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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0052779

Facility Name: St James Wellness Rehab Villas

Address: 1251 East Richton (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) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,090	5,204	11,342	33,636	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,090	5,204	11,342	33,636	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.78%

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 10,372

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	307,722	36,839	15,004	359,565		359,565	6,277	365,842			1
2	Food Purchase		256,658		256,658		256,658	(1,861)	254,797			2
3	Housekeeping	127,956	43,894	1,707	173,557		173,557	866	174,423			3
4	Laundry	68,183	24,166		92,349		92,349		92,349			4
5	Heat and Other Utilities			128,925	128,925		128,925	1,301	130,226			5
6	Maintenance	99,976		173,082	273,058		273,058	(4,442)	268,616			6
7	Other (specify):*							2,230	2,230			7
8	**TOTAL General Services**	603,837	361,557	318,718	1,284,112		1,284,112	4,371	1,288,483			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	2,129,582	289,688	7,668	2,426,938		2,426,938	28,196	2,455,134			10
10a	Therapy	143,621		466	144,087		144,087		144,087			10a
11	Activities	130,045	41,500		171,545		171,545		171,545			11
12	Social Services	168,668	58		168,726		168,726	17,593	186,319			12
13	CNA Training											13
14	Program Transportation			369	369		369		369			14
15	Other (specify):*							6,033	6,033			15
16	**TOTAL Health Care and Programs**	2,571,916	331,246	35,503	2,938,665		2,938,665	51,822	2,990,487			16
	C. General Administration											
17	Administrative	95,631			95,631		95,631	61,809	157,440			17
18	Directors Fees											18
19	Professional Services			448,244	448,244		448,244	(382,825)	65,419			19
20	Dues, Fees, Subscriptions & Promotions			42,647	42,647		42,647	(22,404)	20,243			20
21	Clerical & General Office Expenses	132,386	32,342	975,137	1,139,865		1,139,865	(817,348)	322,517			21
22	Employee Benefits & Payroll Taxes			581,950	581,950		581,950	(6,608)	575,342			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,925	2,925		2,925	1,028	3,953			24
25	Other Admin. Staff Transportation			6,081	6,081		6,081	955	7,036			25
26	Insurance-Prop.Liab.Malpractice			68,442	68,442		68,442	1,356	69,798			26
27	Other (specify):*							25,130	25,130			27
28	**TOTAL General Administration**	228,017	32,342	2,125,426	2,385,785		2,385,785	(1,138,907)	1,246,878			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,403,770	725,145	2,479,647	6,608,562		6,608,562	(1,082,714)	5,525,848			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 Rehab Villas #0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			15,645	15,645		15,645	518,926	534,571			30
31	Amortization of Pre-Op. & Org.			781	781		781	(781)				31
32	Interest			22,758	22,758		22,758	881,311	904,069			32
33	Real Estate Taxes			186,408	186,408		186,408	4,397	190,805			33
34	Rent-Facility & Grounds			1,126,294	1,126,294		1,126,294	(1,125,000)	1,294			34
35	Rent-Equipment & Vehicles			491	491		491	570	1,061			35
36	Other (specify):*											36
37	TOTAL Ownership			1,352,377	1,352,377		1,352,377	279,423	1,631,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		559,496	1,216,944	1,776,440		1,776,440	(2,070)	1,774,370			39
40	Barber and Beauty Shops			16,411	16,411		16,411		16,411			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,950	112,950		112,950		112,950			42
43	Other (specify):*			2,228,849	2,228,849		2,228,849	(2,228,849)	0			43
44	TOTAL Special Cost Centers		559,496	3,575,154	4,134,650		4,134,650	(2,230,919)	1,903,731			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,403,770	1,284,641	7,407,178	12,095,589		12,095,589	(3,034,209)	9,061,380			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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(1,575)	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	(538,101)	30		9
10	Interest and Other Investment Income	(474)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(397)	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				18
19	Entertainment				19
20	Contributions	(1,159)	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	(900,312)	21		24
25	Fund Raising, Advertising and Promotional	(15,414)	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	(2,282,469)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,739,901)		$	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)	705,692		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 705,692		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,034,209)		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

