FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0052779

Facility Name: St James Wellness Rehab Villas

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

County: Will

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,419	4,335	9,030	33,784	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,419	4,335	9,030	33,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.14%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 04/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 110 and days of care provided 7,318

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: 12/31/18 Fiscal Year: 12/31/18

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

STATE OF ILLINOIS

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	317,077	41,375	21,144	379,596		379,596	8,422	388,018			1
2	Food Purchase		241,877		241,877		241,877	(366)	241,511			2
3	Housekeeping	154,276	41,285	2,240	197,801		197,801	804	198,605			3
4	Laundry	36,976	17,976		54,952		54,952		54,952			4
5	Heat and Other Utilities			155,580	155,580		155,580	1,189	156,769			5
6	Maintenance	117,733		209,526	327,259		327,259	(15,270)	311,989			6
7	Other (specify):*							6,489	6,489			7
8	**TOTAL General Services**	626,062	342,513	388,490	1,357,065		1,357,065	1,268	1,358,333			8
	B. Health Care and Programs											
9	Medical Director			23,550	23,550		23,550		23,550			9
10	Nursing and Medical Records	2,459,773	203,748	7,782	2,671,303		2,671,303	30,461	2,701,764			10
10a	Therapy	125,214		236	125,450		125,450		125,450			10a
11	Activities	156,481	46,040		202,521		202,521		202,521			11
12	Social Services	160,163			160,163		160,163	23,579	183,742			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							8,024	8,024			15
16	**TOTAL Health Care and Programs**	2,901,631	249,788	31,568	3,182,987		3,182,987	62,064	3,245,051			16
	C. General Administration											
17	Administrative	76,734			76,734		76,734	79,309	156,043			17
18	Directors Fees											18
19	Professional Services			471,330	471,330	(219)	471,111	(381,238)	89,873			19
20	Dues, Fees, Subscriptions & Promotions			76,843	76,843		76,843	(27,853)	48,990			20
21	Clerical & General Office Expenses	131,303	30,427	559,332	721,062		721,062	(408,122)	312,940			21
22	Employee Benefits & Payroll Taxes			661,051	661,051		661,051	(16,097)	644,954			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,222	1,222		1,222	849	2,071			24
25	Other Admin. Staff Transportation			5,812	5,812		5,812	658	6,470			25
26	Insurance-Prop.Liab.Malpractice			272,284	272,284		272,284	1,338	273,622			26
27	Other (specify):*							31,114	31,114			27
28	**TOTAL General Administration**	208,037	30,427	2,047,874	2,286,338	(219)	2,286,119	(720,042)	1,566,077			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,735,730	622,728	2,467,932	6,826,390	(219)	6,826,171	(656,711)	6,169,460			29

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

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

Facility Name & ID Number St James Wellness Rehab Villas #0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			73,720	73,720		73,720	510,993	584,713			30
31	Amortization of Pre-Op. & Org.			1,007	1,007		1,007	(1,007)				31
32	Interest			12,463	12,463		12,463	1,051,416	1,063,879			32
33	Real Estate Taxes			292,226	292,226	219	292,445	3,554	295,999			33
34	Rent-Facility & Grounds			1,126,416	1,126,416		1,126,416	(1,125,000)	1,416			34
35	Rent-Equipment & Vehicles			5,979	5,979		5,979	327	6,306			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,511,811	1,511,811	219	1,512,030	440,283	1,952,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		354,220	966,348	1,320,568		1,320,568	(23,954)	1,296,614			39
40	Barber and Beauty Shops			60	60		60		60			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			207,343	207,343		207,343		207,343			42
43	Other (specify):*			2,566,421	2,566,421		2,566,421	(2,566,421)				43
44	**TOTAL Special Cost Centers**		354,220	3,740,172	4,094,392		4,094,392	(2,590,375)	1,504,017			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,735,730	976,948	7,719,915	12,432,593		12,432,593	(2,806,803)	9,625,790			45

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(325)	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	(722,123)	30		9
10	Interest and Other Investment Income	(12,105)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(307)	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	(1,222)	21		18
19	Entertainment				19
20	Contributions	(715)	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	(450,048)	21		24
25	Fund Raising, Advertising and Promotional	(21,812)	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	(2,690,450)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,899,107)		$	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)	1,092,304		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,092,304		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,806,803)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St James Wellness Rehab Villas

