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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0052779

Facility Name: St James Wellness Reh Villas

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

County: Will

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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 Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	40,260	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	40,260	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	17,226	2,409	11,832	31,467	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,226	2,409	11,832	31,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.16%

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 8,735

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	325,937	38,841	15,160	379,938		379,938	6,312	386,250			1
2	Food Purchase		245,051		245,051		245,051	(1,460)	243,591			2
3	Housekeeping	136,781	41,942	2,049	180,772		180,772	727	181,499			3
4	Laundry	71,045	21,951		92,996		92,996		92,996			4
5	Heat and Other Utilities			128,293	128,293		128,293	1,006	129,299			5
6	Maintenance	86,261		117,585	203,846		203,846	4,971	208,817			6
7	Other (specify):*							2,523	2,523			7
8	TOTAL General Services	620,024	347,785	263,087	1,230,896		1,230,896	14,079	1,244,975			8
	B. Health Care and Programs											
9	Medical Director			80,550	80,550		80,550		80,550			9
10	Nursing and Medical Records	2,217,114	251,387	6,621	2,475,122		2,475,122	22,620	2,497,742			10
10a	Therapy	134,592		263	134,855		134,855		134,855			10a
11	Activities	139,724	38,991	34	178,749		178,749		178,749			11
12	Social Services	178,084			178,084		178,084	14,995	193,079			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,631	5,631			15
16	TOTAL Health Care and Programs	2,669,514	290,378	87,468	3,047,360		3,047,360	43,246	3,090,606			16
	C. General Administration											
17	Administrative	96,122			96,122		96,122	62,983	159,105			17
18	Directors Fees											18
19	Professional Services			457,824	457,824	(6,650)	451,174	(385,500)	65,673			19
20	Dues, Fees, Subscriptions & Promotions			45,157	45,157		45,157	(20,154)	25,003			20
21	Clerical & General Office Expenses	155,556	27,031	524,782	707,369		707,369	(376,515)	330,854			21
22	Employee Benefits & Payroll Taxes			660,470	660,470		660,470	(8,122)	652,348			22
23	Inservice Training & Education											23
24	Travel and Seminar			772	772		772	569	1,341			24
25	Other Admin. Staff Transportation			6,543	6,543		6,543	662	7,205			25
26	Insurance-Prop.Liab.Malpractice			96,424	96,424		96,424	1,538	97,962			26
27	Other (specify):*							25,529	25,529			27
28	TOTAL General Administration	251,678	27,031	1,791,972	2,070,681	(6,650)	2,064,031	(699,010)	1,365,020			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,541,216	665,194	2,142,527	6,348,937	(6,650)	6,342,287	(641,686)	5,700,601			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St James Wellness Reh Villas #0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			32,979	32,979		32,979	515,027	548,006			30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400	(1,400)				31
32	Interest			6,357	6,357		6,357	847,219	853,576			32
33	Real Estate Taxes			283,677	283,677	6,650	290,327	2,961	293,288			33
34	Rent-Facility & Grounds			1,126,266	1,126,266		1,126,266	(1,125,000)	1,266			34
35	Rent-Equipment & Vehicles			733	733		733	626	1,359			35
36	Other (specify):*											36
37	TOTAL Ownership			1,451,412	1,451,412	6,650	1,458,062	239,433	1,697,495			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		452,967	1,033,362	1,486,329		1,486,329	(26,577)	1,459,752			39
40	Barber and Beauty Shops			3,461	3,461		3,461		3,461			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,914	196,914		196,914		196,914			42
43	Other (specify):*			2,390,808	2,390,808		2,390,808	(2,390,808)	(0)			43
44	TOTAL Special Cost Centers		452,967	3,624,545	4,077,512		4,077,512	(2,417,386)	1,660,126			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,541,216	1,118,161	7,218,484	11,877,861		11,877,861	(2,819,638)	9,058,223			45

