	1,766,088			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		382,002	771,674	1,153,676		1,153,676	(67)	1,153,609			39
40	Barber and Beauty Shops			13,165	13,165		13,165		13,165			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,166	141,166		141,166		141,166			42
43	Other (specify):*			1,663,356	1,663,356		1,663,356	(1,663,356)	0			43
44	**TOTAL Special Cost Centers**		382,002	2,589,361	2,971,363		2,971,363	(1,663,422)	1,307,941			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,398,531	865,713	5,155,047	8,419,291		8,419,291	(1,430,447)	6,988,844			45

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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	(950)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(212,049)	30		9
10	Interest and Other Investment Income	(1,094)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(423)	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	(887)	21		18
19	Entertainment				19
20	Contributions	(57)	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	(309,008)	21		24
25	Fund Raising, Advertising and Promotional	(5,028)	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	(1,825,187)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,354,683)		$	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)	924,236		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 924,236		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,430,447)		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

STATE OF ILLINOIS **Page 5A**

St James Wellness Reh Villas

ID# **0052779**

Report Period Beginning: **04/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (54)	02	1
2	Rental Income	(131)	06	2
3	Jury duty	(52)	10	3
4	Patient Clothing	(966)	10	4
5	Collections	(1,927)	21	5
6	Amortization	(347)	31	6
7	Annual Report	(155)	20	7
8	Prior Period Professional Fees	(970)	19	8
9	Assisted Living Expense	(3,270)	43	9
10	Assisted Living Expense	(1,660,086)	43	10
11	Building Company - Professional Fees	(3,500)	19	11
12	Building Company - Admin Expenses	(250)	21	12
13	Building Company - Amortization	(64,548)	31	13
14	Capitalized R&M	(83,788)	06	14
15	Non-allowable Legal	(2,917)	19	15
16	Non-Allowable Expense	(2,226)	21	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
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**	(1,825,187)		49

St James Wellness Reh Villas

ID# 0052779

Report Period Beginning: 04/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St James Wellness Reh Villas # 0052779 **Report Period Beginning:** 04/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			78		2,403							2,481	1
2	Food Purchase	(1,427)		349									(1,078)	2
3	Housekeeping			261		49							310	3
4	Laundry													4
5	Heat and Other Utilities			589		90							679	5
6	Maintenance	(83,919)		2,430	4,302	75							(77,112)	6
7	Other (specify):*				636	274							910	7
8	**TOTAL General Services**	(85,346)		3,707	4,938	2,891							(73,810)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,018)				22,141							21,123	10
10a	Therapy													10a
11	Activities													11
12	Social Services					10,030							10,030	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					3,672							3,672	15
16	**TOTAL Health Care and Programs**	(1,018)				35,843							34,825	16
	C. General Administration													
17	Administrative			1,615	8,733	35,035							45,383	17
18	Directors Fees													18
19	Professional Services	(7,387)	3,500	(284,538)		411							(288,014)	19
20	Fees, Subscriptions & Promotions	(5,240)		858		128							(4,254)	20
21	Clerical & General Office Expenses	(314,298)	716	5,876	49,890	14,290							(243,526)	21
22	Employee Benefits & Payroll Taxes				(3,632)								(3,632)	22
23	Inservice Training & Education													23
24	Travel and Seminar			134		671							805	24
25	Other Admin. Staff Transportation			660									660	25
26	Insurance-Prop.Liab.Malpractice			709		268							977	26
27	Other (specify):*				12,927	5,546							18,473	27
28	**TOTAL General Administration**	(326,925)	4,216	(274,686)	67,918	56,349							(473,128)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(413,289)	4,216	(270,979)	72,856	95,083							(512,113)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St James Wellness Reh Villas # 0052779 **Report Period Beginning:** 04/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(212,049)	693,001	2,185		631							483,768	30
31	Amortization of Pre-Op. & Org.	(64,895)	64,548										(347)	31
32	Interest	(1,094)	741,965	500		17,886							759,257	32
33	Real Estate Taxes		210,509	1,274		240							212,023	33
34	Rent-Facility & Grounds		(710,000)										(710,000)	34
35	Rent-Equipment & Vehicles			388									388	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(278,038)	1,000,023	4,347		18,757							745,089	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(67)						(67)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,663,356)											(1,663,356)	43
44	**TOTAL Special Cost Centers**	(1,663,356)					(67)						(1,663,422)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,354,683)	1,004,239	(266,632)	72,856	113,840	(67)						(1,430,447)	45