St James Wellness Rehab Villas

ID# 0052779

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (185)	02	1
2	Rental Income	(150)	06	2
3	Other Income	(6,071)	21	3
4	Jury Duty	(17)	10	4
5	Patient Clothing	(1,726)	10	5
6	Theft Loss	(500)	21	6
7	Collections	(5,445)	21	7
8	Assisted Living Expense	(2,222,852)	43	8
9	Capitalized R&M	(14,586)	06	9
10	Amortization	(781)	31	10
11	Annual Report	(250)	20	11
12	Pac Dues	(6,404)	20	12
13	Non-Allowable Legal	(1,551)	19	13
14	Non-Allowable Professional Fees	(5,997)	43	14
15	Building Company - Professional Fees	(4,875)	19	15
16	Building Company - Admin Expenses	(188)	21	16
17	Building Company - Amortization	(10,547)	31	17
18	Building Company - Bank Fees	(345)	21	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**	(2,282,469)		49

St James Wellness Rehab Villas

ID# 0052779

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number St James Wellness Rehab Villas **#** 0052779 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			111		6,166							6,277	1
2	Food Purchase	(2,157)		296									(1,861)	2
3	Housekeeping			782		84							866	3
4	Laundry													4
5	Heat and Other Utilities			1,185		116							1,301	5
6	Maintenance	(14,736)		3,410	6,797	87							(4,442)	6
7	Other (specify):*				1,451	779							2,230	7
8	**TOTAL General Services**	(16,893)		5,784	8,248	7,232							4,371	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,743)				30,155			(216)				28,196	10
10a	Therapy													10a
11	Activities													11
12	Social Services					17,593							17,593	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,033							6,033	15
16	**TOTAL Health Care and Programs**	(1,743)				53,781			(216)				51,822	16
	C. General Administration													
17	Administrative			2,131	11,921	47,757							61,809	17
18	Directors Fees													18
19	Professional Services	(6,426)	4,875	(252,945)		(128,329)							(382,825)	19
20	Fees, Subscriptions & Promotions	(23,227)		698		125							(22,404)	20
21	Clerical & General Office Expenses	(912,861)	533	8,722	71,400	14,858							(817,348)	21
22	Employee Benefits & Payroll Taxes				(6,608)								(6,608)	22
23	Inservice Training & Education													23
24	Travel and Seminar			240		788							1,028	24
25	Other Admin. Staff Transportation			955									955	25
26	Insurance-Prop.Liab.Malpractice			975		381							1,356	26
27	Other (specify):*				17,353	7,777							25,130	27
28	**TOTAL General Administration**	(942,514)	5,408	(239,224)	94,066	(56,643)							(1,138,907)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(961,149)	5,408	(233,440)	102,314	4,370			(216)				(1,082,714)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St James Wellness Rehab Villas** **#** **0052779** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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	(538,101)	1,054,970	1,545		512							518,926	30
31	Amortization of Pre-Op. & Org.	(11,328)	10,547										(781)	31
32	Interest	(474)	875,425	6,214		146							881,311	32
33	Real Estate Taxes		961	3,114		322							4,397	33
34	Rent-Facility & Grounds		(1,125,000)										(1,125,000)	34
35	Rent-Equipment & Vehicles			570									570	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(549,903)	816,903	11,443		980							279,423	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(2,070)				(2,070)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,228,849)											(2,228,849)	43
44	**TOTAL Special Cost Centers**	(2,228,849)							(2,070)				(2,230,919)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,739,901)	822,311	(221,997)	102,314	5,350			(2,286)				(3,034,209)	45

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,125,000	St. James Property	100.00%	$	$ (1,125,000)	1
2	V	19	Professional Fees		St. James Property	100.00%	4,875	4,875	2
3	V	21	A & G Expense		St. James Property	100.00%	188	188	3
4	V	21	Bank Charges		St. James Property	100.00%	345	345	4
5	V	30	Depreciation Expense		St. James Property	100.00%	1,054,970	1,054,970	5
6	V	31	Amortization Expense		St. James Property	100.00%	10,547	10,547	6
7	V	33	Real Estate Taxes	186,408	St. James Property	100.00%	187,369	961	7
8	V	32	Interest Expense - Leumi		St. James Property	100.00%	648,336	648,336	8
9	V	32	Interest Expense - Trilogy		St. James Property	100.00%	81,250	81,250	9
10	V	32	Interest Expense - Tov Funding		St. James Property	100.00%	145,839	145,839	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,311,408			$ 2,133,719	$ * 822,311	14