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(1,530)	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	(362,303)	30		9
10	Interest and Other Investment Income	(116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(185)	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	(931)	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	(450,027)	21		24
25	Fund Raising, Advertising and Promotional	(13,792)	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	(2,432,501)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,261,385)		$	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)	441,747		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 441,747		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,819,638)		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 Reh Villas

ID# 0052779

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rental Income	$ (75)	06	1
2	Patient Clothing	(868)	10	2
3	Theft Loss	(408)	21	3
4	Collection Expense	(8,344)	21	4
5	Assisted Living Expenses	(2,372,975)	43	5
6	Amortization	(1,400)	31	6
7	PAC Dues	(4,765)	20	7
8	Annual Report	(250)	20	8
9	Non-allowable Professional Fees	(17,833)	43	9
10	Lobbying	(1,660)	20	10
11	Non-allowable Legal	(4,318)	19	11
12	Building Company - Management Fee	(4,809)	17	12
13	Building Company - Miscellaneous Expense	(188)	21	13
14	Building Company - Bank Charges	(222)	21	14
15	Building Company - Amortization Expense	(11,531)	36	15
16	Capitalized R&M	(2,764)	06	16
17	Chamber of Commerce Dues	(90)	20	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,432,501)		49

St James Wellness Reh Villas

ID# 0052779

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			119				6,193					6,312	1
2	Food Purchase	(1,715)		255									(1,460)	2
3	Housekeeping			656				71					727	3
4	Laundry													4
5	Heat and Other Utilities			915				91					1,006	5
6	Maintenance	(2,839)		1,913	5,730			167					4,971	6
7	Other (specify):*				1,668			855					2,523	7
8	**TOTAL General Services**	(4,554)		3,858	7,398			7,377					14,079	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(868)				(2,275)		25,763					22,620	10
10a	Therapy													10a
11	Activities													11
12	Social Services							14,995					14,995	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*							5,631					5,631	15
16	**TOTAL Health Care and Programs**	(868)				(2,275)		46,389					43,246	16
	C. General Administration													
17	Administrative	(4,809)	4,809	1,914	10,897			50,172					62,983	17
18	Directors Fees													18
19	Professional Services	(4,318)		(252,888)				(128,294)					(385,500)	19
20	Fees, Subscriptions & Promotions	(21,487)		621				712					(20,154)	20
21	Clerical & General Office Expenses	(459,190)	410	3,857	66,036			12,372					(376,515)	21
22	Employee Benefits & Payroll Taxes				(8,122)								(8,122)	22
23	Inservice Training & Education													23
24	Travel and Seminar			98				471					569	24
25	Other Admin. Staff Transportation			662									662	25
26	Insurance-Prop.Liab.Malpractice			1,146				392					1,538	26
27	Other (specify):*				17,144			8,385					25,529	27
28	**TOTAL General Administration**	(489,804)	5,219	(244,590)	85,955			(55,790)					(699,010)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(495,227)	5,219	(240,732)	93,353	(2,275)		(2,024)					(641,686)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St James Wellness Reh Villas # 0052779 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(362,303)	875,341	1,528				461					515,027	30
31	Amortization of Pre-Op. & Org.	(1,400)											(1,400)	31
32	Interest	(116)	841,655	5,547				133					847,219	32
33	Real Estate Taxes			2,672				289					2,961	33
34	Rent-Facility & Grounds		(1,125,000)										(1,125,000)	34
35	Rent-Equipment & Vehicles			626									626	35
36	Other (specify):*	(11,531)	11,531											36
37	TOTAL Ownership	(375,350)	603,527	10,373				883					239,433	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(26,577)							(26,577)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,390,808)											(2,390,808)	43
44	TOTAL Special Cost Centers	(2,390,808)				(26,577)							(2,417,386)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,261,385)	608,746	(230,359)	93,353	(28,852)		(1,141)					(2,819,638)	45