ID# **0052779**

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (290)	10	1
2	Theft Loss	(1,433)	21	2
3	Collection Expense	(61,644)	21	3
4	Amortization	(1,007)	31	4
5	Assisted Living Expenses	(2,563,571)	43	5
6	Capitalized R&M	(24,186)	06	6
7	Building Company - Management Fees	(8,550)	19	7
8	Building Company - Administrative Expenses	(75)	21	8
9	Building Company - Bank Charges	(664)	21	9
10	Building Company - Amortization	(18,653)	36	10
11	PAC Dues	(7,374)	20	11
12	Referrals	(2,850)	43	12
13	Non Allowable Legal	(153)	19	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
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**	(2,690,450)		49

St James Wellness Rehab Villas

ID# 0052779

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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			131		8,291							8,422	1
2	Food Purchase	(632)		266									(366)	2
3	Housekeeping			712		92							804	3
4	Laundry													4
5	Heat and Other Utilities			1,064		125							1,189	5
6	Maintenance	(24,186)		2,850	6,021	45							(15,270)	6
7	Other (specify):*				5,325	1,164							6,489	7
8	**TOTAL General Services**	(24,818)		5,023	11,346	9,717							1,268	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(290)				33,573	(2,822)						30,461	10
10a	Therapy													10a
11	Activities													11
12	Social Services					23,579							23,579	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,024							8,024	15
16	**TOTAL Health Care and Programs**	(290)				65,176	(2,822)						62,064	16
	C. General Administration													
17	Administrative			1,021	11,725	66,563							79,309	17
18	Directors Fees													18
19	Professional Services	(8,703)	8,550	(285,176)		(95,909)							(381,238)	19
20	Fees, Subscriptions & Promotions	(29,901)		1,309		739							(27,853)	20
21	Clerical & General Office Expenses	(515,086)	739	6,717	76,778	22,736	(6)						(408,122)	21
22	Employee Benefits & Payroll Taxes				(16,097)								(16,097)	22
23	Inservice Training & Education													23
24	Travel and Seminar			248		601							849	24
25	Other Admin. Staff Transportation			658									658	25
26	Insurance-Prop.Liab.Malpractice			1,196		142							1,338	26
27	Other (specify):*				18,789	12,325							31,114	27
28	**TOTAL General Administration**	(553,690)	9,289	(274,027)	91,195	7,197	(6)						(720,042)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(578,798)	9,289	(269,004)	102,541	82,090	(2,829)						(656,711)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	(722,123)	1,231,280	1,739		97							510,993	30
31	Amortization of Pre-Op. & Org.	(1,007)											(1,007)	31
32	Interest	(12,105)	1,048,500	14,910		111							1,051,416	32
33	Real Estate Taxes			3,147		407							3,554	33
34	Rent-Facility & Grounds		(1,125,000)										(1,125,000)	34
35	Rent-Equipment & Vehicles			327									327	35
36	Other (specify):*	(18,653)	18,653											36
37	TOTAL Ownership	(753,888)	1,173,433	20,123		615							440,283	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(23,954)						(23,954)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,566,421)											(2,566,421)	43
44	TOTAL Special Cost Centers	(2,566,421)					(23,954)						(2,590,375)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,899,107)	1,182,722	(248,881)	102,541	82,705	(26,783)						(2,806,803)	45

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Rent	$ 1,125,000	St. James Property LLC		$	$ (1,125,000)	1
2	V	19	Management Fee		St. James Property LLC		8,550	8,550	2
3	V	21	Administrative Expense		St. James Property LLC		75	75	3
4	V	21	Bank Charge		St. James Property LLC		664	664	4
5	V	30	Depreciation		St. James Property LLC		1,231,280	1,231,280	5
6	V	36	Amortization		St. James Property LLC		18,653	18,653	6
7	V	33	Real Estate Tax	395,313	St. James Property LLC		395,313		7
8	V	32	Interest		St. James Property LLC		1,048,500	1,048,500	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,520,313			$ 2,703,035	$ * 1,182,722	14