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 111	$ 111	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	296	296	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	782	782	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,185	1,185	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,410	3,410	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,131	2,131	20
21	V	19	Professional Fees	256,710	Extended Care Consulting, LLC	100.00%	3,765	(252,945)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	698	698	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,722	8,722	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	240	240	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	955	955	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	975	975	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,545	1,545	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,214	6,214	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,114	3,114	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	570	570	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			$ 256,710			$ 34,713	$ * (221,997)	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	6,798	$ 6,798	15
16	V	06	Maintenance (Direct)	5,974	Extended Care Consulting, LLC	100.00%	5,973	(1)	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	585	585	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	866	866	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	11,921	11,921	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	71,400	71,400	22
23	V	21	Office and Clerical (Direct)	11,359	Extended Care Consulting, LLC	100.00%	11,359		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	14,303	14,303	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,050	3,050	25
26	V	22	Employee Benefits	6,608	Extended Care Consulting, LLC	100.00%		(6,608)	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			$ 23,941			$ 126,255	$ * 102,314	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 84	$ 84	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	116	116	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	87	87	17
18	V	19	Professional Fees	128,760	Extended Care Clinical, LLC	100.00%	431	(128,329)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	125	125	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,067	1,067	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	788	788	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	381	381	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	512	512	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	146	146	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	322	322	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	6,166	6,166	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	779	779	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	30,155	30,155	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	17,593	17,593	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,033	6,033	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	47,757	47,757	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	13,791	13,791	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	7,777	7,777	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,760			$ 134,110	$ * 5,350	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	450	Vent Lease LLC	100.00%	450	$	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			$ 450			$ 450	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 173,818	$ 173,818	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	173,818	CCS Employee Benefits Group	100.00%		(173,818)	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			$ 173,818			$ 173,818	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 16,366	MAC Rx, LLC	100.00%	$ 16,150	$ (216)	15
16	V	39	Ancillary	156,786	MAC Rx, LLC	100.00%	154,715	(2,070)	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			$ 173,151			$ 170,865	$ * (2,286)	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	NATHAN & SHIRLEY ROTHNER ACCUM TRUST	8.50%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	B & Z GRANDCHILDREN TRUST	20.00%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO	4
5	DANIEL ROTHNER ACCUM TRUST	9.00%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6	KIMBERLY VALES ACCUM TRUST	9.00%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRI CARE REHAB	HILLSIDE	THERAPY	6
7	RACHEL ROTHNER ACCUM TRUST	9.00%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8	KATHRYN VALES ACCUM TRUST	9.00%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9	WILLIAM ROTHNER ACCUM TRUST	9.00%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	33,636	$ 111	1
2	02	Food	Patient Days	1,326,152	31	11,689		33,636	296	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		33,636	782	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		33,636	1,185	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		33,636	3,410	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		33,636	2,131	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		33,636	3,765	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		33,636	698	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		33,636	8,722	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		33,636	240	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		33,636	955	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		33,636	975	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		33,636	1,545	13
14	32	Interest	Patient Days	1,326,152	31	244,990		33,636	6,214	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		33,636	3,114	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		33,636	570	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 34,713	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	33,636	6,798	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		5,973	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		33,636	585	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			866	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	33,636	11,921	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	33,636	71,400	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		11,359	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		33,636	14,303	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			3,050	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					$ 4,964,932	$ 4,280,758		$ 126,255	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	794,254	19	$ 1,974	$	33,636	$ 84	1
2	05	Utilities	Patient Days	794,254	19	2,745		33,636	116	2
3	06	Maintenance	Patient Days	794,254	19	2,053		33,636	87	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		33,636	431	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		33,636	125	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		33,636	1,067	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		33,636	788	7
8	26	Insurance	Patient Days	794,254	19	9,008		33,636	381	8
9	30	Depreciation	Patient Days	794,254	19	12,096		33,636	512	9
10	32	Interest	Patient Days	794,254	19	3,455		33,636	146	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		33,636	322	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	33,636	6,166	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		33,636	779	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	33,636	30,155	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	33,636	17,593	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		33,636	6,033	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	33,636	47,757	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	33,636	13,791	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		33,636	7,777	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 134,110	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						450	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					$	$		$ 450	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 173,818	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					$	$		$ 173,818	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 16,150	1
2	39	Ancillary	Direct Allocation						154,715	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					$	$		$ 170,865	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank Leumi		X	Mortgage			$	$ 16,692,967			$ 648,336	1
2	Trilogy		X	Note Payable				2,000,000			81,250	2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				870,472			22,758	6
7	Dell		X	Note Payable				25,667				7
8	See Supplemental Schedule										145,839	8
9	TOTAL Facility Related						$	$ 19,589,106			$ 898,183	9
	B. Non-Facility Related*											
10	Interest Income		X								(474)	10
11	Allocated - EC Consulting	X									6,214	11
12	Allocated - EC Clinical	X									146	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 5,886	14
15	TOTALS (line 9+line14)						$	$ 19,589,106			$ 904,069	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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	First Bank		X				$	$			$ 145,839	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										145,839	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 Rehab Villas **#** 0052779 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 227,989	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.)		$ 236,516	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,527	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 244,734	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.		$ 253,261	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2010	8
	2011	9
	2012	10
	2013 217,132	11
	2014 233,080	12