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 LLC	100.00%	$	$ (1,125,000)	1
2	V	17	Management Fee		St. James Property LLC	100.00%	4,809	4,809	2
3	V	21	Miscellaneous Expense		St. James Property LLC	100.00%	188	188	3
4	V	21	Bank Charges		St. James Property LLC	100.00%	222	222	4
5	V	30	Depreciation Expense		St. James Property LLC	100.00%	875,341	875,341	5
6	V	36	Amortization Expense		St. James Property LLC	100.00%	11,531	11,531	6
7	V	32	Interest Expense - Leumi		St. James Property LLC	100.00%	627,336	627,336	7
8	V	32	Interest Expense - Capex		St. James Property LLC	100.00%	15,794	15,794	8
9	V	32	Interest Expense - Trilogy		St. James Property LLC	100.00%	75,000	75,000	9
10	V	32	Interest Expense - First Bank		St. James Property LLC	100.00%	123,525	123,525	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,125,000			$ 1,733,746	$ * 608,746	14

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 119	$ 119	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	255	255	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	656	656	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	915	915	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,913	1,913	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,914	1,914	20
21	V	19	Professional Fees	256,710	Extended Care Consulting, LLC	100.00%	3,822	(252,888)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	621	621	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	3,857	3,857	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	98	98	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	662	662	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,146	1,146	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,528	1,528	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	5,547	5,547	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,672	2,672	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	626	626	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			$ 26,351	$ * (230,359)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	5,730	$ 5,730	15
16	V	06	Maintenance (Direct)	9,847	Extended Care Consulting, LLC	100.00%	9,847		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	537	537	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,131	1,131	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	10,897	10,897	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	66,036	66,036	22
23	V	21	Office and Clerical (Direct)	10,813	Extended Care Consulting, LLC	100.00%	10,813		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	14,071	14,071	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,073	3,073	25
26	V	22	Employee Benefits	8,122	Extended Care Consulting, LLC	100.00%		(8,122)	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			$ 28,782			$ 122,135	$ * 93,353	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 31,587	MAC Rx, LLC	100.00%	$ 29,312	$ (2,275)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	369,021	MAC Rx, LLC	100.00%	342,444	(26,577)	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			$ 400,609			$ 371,757	$ * (28,852)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 288,401	$ 288,401	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	288,401	CCS Employee Benefits Group	100.00%		(288,401)	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			$ 288,401			$ 288,401	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 71	$ 71	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	91	91	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	167	167	17
18	V	19	Professional Fees	128,760	Extended Care Clinical, LLC	100.00%	466	(128,294)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	712	712	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,851	1,851	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	471	471	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	392	392	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	461	461	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	133	133	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	289	289	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	6,193	6,193	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	855	855	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	25,763	25,763	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	14,995	14,995	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,631	5,631	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	50,172	50,172	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	10,521	10,521	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	8,385	8,385	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,760			$ 127,619	$ * (1,141)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 COMPANY	4
5	DANIEL ROTHNER ACCUM TRUST	9.00%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	KIMBERLY VALES ACCUM TRUST	9.00%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	RACHEL ROTHNER ACCUM TRUST	9.00%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	KATHRYN VALES ACCUM TRUST	9.00%	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9	WILLIAM ROTHNER ACCUM TRUST	9.00%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10	N & S ROTHNER TRUST	8.50%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			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 Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Adam Vales	Relative	Clerical	0%	See Attached	1.46	3.66%	Alloc Salary	$ 2,687	22-7	1
2	Mark Steinberg	Relative	Administrative	0%	See Attached	2.98	5.42%	Mgmt Fee/Salary	10,790	17-7	2
3	Kimberly Rudolph	Relative	Clerical	0%	See Attached	0.17	2.28%	Alloc Salary	53	21-7	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	$ 13,530		13