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 131	$ 131	15
16	V	02	Food		Extended Care Consulting, LLC		266	266	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		712	712	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,064	1,064	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,850	2,850	19
20	V	17	Administrative		Extended Care Consulting, LLC		1,021	1,021	20
21	V	19	Professional Fees	288,900	Extended Care Consulting, LLC		3,724	(285,176)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		1,309	1,309	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		6,717	6,717	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		248	248	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		658	658	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,196	1,196	26
27	V	30	Depreciation		Extended Care Consulting, LLC		1,739	1,739	27
28	V	32	Interest		Extended Care Consulting, LLC		14,910	14,910	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		3,147	3,147	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		327	327	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			$ 288,900			$ 40,019	$ * (248,881)	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		6,021	$ 6,021	15
16	V	06	Maintenance (Direct)	39,485	Extended Care Consulting, LLC		39,485		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		522	522	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC		4,803	4,803	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC		11,725	11,725	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC		76,778	76,778	22
23	V	21	Office and Clerical (Direct)	2,838	Extended Care Consulting, LLC		2,838		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		17,698	17,698	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC		1,091	1,091	25
26	V	22	Employee Benefits	16,097	Extended Care Consulting, LLC			(16,097)	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			$ 58,420			$ 160,961	$ * 102,541	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	$ 92	$ 92	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	125	125	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	45	45	17
18	V	19	Professional Fees	96,570	Extended Care Clinical, LLC	100.00%	661	(95,909)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	739	739	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,513	1,513	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	601	601	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	142	142	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	97	97	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	111	111	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	407	407	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,291	8,291	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,164	1,164	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	33,573	33,573	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	23,579	23,579	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,024	8,024	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	66,563	66,563	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	21,223	21,223	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	12,325	12,325	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,570			$ 179,275	$ * 82,705	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	32,749	MAC Rx, LLC		29,926	(2,822)	15
16	V	21	Clerical & General Office Expenses	74	MAC Rx, LLC		68	(6)	16
17	V	39	Ancillary	277,935	MAC Rx, LLC		253,981	(23,954)	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			$ 310,757			$ 283,974	$ * (26,783)	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 320,657	$ 320,657	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	320,657	CCS Employee Benefits Group			(320,657)	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			$ 320,657			$ 320,657	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 LLC	CRETE	BUILDING COMPANY	1
2	MELISSA ROTHNER ACCUM TRUST	9.00%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	NATHAN & SHIRLEY ROTHNER ACCUM TRUST	8.50%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	B & Z GRANDCHILDREN TRUST	20.00%	GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	DANIEL ROTHNER ACCUM TRUST	9.00%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	KIMBERLY VALES ACCUM TRUST	9.00%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	RACHEL ROTHNER ACCUM TRUST	9.00%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8	KATHRYN VALES ACCUM TRUST	9.00%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				8
9	WILLIAM ROTHNER ACCUM TRUST	9.00%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10	N & S ROTHNER TRUST	8.50%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			NAPERVILLE MANOR HEALTH & REHAB CENTER	NAPERVILLE				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			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			SPRING CREEK NURSING & REHAB CENTER	JOLIET				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			THE PARC AT JOLIET	JOLIET				25
26			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				26
27			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				27
28								28
29								29
30								30

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Adam Vales	Relative	Clerical	0	See Attached	1.52	3.80%	Alloc Salary	$ 2,884	22-7	1
2	Mark Steinberg	Relative	Administrative	0	See Attached	0.97	1.76%	Alloc Fee/Sal	8,056	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 10,940		13