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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. [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	34	Rental Income	$ 870,000	St. James Property	100.00%	$	$ (870,000)	1
2	V	19	Professional Fees		St. James Property	100.00%	3,500	3,500	2
3	V	21	A & G Expense		St. James Property	100.00%	250	250	3
4	V	21	Bank Charges		St. James Property	100.00%	466	466	4
5	V	30	Depreciation Expense		St. James Property	100.00%	693,001	693,001	5
6	V	31	Amortization Expense		St. James Property	100.00%	64,548	64,548	6
7	V	33	Real Estate Taxes		St. James Property	100.00%	210,509	210,509	7
8	V	32	Interest Expense - Leumi		St. James Property	100.00%	564,517	564,517	8
9	V	32	Interest Expense - Trilogy		St. James Property	100.00%	58,333	58,333	9
10	V	32	Interest Expense - Eric Rothner		St. James Property	100.00%	119,115	119,115	10
11	V	34	Rent Expense - Trilogy		St. James Property	100.00%	160,000	160,000	11
12	V								12
13	V								13
14	Total			$ 870,000			$ 1,874,239	$ * 1,004,239	14

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 78	$ 78	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	349	349	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	261	261	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	589	589	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,430	2,430	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,615	1,615	20
21	V	19	Professional Fees	289,144	Extended Care Consulting, LLC	100.00%	4,606	(284,538)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	858	858	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,876	5,876	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	134	134	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	660	660	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	709	709	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,185	2,185	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	500	500	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,274	1,274	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	388	388	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			$ 289,144			$ 22,512	$ * (266,632)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,188	$ 4,188	15
16	V	06	Maintenance (Direct)	1,729	Extended Care Consulting, LLC	100.00%	1,843	114	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	397	397	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	239	239	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,733	8,733	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	51,243	51,243	22
23	V	21	Office and Clerical (Direct)	8,155	Extended Care Consulting, LLC	100.00%	6,802	(1,353)	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	11,047	11,047	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,880	1,880	25
26	V	22	Employee Benefits	3,632	Extended Care Consulting, LLC	100.00%		(3,632)	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			$ 13,516			$ 86,372	$ * 72,856	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 49	$ 49	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	90	90	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	75	75	17
18	V	19	Professional Fees	68	Extended Care Clinical, LLC	100.00%	479	411	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	128	128	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	739	739	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	671	671	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	268	268	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	631	631	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	17,886	17,886	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	240	240	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	2,403	2,403	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	274	274	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	22,141	22,141	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	10,030	10,030	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,672	3,672	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	35,035	35,035	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	13,551	13,551	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,546	5,546	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68			$ 113,908	$ * 113,840	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	39	Various Equipment	750	Vent Lease LLC	100.00%	683	$ (67)	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			$ 750			$ 683	$ * (67)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	1	Dietary Supplies, Supplements	$ 247	Care Centers Health Systems, Inc.	100.00%	$ 247	$	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			$ 247			$ 247	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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	ADAM VALES ACCUM TRUST	9.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	ST. JAMES PROPERTY		BUILDING CO	1
2	MELISSA ROTHNER ACCUM TRUST	9.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKEEP	2
3	NATHAN & SHIRLEY ROTHNER ACCUM TRUST	8.50%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	B & Z GRANDCHILDREN TRUST	20.00%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEM	4
5	DANIEL ROTHNER ACCUM TRUST	9.00%	GRASMERE PLACE, LLC	CHICAGO	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	5
6	KIMBERLY VALES ACCUM TRUST	9.00%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	6
7	RACHEL ROTHNER ACCUM TRUST	9.00%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				7
8	KATHRYN VALES ACCUM TRUST	9.00%	MAJOR HOSPITAL DYER	DYER, IN				8
9	WILLIAM ROTHNER ACCUM TRUST	9.00%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10	N & S ROTHNER TRUST	8.50%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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 [X]