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,380,761	34	$ 5,206	$	31,467	$ 119	1
2	02	Food	Patient Days	1,380,761	34	11,203		31,467	255	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		31,467	656	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		31,467	915	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		31,467	1,913	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		31,467	1,914	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		31,467	3,822	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		31,467	621	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		31,467	3,857	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		31,467	98	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		31,467	662	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		31,467	1,146	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		31,467	1,528	13
14	32	Interest	Patient Days	1,380,761	34	243,379		31,467	5,547	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		31,467	2,672	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		31,467	626	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 26,351	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,380,761	34	251,431	251,431	31,467	5,730	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		9,847	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		31,467	537	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			1,131	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	31,467	10,897	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	31,467	66,036	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		10,813	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		31,467	14,071	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			3,073	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					$ 5,222,483	$ 4,461,323		$ 122,135	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 29,312	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						342,444	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					$	$		$ 371,757	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 288,401	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					$	$		$ 288,401	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	818,091	19	$ 1,844	$	31,467	$ 71	1
2	05	Utilities	Patient Days	818,091	19	2,355		31,467	91	2
3	06	Maintenance	Patient Days	818,091	19	4,352		31,467	167	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		31,467	466	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		31,467	712	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		31,467	1,851	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		31,467	471	7
8	26	Insurance	Patient Days	818,091	19	10,196		31,467	392	8
9	30	Depreciation	Patient Days	818,091	19	11,978		31,467	461	9
10	32	Interest	Patient Days	818,091	19	3,446		31,467	133	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		31,467	289	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	31,467	6,193	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		31,467	855	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	31,467	25,763	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	31,467	14,995	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		31,467	5,631	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	31,467	50,172	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	31,467	10,521	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		31,467	8,385	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 127,619	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage			$	$ 16,322,917			$ 627,336	1
2	First Bank		X	Note Payable				3,600,000			123,525	2
3	Trilogy		X	Note Payable				2,000,000			75,000	3
4												4
5					-							5
	Working Capital											
6	Bank Leumi		X	LOC				100,000			6,357	6
7	Bank Leumi		X	Capex				378,890			15,794	7
8					-							8
9	TOTAL Facility Related						$	$ 22,401,807			$ 848,012	9
	B. Non-Facility Related*											
10	Interest Income		X								(116)	10
11	Allocated - EC Consulting	X									5,547	11
12	Allocated - EC Clinical	X									133	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ 5,564	14
15	TOTALS (line 9+line14)						$	$ 22,401,807			$ 853,576	15

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St James Wellness Reh Villas **#** 0052779 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 244,734	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.)		$ 234,173	2
3. Under or (over) accrual (line 2 minus line 1).		$ (10,561)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 391,759	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.**		$ 6,650	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.		$ 387,848	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	217,132	10
2014	233,080	11
2015	231,212	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 the building
Allocated - Extended Care Consulting, LLC - $2,672
Allocated - Extended Care Clinical, LLC - $289

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

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Reh Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) 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	$ 202,394.42	$ 151,795.82
2.	23-15-02-400-023-0000	Long Term Care Property	$ 28,817.50	$ 21,613.13
3.	See Attached	Allocated - Extended Care Consulting	$ 167,518.13	$ 2,671.71
4.	See Attached	Allocated - Extended Care Clinical	$ 167,518.13	$ 288.72
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 566,248.18	$ 176,369.38

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Reh Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Allocated - Care Centers Building, LLC			14,491	2
3	TOTALS			$ 245,181	3

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 875,341	35	$ 359,061	$ (516,280)	$ 1,278,221	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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)		68,800	958		958		46,357	68
69	Financial Statement Depreciation			32,979			(32,979)		69
70	TOTAL (lines 4 thru 69)		$ 12,635,946	$ 909,278		$ 360,019	$ (549,259)	$ 1,324,578	70