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	$ 5,386	$	33,784	$ 131	1
2	02	Food	Patient Days	1,389,746	40	10,961		33,784	266	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295		33,784	712	3
4	05	Utilities	Patient Days	1,389,746	40	43,781		33,784	1,064	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234		33,784	2,850	5
6	17	Administrative	Patient Days	1,389,746	40	42,000		33,784	1,021	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207		33,784	3,724	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847		33,784	1,309	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330		33,784	6,717	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217		33,784	248	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054		33,784	658	11
12	26	Insurance	Patient Days	1,389,746	40	49,193		33,784	1,196	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516		33,784	1,739	13
14	32	Interest	Patient Days	1,389,746	40	613,328		33,784	14,910	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471		33,784	3,147	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470		33,784	327	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,291	$		$ 40,019	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	247,664	247,664	33,784	6,021	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298		39,485	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		33,784	522	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140			4,803	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	33,784	11,725	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	33,784	76,778	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		2,838	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		33,784	17,698	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			1,091	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					$ 5,599,498	$ 4,730,091		$ 160,961	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	710,509	22	$ 1,936	$	33,784	$ 92	1
2	05	Utilities	Patient Days	710,509	22	2,630		33,784	125	2
3	06	Maintenance	Patient Days	710,509	22	952		33,784	45	3
4	19	Professional Fees	Patient Days	710,509	22	13,906		33,784	661	4
5	20	Dues and Subscriptions	Patient Days	710,509	22	15,540		33,784	739	5
6	21	Office & Clerical	Patient Days	710,509	22	31,816		33,784	1,513	6
7	24	Travel and Seminar	Patient Days	710,509	22	12,645		33,784	601	7
8	26	Insurance	Patient Days	710,509	22	2,983		33,784	142	8
9	30	Depreciation	Patient Days	710,509	22	2,046		33,784	97	9
10	32	Interest	Patient Days	710,509	22	2,330		33,784	111	10
11	33	Real Estate Taxes	Patient Days	710,509	22	8,555		33,784	407	11
12	01	Dietary Salary	Patient Days	710,509	22	174,364	174,364	33,784	8,291	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	710,509	22	24,481		33,784	1,164	13
14	10	Nursing Salary	Patient Days	710,509	22	706,073	706,073	33,784	33,573	14
15	12	Social Service Salary	Patient Days	710,509	22	495,889	495,889	33,784	23,579	15
16	15	Emp. Ben. - Healthcare	Patient Days	710,509	22	168,758		33,784	8,024	16
17	17	Administration Salary	Patient Days	710,509	22	1,399,873	1,399,873	33,784	66,563	17
18	21	Office Salary	Patient Days	710,509	22	446,345	446,345	33,784	21,223	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	710,509	22	259,213		33,784	12,325	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,770,337	$ 3,222,544		$ 179,275	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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						29,926	1
2	21	Clerical & General Office Expense	Direct Allocation						68	2
3	39	Ancillary	Direct Allocation						253,981	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					$	$		$ 283,974	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 320,657	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					$	$		$ 320,657	25

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Midwest Mechanical		X	Note Payable			$	$ 50,988			$	1
2	Bank Leumi		X	Mortgage				15,519,384			796,747	2
3	First Bank		X	Note Payable				3,380,000			173,973	3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,972,133			12,463	6
7	Bank Leumi		X	CapEx - Line of Credit				181,392			77,780	7
8												8
9	TOTAL Facility Related						$	$ 21,103,897			$ 1,060,963	9
	B. Non-Facility Related*											
10	Interest Income		X								(12,105)	10
11	Alloc - Extended Care Consultin	X									14,910	11
12	Alloc - Extended Care Clinical	X									111	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,916	14
15	TOTALS (line 9+line14)						$	$ 21,103,897			$ 1,063,879	15

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 414,653	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.)		$ 298,087	2
3. Under or (over) accrual (line 2 minus line 1).		$ (116,566)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 412,346	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.)**		$ 219	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** $ 537 **For** 13-15 **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.		$ 295,999	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	217,132	8
	2014	233,080	9
	2015	231,212	10
	2016	294,778	11
	2017	294,533	12

2018 Accrual = Full Tax Bills $392,710 x 1.05 = $412,346
Allocated from Extended Care Consulting = $3,147
Allocated from Extended Care Clinical = $407
***Beginning Accrual Adjusted**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Rehab Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 353,863.90	$ 265,397.93
2.	23-15-02-400-023-0000	Long Term Care Property	$ 38,846.56	$ 29,134.92
3.	See Attached	Allocated Care Center Building	$ 190,923.89	$ 3,147.36
4.	See Attached	Allocated Care Center Building	$ 190,923.89	$ 406.78
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 774,558.24	$ 298,086.99

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Rehab Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 from Care Centers Building			15,265	2
3	TOTALS			$ 245,955	3