The difference in the amount above on line 7 and line 33 on page 4 is the RE tax allocated to the assisted living portion of building.

2015 Accrual = $233,080 x 1.05 = $244,734

Allocated - Extended Care Consulting - $3,114

Allocated - Extended Care Clinical - $322

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Rehab 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 2014 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 2014.

	(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	$ 204,029.46	$ 153,022.10
2.	23-15-02-400-023-0000	Long Term Care Property	$ 29,050.30	$ 21,787.73
3.	See Attached	Allocated from 2201 W. Main	$ 165,913.23	$ 3,259.82
4.	See Attached	Allocated from 502 Main Street	$ 3,814.66	$ 96.75
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 402,807.65	$ 178,166.39

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Rehab 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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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			16,111	2
3	TOTALS			$ 246,801	3

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,054,970	35	$ 359,061	$ (695,909)	$ 919,160	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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		67,854	913		913		49,329	68
69	Financial Statement Depreciation			15,645			(15,645)		69
70	TOTAL (lines 4 thru 69)		$ 12,635,000	$ 1,071,528		$ 359,974	$ (711,554)	$ 968,489	70

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 12,635,000	$ 1,071,528		$ 359,974	$ (711,554)	$ 968,489	1
2	Repaired Shingles, Valleys & Buckles	2014	8,500		20	425	425	744	2
3	Lobby - Replace Damaged Drywall, Patch, Prime & Paint Walls &	2014	7,745		20	387	387	613	3
4	Relocate 174 Receptables	2014	3,480		20	696	696	1,102	4
5	Installed 100 Ton Chiller	2014	87,074		20	4,354	4,354	6,531	5
6	1St Floor Shower Room - Remove Slab, Trench Plumbing Drain L	2014	8,800		20	440	440	623	6
7	Chiller Work	2014	3,807		20	190	190	270	7
8	Replaced Tda Assembly For Generator	2014	4,963		20	248	248	310	8
9	Chapel - Completed Carpentry / Taping Work, Electrical, Hvac &	2014	13,300		20	665	665	720	9
10	2Nd Floor Shower Room - Relocate Drain & Relevel Floor	2015	8,800		20	440	440	440	10
11	Front Lobby Demolition/Reconstruction Into Chapel/Library- Plu	2015	28,700		20	1,435	1,435	1,435	11
12	2 Auto Door Openers	2015	6,356		20	106	106	106	12
13	1St & 2Nd Dining Room Flooring	2015	29,950		20	499	499	499	13
14	Replace 2 Exterior Doors/Add 4 Smoke Detectors	2015	10,000		20	42	42	42	14
15	Electrical Outlet Repair/Installation 18 Rooms	2015	3,586		20	179	179	179	15
16	Repair Outlets 54 Rooms, Fix Holes In Drywall	2015	11,000		20	550	550	550	16
17	Amenity Mall- Beauty Salon, Barber Shop, Library, Gift Shop, Mc	2015	456,321		20	22,816	22,816	22,816	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)		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	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)		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	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)		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	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
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18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,327,381	$ 1,071,528		$ 393,447	$ (678,081)	$ 1,005,469	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	20,058	514	39	514		6,836	3
4									4
5	Allocated from Extended Care Clinical, LLC	2002	2,144	55	39	55		731	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	117	6	20	6		53	9
10	Allocated from Extended Care Consulting, LLC	2009	70	3	20	3		25	10
11	Allocated from Extended Care Consulting, LLC	2010	684	34	20	34		205	11
12	Allocated from Extended Care Consulting, LLC	2011	246	12	20	12		62	12
13	Allocated from Extended Care Consulting, LLC	2012	81	4	20	4		16	13
14	Allocated from Extended Care Consulting, LLC	2014	1,125	56	20	56		113	14
15									15
16	Allocated from 2201 W. Main, LLC	2002	16,569		20			16,569	16
17	Allocated from 2201 W. Main, LLC	2003	19,526		20			19,526	17
18	Allocated from 2201 W. Main, LLC	2005	970	103	20	103		968	18
19	Allocated from 2201 W. Main, LLC	2009	175	9	20	9		61	19
20	Allocated from 2201 W. Main, LLC	2014	1,628	81	20	81		163	20
21	Allocated from 2201 W. Main, LLC	2015	276	14	20	14		14	21
22									22
23	Allocated from Extended Care Clinical, LLC	2002	1,771		20			1,771	23