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,251,572	31	$ 4,057	$	24,066	$ 78	1
2	02	Food	Patient Days	1,251,572	31	18,150		24,066	349	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		24,066	261	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		24,066	589	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		24,066	2,430	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		24,066	1,615	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		24,066	4,606	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		24,066	858	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		24,066	5,876	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		24,066	134	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		24,066	660	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		24,066	709	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		24,066	2,185	13
14	32	Interest	Patient Days	1,251,572	31	26,010		24,066	500	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		24,066	1,274	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		24,066	388	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 22,512	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	24,066	4,188	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		1,843	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		24,066	397	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			239	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	24,066	8,733	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	24,066	51,243	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		6,802	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		24,066	11,047	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			1,880	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					$ 4,662,721	$ 3,975,053		$ 86,372	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	758,409	19	$ 1,549	$	24,066	$ 49	1
2	05	Utilities	Patient Days	758,409	19	2,849		24,066	90	2
3	06	Maintenance	Patient Days	758,409	19	2,348		24,066	75	3
4	19	Professional Fees	Patient Days	758,409	19	15,090		24,066	479	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042		24,066	128	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285		24,066	739	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158		24,066	671	7
8	26	Insurance	Patient Days	758,409	19	8,431		24,066	268	8
9	30	Depreciation	Patient Days	758,409	19	19,889		24,066	631	9
10	32	Interest	Patient Days	758,409	19	563,670		24,066	17,886	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558		24,066	240	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	24,066	2,403	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645		24,066	274	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	24,066	22,141	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	24,066	10,030	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731		24,066	3,672	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	24,066	35,035	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	24,066	13,551	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785		24,066	5,546	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,589,719	$ 2,620,691		$ 113,908	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Various Equipment	Direct Allocation						683	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					$	$		$ 683	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	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 Supplies, Supplements	Direct Allocation			$	$		$ 247	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					$	$		$ 247	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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	Bank Leumi		X	Mortgage			$	$ 17,047,066			$ 564,517	1
2	Trilogy		X	Note Payable				2,000,000			58,333	2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				750,000			5,891	6
7	Dell		X	Note Payable				24,660				7
8	See Supplemental Schedule										137,501	8
9	TOTAL Facility Related						$	$ 19,821,726			$ 766,242	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,094)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,094)	14
15	TOTALS (line 9+line14)						$	$ 19,821,726			$ 765,148	15

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated - Ext. Care Consult.		X				$	$			$ 500	8
9	Allocated - Ext. Care Clinical		X								17,886	9
10	First Bank		X								119,115	10
11												11
12												12
13												13
14	TOTAL Working Capital										137,501	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 106,362	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.)		$ 218,646	2
3. Under or (over) accrual (line 2 minus line 1).		$ 112,284	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 227,989	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.		$ 340,273	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013	217,132	12

Beginning Accrual Adjusted
2014 Accural = $217,132 x 1.05 = $227,989
Allocated - Extended Care Consulting - $1,274
Allocated - Extended Care Clinical - $240

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Reh Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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 Property	$ 190,069.48	$ 190,069.48
2.	23-15-02-400-023-0000	Long Term Care Property	$ 27,062.64	$ 27,062.64
3.	See Attached	Care Centers Building LLC	$ 162,082.08	$ 1,441.50
4.	See Attached		$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 379,214.20	$ 218,573.62

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Reh Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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? [ ] (a) Own the Facility [X] (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 [X] (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).

St. James Assisted Living - 61 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	Facility		2014	$ 230,690	1
2	Alloc - Care Centers Building & Ext. Care Clinical			7,293	2
3	TOTALS			$ 237,983	3

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		2014	1988	$ 12,567,146	$ 445,533	35	$ 359,061	$ (86,472)	$ 560,099	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		31,872	2,013		2,013		22,052	68
69	Financial Statement Depreciation			7,436			(7,436)		69
70	TOTAL (lines 4 thru 69)		$ 12,599,018	$ 454,982		$ 361,074	$ (93,907)	$ 582,151	70