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 12,635,946	$ 909,278		$ 360,019	$ (549,259)	$ 1,324,578	1
2	Repaired Shingles, Valleys & Buckles	2014	8,500		20	425	425	1,169	2
3	Lobby - Replace Damaged Drywall, Patch, Prime & Paint Walls &	2014	7,745		20	387	387	1,000	3
4	Relocate 174 Receptables	2014	3,480		20	696	696	1,798	4
5	Installed 100 Ton Chiller	2014	87,074		20	4,354	4,354	10,884	5
6	1St Floor Shower Room - Remove Slab, Trench Plumbing Drain L	2014	8,800		20	440	440	1,063	6
7	Chiller Work	2014	3,807		20	190	190	460	7
8	Replaced Tda Assembly For Generator	2014	4,963		20	248	248	558	8
9	Chapel - Completed Carpentry / Taping Work, Electrical, Hvac &	2014	13,300		20	665	665	1,385	9
10	2Nd Floor Shower Room - Relocate Drain & Relevel Floor	2015	8,800		20	440	440	880	10
11	Chapel - Millwork, Stained Glass, 8 Sconces, Hvac, Plumbing	2015	28,700		20	1,435	1,435	2,870	11
12	2 Auto Door Openers	2015	6,356		20	318	318	424	12
13	1St & 2Nd Dining Room Flooring	2015	29,950		20	5,990	5,990	6,489	13
14	2 Exit Doors	2015	10,000		20	500	500	542	14
15	Amenity Mall-Barber & Beauty Shops, Library, Gift Shop, Media	2015	456,321		20	22,816	22,816	28,520	15
16	Electrical Outlet Repair/Installation - 18 Rooms	2015	3,586		20	179	179	359	16
17	Repair Outlets In 54 Rooms, Fix Holes In Drywall	2015	11,000		20	550	550	1,100	17
18	Separation Wall	2016	37,500		20	1,875	1,875	1,875	18
19	Relocate Circuits - Generator Critical Panel	2016	12,500		20	573	573	573	19
20	1St & 2Nd Dining Room Flooring	2016	18,200		20	1,244	1,244	1,244	20
21	Beauty Shop Renovation - Flooring & Electrical	2016	7,930		20	330	330	330	21
22	Electrical Panel Work	2016	5,588		20	210	210	210	22
23	Water Heater	2016	19,626		20	818	818	818	23
24	Fixed Leak In Attic (Room 1102)	2016	2,674		20	134	134	134	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)		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	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
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17									17
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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)		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	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)		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	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)		$ 13,432,345	$ 909,278		$ 404,836	$ (504,442)	$ 1,389,263	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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 - Extended Care Consulting - Dyer	2007	5,470	121	39	121		1,151	3
4	Allocated - Consulting Care Centers Building, LLC	2002	18,022	462	39	462		6,604	4
5	Allocated - Extended Care Clinical	2002	1,948	50	39	50		714	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Extended Care Consulting, LLC	2007	105	5	20	5		52	9
10	Allocated - Extended Care Consulting, LLC	2009	63	3	20	3		25	10
11	Allocated - Extended Care Consulting, LLC	2010	615	31	20	31		215	11
12	Allocated - Extended Care Consulting, LLC	2011	221	11	20	11		66	12
13	Allocated - Extended Care Consulting, LLC	2012	73	4	20	4		18	13
14	Allocated - Extended Care Consulting, LLC	2014	1,011	51	20	51		152	14
15	Allocated - Extended Care Consulting, LLC	2016	1,212	61	20	61		61	15
16									16
17	Allocated - Consulting Care Centers Building, LLC	2002	14,888		20			14,888	17
18	Allocated - Consulting Care Centers Building, LLC	2003	17,545		20			17,545	18
19	Allocated - Consulting Care Centers Building, LLC	2005	872	2	20	2		872	19
20	Allocated - Consulting Care Centers Building, LLC	2009	157	8	20	8		63	20
21	Allocated - Consulting Care Centers Building, LLC	2014	1,463	73	20	73		219	21
22	Allocated - Consulting Care Centers Building, LLC	2015	248	12	20	12		25	22
23	Allocated - Consulting Care Centers Building, LLC	2016	980	49	20	49		49	23
24									24
25	Allocated - Extended Care Clinical, LLC	2002	1,609		20			1,609	25
26	Allocated - Extended Care Clinical, LLC	2003	1,896		20			1,896	26
27	Allocated - Extended Care Clinical, LLC	2005	94		20			94	27
28	Allocated - Extended Care Clinical, LLC	2009	17	1	20	1		7	28
29	Allocated - Extended Care Clinical, LLC	2014	158	8	20	8		24	29
30	Allocated - Extended Care Clinical, LLC	2015	27	1	20	1		3	30
31	Allocated - Extended Care Clinical, LLC	2016	106	5	20	5		5	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 68,800	$ 958		$ 958	$	$ 46,357	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 68,800	$ 958		$ 958	$	$ 46,357	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 68,800	$ 958		$ 958	$	$ 46,357	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 1,306,199	$ 519	$ 142,139	$ 141,620	10	$ 409,903	71
72	Current Year Purchases	6,528		519	519	10	519	72
73	Fully Depreciated Assets	70,126				10	70,126	73
74								74
75	TOTALS	$ 1,382,853	$ 519	$ 142,658	$ 142,139		$ 480,548	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 - EC Consulting, LLC	2016	$ 4,113	$ 116	$ 116	$	5	$ 3,880	76
77		Allocated - EC Clinical, LLC	2016	1,976	395	395		5	1,770	77
78										78
79										79
80	TOTALS			$ 6,089	$ 511	$ 511	$		$ 5,650	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)	$ 15,066,469	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 910,308	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 548,005	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (362,303)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,875,461	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 - 2014	$ 127,928	$	$	86
87	Building - 2014 - 2014	6,972,854			87
88	Furniture and Fixtures - 2014 - 2014	664,190			88
89	Amenity Mall - Assisted Living Portion - 2	164,296			89
90					90
91	TOTALS	$ 7,929,268	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Boiler	$ 72,665	92
93			93
94			94
95		$ 72,665	95