24	Allocated from Extended Care Clinical, LLC	2003	2,087		20			2,087	24
25	Allocated from Extended Care Clinical, LLC	2005	104	11	20	11		104	25
26	Allocated from Extended Care Clinical, LLC	2009	19	1	20	1		7	26
27	Allocated from Extended Care Clinical, LLC	2014	174	9	20	9		17	27
28	Allocated from Extended Care Clinical, LLC	2015	30	1	20	1		1	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 67,854	$ 913		$ 913	$	$ 49,329	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 67,854	$ 913		$ 913	$	$ 49,329	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 67,854	$ 913		$ 913	$	$ 49,329	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,277,240	$ 500	$ 136,367	$ 135,867	10	$ 263,814	71
72	Current Year Purchases	29,545	78	4,191	4,113	10	4,191	72
73	Fully Depreciated Assets	78,040				10	78,040	73
74								74
75	TOTALS	$ 1,384,825	$ 578	$ 140,559	$ 139,981		$ 346,046	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from EC Consulting, LL	2015	$ 4,577	$ 129	$ 129	$	5	$ 4,189	76
77		Allocated from EC Clinical, LLC	2012	2,176	435	435		5	1,513	77
78										78
79										79
80	TOTALS			$ 6,753	$ 564	$ 564	$		$ 5,702	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)	$ 14,965,760	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,072,670	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 534,569	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (538,101)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,357,217	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	Amenity Mall- Assisted Living Portion -	164,296			89
90					90
91	TOTALS	$ 7,929,268	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [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:				$			3
4	Additions							4
5	Storage Rental				1,294			5
6								6
7	TOTAL				$ 1,294 **			7

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.	/2016	$
13.	/2017	$
14.	/2018	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 1,061 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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs		$		$ 557,406	$		$ 557,406	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				142,973			142,973	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				516,115			516,115	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					496,284		496,284	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						450	63,212		63,662	13
14	TOTAL				$		$ 1,216,944	$ 559,496		$ 1,776,440	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 Rehab Villas **#** 0052779 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 2,300	$ 49,562	1
2	Cash-Patient Deposits	11,536	11,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,339,963	2,584,697	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,196	55,196	6
7	Other Prepaid Expenses	14,279	14,279	7
8	Accounts Receivable (owners or related parties)	204,538		8
9	Other(specify):	613,850	613,850	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,241,662	$ 3,329,120	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		20,858,899	14
15	Leasehold Improvements, at Historical Cost	228,376	848,994	15
16	Equipment, at Historical Cost	14,030	1,870,038	16
17	Accumulated Depreciation (book methods)	(30,126)	(2,158,286)	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):	3,703	57,766	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 215,983	$ 21,837,193	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,457,645	$ 25,166,313	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 523,358	$ 523,359	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,124	7,124	28
29	Short-Term Notes Payable	425,667	896,139	29
30	Accrued Salaries Payable	154,230	154,230	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,389	5,389	31
32	Accrued Real Estate Taxes(Sch.IX-B)		244,734	32
33	Accrued Interest Payable	244,734	306,615	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	561,630	4,412,630	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,922,132	$ 6,550,220	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,000,000	39
40	Mortgage Payable		16,692,967	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 18,692,967	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,922,132	$ 25,243,187	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,535,513	$ (76,874)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,457,645	$ 25,166,313	48