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		$ 12,599,018	$ 454,982		$ 361,074	$ (93,907)	$ 582,151	1
2	Repaired Shingles, Valleys, And Buckles	2014	8,500		20	319	319	319	2
3	Repair, Prime & Paint Walls & Ceilings	2014	7,745		20	226	226	226	3
4	Installed 174 20Amp Receptacles	2014	3,480		20	406	406	406	4
5	Installed 1 100 Ton Chiller	2014	87,074		20	2,177	2,177	2,177	5
6	Repair 1St Floor Shower Room	2014	8,800		20	183	183	183	6
7	Chiller Work	2014	3,807		20	79	79	79	7
8	Replaced Tda Assembly For Generator	2014	4,963		20	248	248	248	8
9	Chapel - Completed Carpentry/Taping Work, Electrical, Hvac And	2014	13,300		20	55	55	55	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)		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	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)		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	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)		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	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)		$ 12,736,687	$ 454,982		$ 364,768	$ (90,214)	$ 585,845	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - Care Centers Building, LLC	2002	8,457	217	35	217		2,665	3
4									4
5	Allocated - Extended Care Clinical	2002	1,593	41	35	41		502	5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Extended Care Consulting	2007	88	4	20	4		35	9
10	Allocated - Extended Care Consulting	2009	53	3	20	3		16	10
11	Allocated - Extended Care Consulting	2010	519	26	20	26		130	11
12	Allocated - Extended Care Consulting	2011	187	9	20	9		37	12
13	Allocated - Extended Care Consulting	2012	62	3	20	3		9	13
14	Allocated - Extended Care Consulting	2014	853	43	20	43		43	14
15									15
16	Allocated - Care Centers Building, LLC	2002	6,986	595	20	595		6,986	16
17	Allocated - Care Centers Building, LLC	2003	8,233	702	20	702		8,233	17
18	Allocated - Care Centers Building, LLC	2005	409	43	20	43		365	18
19	Allocated - Care Centers Building, LLC	2009	74	4	20	4		22	19
20	Allocated - Care Centers Building, LLC	2014	1,179	59	20	59		59	20
21									21
22	Allocated - Extended Care Clinical	2002	1,316	112	20	112		1,316	22
23	Allocated - Extended Care Clinical	2003	1,550	132	20	132		1,550	23
24	Allocated - Extended Care Clinical	2005	77	8	20	8		69	24
25	Allocated - Extended Care Clinical	2009	14	1	20	1		4	25
26	Allocated - Extended Care Clinical	2014	222	11	20	11		11	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 31,872	$ 2,013		$ 2,013	$	$ 22,052	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		$ 31,872	$ 2,013		$ 2,013	$	$ 22,052	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
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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)		$ 31,872	$ 2,013		$ 2,013	$	$ 22,052	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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	$ 2,368	$ 237	$ 237	$	10	$ 1,234	71
72	Current Year Purchases	1,273,663	247,610	125,774	(121,836)	10	125,774	72
73	Fully Depreciated Assets	57,285				10	57,285	73
74								74
75	TOTALS	$ 1,333,316	$ 247,847	$ 126,011	$ (121,836)		$ 184,293	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		Allocated - Ext. Care Consulting	2011	$ 3,470	$ 98	$ 98	$	5	$ 3,078	76
77		Allocated - Ext. Care Clinical	2012	1,630	326	326		5	808	77
78										78
79										79
80	TOTALS			$ 5,100	$ 424	$ 424	$		$ 3,886	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)	$ 14,313,086	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 703,253	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 491,203	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (212,049)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 774,024	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	Land - 2014	$ 127,928	$	$	86
87	Building - 2014	6,972,854			87
88	Furniture and Fixtures - 2014	664,190			88
89					89
90					90
91	TOTALS	$ 7,764,972	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Legat Architect	$ 8,618	92
93			93
94			94
95		$ 8,618	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.

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Trilogy Health Services (4/1/14 - 5/5/14)
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. [X] 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:				$ 160,000			3
4	Additions							4
5	Storage Rental				1,053			5
6								6
7	TOTAL				$ 161,053 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,411 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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.

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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	$		$ 315,973	$		$ 315,973	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			113,534			113,534	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			341,417			341,417	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				332,678		332,678	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					750	49,324		50,074	13
14	TOTAL			$		$ 771,674	$ 382,002		$ 1,153,676	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.

STATE OF ILLINOIS

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 71,818	$ 142,944	1
2	Cash-Patient Deposits	12,949	12,949	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,237,504	2,389,496	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,553	58,553	6
7	Other Prepaid Expenses	19,435	19,435	7
8	Accounts Receivable (owners or related parties)		19,483	8
9	Other(specify):	213,346	213,346	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,613,605	$ 2,856,206	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		359,782	13
14	Buildings, at Historical Cost		19,603,453	14
15	Leasehold Improvements, at Historical Cost	129,226	129,226	15
16	Equipment, at Historical Cost	11,087	1,867,095	16
17	Accumulated Depreciation (book methods)	(7,343)	(700,344)	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):	54,211	1,310,734	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 187,181	$ 22,569,946	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,800,786	$ 25,426,152	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,020,831	$ 1,020,831	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,850	7,850	28
29	Short-Term Notes Payable	774,660	774,660	29
30	Accrued Salaries Payable	134,249	134,249	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		227,989	32
33	Accrued Interest Payable		61,559	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	315,132	566,132	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,252,722	$ 2,793,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,000,000	39
40	Mortgage Payable		17,047,066	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			3,600,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 22,647,066	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,252,722	$ 25,440,336	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 548,064	$ (14,184)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,800,786	$ 25,426,152	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	548,064		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)**	$ 548,064		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)**	$ 548,064		24 *