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off Site Storage Rental				1,266			5
6								6
7	TOTAL				$ 1,266 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 1,359 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 444,365	$		$ 444,365	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			137,720			137,720	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			450,455			450,455	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			202			202	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				368,505		368,505	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					620	84,462		85,082	13
14	TOTAL			$		$ 1,033,362	$ 452,967		$ 1,486,329	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.

Facility Name & ID Number St James Wellness Reh Villas **#** 0052779 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 5,313	$ 70,816	1
2	Cash-Patient Deposits	9,806	9,806	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,424,143	2,424,143	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,871	60,871	6
7	Other Prepaid Expenses	18,412	18,412	7
8	Accounts Receivable (owners or related parties)	317,491		8
9	Other(specify): See Attached Schedule	979,588	979,588	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,815,624	$ 3,563,636	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	344,695	965,313	15
16	Equipment, at Historical Cost	20,558	1,876,566	16
17	Accumulated Depreciation (book methods)	(73,924)	(3,369,205)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	76,612	115,300	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 367,941	$ 20,806,655	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,183,565	$ 24,370,291	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 622,983	$ 622,984	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,265	6,265	28
29	Short-Term Notes Payable	100,000	478,890	29
30	Accrued Salaries Payable	200,796	200,796	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,279	7,279	31
32	Accrued Real Estate Taxes(Sch.IX-B)	391,759	391,759	32
33	Accrued Interest Payable		57,966	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	972,674	1,223,674	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,301,756	$ 2,989,613	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,600,000	39
40	Mortgage Payable		16,322,917	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 21,922,917	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,301,756	$ 24,912,530	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,881,809	$ (542,239)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,183,565	$ 24,370,291	48

***(See instructions.)**

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,535,513	1
2	Restatements (describe):		2
3	Rounding	10	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,535,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	346,286	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)**	$ 346,286	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)**	$ 1,881,809	24 *