***(See instructions.)**

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 548,064	1
2	Restatements (describe):		2
3	Rounding	(5)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 548,059	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	987,454	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)**	$ 987,454	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,535,513	24 *

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,484,335	1
2	Discounts and Allowances for all Levels	(6,416,722)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,067,613	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,861,695	6
7	Oxygen	1,155	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,862,850	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	17,103	13
14	Non-Patient Meals	1,575	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	150	16
17	Sale of Drugs	572,361	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,922	19
20	Radiology and X-Ray	7,515	20
21	Other Medical Services	(87,813)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 540,813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	474	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 474	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,611,293	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,611,293	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,083,043	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,284,112	31
32	Health Care	2,938,665	32
33	General Administration	2,385,785	33
	B. Capital Expense		
34	Ownership	1,352,377	34
	C. Ancillary Expense		
35	Special Cost Centers	4,021,700	35
36	Provider Participation Fee	112,950	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,095,589	40
41	**Income before Income Taxes (line 30 minus line 40)****	987,454	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 987,454	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,185,941	44
45	Private Pay - Net Inpatient Revenue	1,347,514	45
46	Medicare - Net Inpatient Revenue	82,138	46
47	Other-(specify) Hospice	419,839	47
48	Other-(specify) Insurance	32,181	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,067,613	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	1,668	1,909	$ 76,882	$ 40.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,384	13,803	428,160	31.02	3
4	Licensed Practical Nurses	27,440	30,211	757,698	25.08	4
5	CNAs & Orderlies	58,986	65,249	766,388	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,475	7,164	143,621	20.05	8
9	Activity Director	1,182	1,371	30,068	21.93	9
10	Activity Assistants	7,729	8,801	99,977	11.36	10
11	Social Service Workers	6,918	7,681	168,668	21.96	11
12	Dietician					12
13	Food Service Supervisor	2,520	2,834	58,825	20.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,343	8,240	103,509	12.56	15
16	Dishwashers	12,512	13,869	145,388	10.48	16
17	Maintenance Workers	4,559	5,069	99,976	19.72	17
18	Housekeepers	11,241	12,101	127,956	10.57	18
19	Laundry	6,556	7,188	68,183	9.49	19
20	Administrator	471	492	22,226	45.17	20
21	Assistant Administrator	1,897	2,939	73,405	24.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,396	8,257	132,386	16.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,509	2,740	70,393	25.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,894	2,113	30,060	14.22	33
34	TOTAL (lines 1 - 33)	181,680	202,031	$ 3,403,769 *	$ 16.85	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	726	$ 15,004	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,668	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	466	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	733	$ 50,138		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	$ 22,225
Kimberly Steele	Assistant Admin	0	73,405
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,630

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
See Attached	Legal	$ 3,453
Ext. Care Consulting	Home Office Expense	256,710
Ext. Care Clinical	Home Office Expense	128,760
Personnel Planners	Unemployment Consulting	2,273
Frost/Marcum	Accounting	17,053
Paycor	Payroll Services	24,656
Ability Network	Medicare Billing	2,649
AIS Assessment & Intelligence	MDS Consultant	1,319
National Data Care Corporation	Resident Fund Processing	919
Legat Architechs	Architecture Consultant	1,580
Pinnacle Quality Insight	Customer Satisfaction	2,461
See Supplemental Schedule		6,410
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 448,243

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,893
Unemployment Compensation Insurance	107,447
FICA Taxes	260,389
Employee Health Insurance	88,590
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	9,009
Other Employee Welfare	7,798
Holiday Expense	2,216
TOTAL (agree to Schedule V, line 22, col.8)	$ 575,342

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	2,069
Health Care Worker Background Check	2,222
(Indicate # of checks performed 208)	
Patient Background Checks	
Dues and Subscriptions	10,870
Licenses and Permits	4,259
Allocated - Ext. Care Consulting	698
Allocated - Ext. Care Clinical	125
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,244

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,925
Allocated - Ext. Care Consulting	240
Allocated - Ext. Care Clinical	788
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,953

**See instructions.

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St James Wellness Rehab Villas **#** 0052779 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $19,405**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,660** 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. $ **112,950**
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. $ **1,575**

(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.