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

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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	$ 7,179,613	1
2	Discounts and Allowances for all Levels	(4,420,812)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,758,801	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,918,478	6
7	Oxygen	1,483	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,919,961	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	15,225	13
14	Non-Patient Meals	950	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	131	16
17	Sale of Drugs	366,918	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,332	19
20	Radiology and X-Ray	4,766	20
21	Other Medical Services	12,511	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 421,833	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,094	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,094	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,865,666	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,865,666	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,967,355	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	939,258	31
32	Health Care	2,069,958	32
33	General Administration	1,417,713	33
	B. Capital Expense		
34	Ownership	1,020,999	34
	C. Ancillary Expense		
35	Special Cost Centers	2,830,197	35
36	Provider Participation Fee	141,166	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,419,291	40
41	**Income before Income Taxes (line 30 minus line 40)****	548,064	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 548,064	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,272,354	44
45	Private Pay - Net Inpatient Revenue	1,227,292	45
46	Medicare - Net Inpatient Revenue	(68,401)	46
47	Other-(specify) Hospice	272,827	47
48	Other-(specify) Insurance	54,729	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,758,801	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.**

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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	1,293	1,480	$ 55,615	$ 37.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,734	11,231	327,331	29.15	3
4	Licensed Practical Nurses	19,531	21,700	532,961	24.56	4
5	CNAs & Orderlies	45,201	50,617	585,128	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,925	2,451	53,865	21.98	8
9	Activity Director	928	1,073	23,418	21.82	9
10	Activity Assistants	4,990	5,573	65,424	11.74	10
11	Social Service Workers	4,475	5,172	118,439	22.90	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,166	45,941	21.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,253	12,965	144,559	11.15	15
16	Dishwashers					16
17	Maintenance Workers	4,139	4,525	84,363	18.64	17
18	Housekeepers	7,289	8,306	82,315	9.91	18
19	Laundry	4,419	4,978	46,442	9.33	19
20	Administrator	1,496	1,605	71,048	44.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,526	6,182	90,197	14.59	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	1,504	1,692	50,726	29.98	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,369	1,519	20,759	13.67	33
34	TOTAL (lines 1 - 33)	126,944	143,235	$ 2,398,531 *	$ 16.75	34

* 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	188	$ 9,655	01-03	35
36	Medical Director	Monthly	22,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,079	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)	188	$ 37,734		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
Michael Hunter	Administrator	0	$ 71,048
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,048

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 11,155
Ext. Care Consulting	Home Office Expense	289,145
Ext. Care Clinical	Home Office Expense	68
Personnel Planners	Unemployment Consulting	853
Legal	See Attached	3,165
Paycor	Payroll Services	11,238
Matrixcare	Electronic Medical Records	6,815
Ability	Medicare Billing	52
AIS Assessment & Intelligence	MDS Consultant	850
National Data Care Corporation	Resident Fund Processing	172
Prior Period Professional Fees	ADJ PG5A	620
See Supplemental Schedule		1,204
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 325,337

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,081
Unemployment Compensation Insurance	94,794
FICA Taxes	179,982
Employee Health Insurance	105,077
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	8,723
Other Employee Welfare	8,479
Holiday Expense	1,497
TOTAL (agree to Schedule V, line 22, col.8)	$ 479,634

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,836
Health Care Worker Background Check	2,640
(Indicate # of checks performed 247)	
Patient Background Checks	
Dues and Subscriptions	507
Licenses and Permits	1,912
Allocated - Ext. Care Consulting	858
Allocated - Ext. Care Clinical	128
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,882

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,910
Allocated - Ext. Care Consulting	134
Allocated - Ext. Care Clinical	671
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,715

**See instructions.

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 04/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,394** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **141,166**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **950**

(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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.