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 9,487,187	1
2	Discounts and Allowances for all Levels	(5,412,077)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,075,110	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,869,305	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,869,305	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	3,801	13
14	Non-Patient Meals	1,530	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	75	16
17	Sale of Drugs	378,242	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,287	19
20	Radiology and X-Ray	9,295	20
21	Other Medical Services	91,644	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 513,874	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	116	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 116	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,765,742	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,765,742	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,224,147	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,230,896	31
32	Health Care	3,047,360	32
33	General Administration	2,070,681	33
	B. Capital Expense		
34	Ownership	1,451,412	34
	C. Ancillary Expense		
35	Special Cost Centers	3,880,598	35
36	Provider Participation Fee	196,914	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,877,861	40
41	**Income before Income Taxes (line 30 minus line 40)****	346,286	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 346,286	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,836,568	44
45	Private Pay - Net Inpatient Revenue	735,015	45
46	Medicare - Net Inpatient Revenue	257,226	46
47	Other-(specify) Hospice	268,506	47
48	Other-(specify) Insurance	(22,205)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,075,110	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.**

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,816	2,375	$ 97,901	$ 41.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,322	13,573	433,795	31.96	3
4	Licensed Practical Nurses	27,489	30,238	805,758	26.65	4
5	CNAs & Orderlies	60,901	67,041	818,062	12.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,327	6,938	134,592	19.40	8
9	Activity Director	1,199	1,402	30,665	21.87	9
10	Activity Assistants	8,550	9,554	109,059	11.42	10
11	Social Service Workers	6,944	7,593	178,084	23.45	11
12	Dietician					12
13	Food Service Supervisor	2,629	2,979	63,433	21.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,474	8,470	107,847	12.73	15
16	Dishwashers	13,047	14,339	154,657	10.79	16
17	Maintenance Workers	4,098	4,415	86,261	19.54	17
18	Housekeepers	11,830	12,679	136,781	10.79	18
19	Laundry	6,714	7,262	71,045	9.78	19
20	Administrator	525	544	25,159	46.25	20
21	Assistant Administrator	1,959	2,703	70,963	26.25	21
22	Other Administrative					22
23	Office Manager	1,046	1,164	26,784	23.01	23
24	Clerical	6,539	7,172	128,772	17.95	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	2,015	2,232	34,234	15.34	31
32	Other Health Care(specify)					32
33	Other(specify)	1,688	1,905	27,363	14.36	33
34	TOTAL (lines 1 - 33)	185,112	204,578	$ 3,541,215 *	$ 17.31	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	417	$ 15,160	01-03	35
36	Medical Director	Monthly	80,550	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,621	10-03	39
40	Physical Therapy Consultant	1	79	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	184	10a-03	43
44	Activity Consultant	1	34	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	421	$ 102,628		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	$ 25,159
Kimberly Steele	Assistant Admin	0	70,963
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,122

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
Paycor	Payroll Services	$ 30,386
Ability Network	Medicare Billing	3,107
National Datacare Corporation	Resident Fund Processing	824
ECC Consulting	Home Office Expense	256,710
ECC Clinical	Home Office Expense	128,760
Marcum	Accounting	15,173
Legal	See Attached	6,847
Personnel Planners	Unemployment Tax	1,257
Blymas	Tax Credit Services	5,479
Navex Global	Compliance Software	102
Legat Architects	Architecture Consultant	720
See Supplemental Schedule		8,461
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 457,825

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,443
Unemployment Compensation Insurance	118,942
FICA Taxes	270,903
Employee Health Insurance	155,997
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,729
Other Employee Welfare	7,461
Holiday Expense	1,873
TOTAL (agree to Schedule V, line 22, col.8)	$ 652,349

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,749
Health Care Worker Background Check	2,263
(Indicate # of checks performed 306)	
Patient Background Checks	
Dues & Subscriptions	8,786
Licenses & Fees	5,872
Allocated - Extended Care Consulting	621
Allocated - Extended Care Clinical	712
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,002

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	773
Allocated - Extended Care Consulting	98
Allocated - Extended Care Clinical	471
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,342

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $14,438**

(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. $ **47,358** 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. $ **196,914**
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. $ **1,530**

(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