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		2014	1988	$ 12,567,146	$ 1,231,280	35	$ 359,061	$ (872,219)	$ 1,996,343	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	137,669		20	7,405	7,405	33,129	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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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)		75,526	1,160		1,160		51,198	68
69	Financial Statement Depreciation			73,720			(73,720)		69
70	TOTAL (lines 4 thru 69)		$ 12,780,341	$ 1,306,160		$ 367,626	$ (938,533)	$ 2,080,671	70

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 12,780,341	$ 1,306,160		$ 367,626	$ (938,533)	$ 2,080,671	1
2	2Nd Floor Shower Room - Relocate Drain & Relevel Floor	2015	8,800		20	440	440	1,760	2
3	Chapel - Millwork, Stained Glass, 8 Sconces, Hvac, Plumbing	2015	28,700		20	1,435	1,435	5,740	3
4	2 Auto Door Openers	2015	6,356		20	318	318	1,059	4
5	1St & 2Nd Dining Room Flooring	2015	29,950		20	5,990	5,990	18,469	5
6	2 Exit Doors	2015	10,000		20	500	500	1,542	6
7	Amenity Mall-Barber & Beauty Shops, Library, Gift Shop, Media C	2015	456,321		20	22,816	22,816	74,152	7
8	Electrical Outlet Repair/Installation - 18 Rooms	2015	3,586		20	179	179	717	8
9	Repair Outlets In 54 Rooms, Fix Holes In Drywall	2015	11,000		20	550	550	2,200	9
10	Separation Wall	2016	37,500		20	1,875	1,875	5,625	10
11	Relocate Circuits - Generator Critical Panel	2016	12,500		20	625	625	1,823	11
12	1St & 2Nd Dining Room Flooring	2016	18,200		20	910	910	2,503	12
13	Beauty Shop Renovation - Flooring & Electrical	2016	7,930		20	397	397	1,123	13
14	Electrical Panel Work	2016	5,588		20	279	279	768	14
15	Water Heater	2016	19,626		20	981	981	2,780	15
16	Fixed Leak In Attic (Room 1102)	2016	2,674		20	134	134	368	16
17	Retractable Pit Ladders In Elevator	2017	14,058		20	703	703	1,406	17
18	Exterior Steel Door Replacement	2017	3,900		20	195	195	390	18
19	Repair Failing Storm Structure	2017	4,675		20	234	234	448	19
20	Replacement Of Thermostatic Mixing Valve	2017	5,320		20	266	266	466	20
21	Replace 4 Condenser Fan Motors & Blades On Chiller	2017	4,473		20	224	224	391	21
22	Rebuilt Chiller Pump	2017	3,765		20	188	188	329	22
23	Roof/Siding/Sofit & Fascial Replacement	2017	56,786		20	2,839	2,839	4,496	23
24	Hallway Ceiling Replacement	2017	87,900		20	4,395	4,395	6,226	24
25	Lvt Flooring Installation - Dining Room	2017	25,851		20	5,170	5,170	7,324	25
26	New Sump Pump In Elevator Shaft	2017	4,450		20	223	223	297	26
27	Ats Em Service - Wireless Update	2017	9,360		20	468	468	585	27
28	Hvac	2017	104,664		20	5,233	5,233	6,105	28
29	Domestic Water Heaters - Manor Building'	2017	163,471		20	8,174	8,174	9,536	29
30	Dry Sprinkler Repair - Pipe Replacement, Wet System Leak	2017	4,048		20	202	202	354	30
31	Fire Damper Repair - Replace Actuators	2017	2,789		20	139	139	209	31
32	Wet Sprinkler System - Repair Main Drain Valve	2017	2,678		20	134	134	245	32
33	Wet Sprinkler System - Install Sidewall Heads In End Hallway 100(	2017	2,622		20	131	131	240	33
34	TOTAL (lines 1 thru 33)		$ 13,939,882	$ 1,306,160		$ 433,973	$ (872,186)	$ 2,240,349	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 13,939,882	$ 1,306,160		$ 433,973	$ (872,186)	$ 2,240,349	1
2	Replace Thermostat Cable	2018	3,539		20	177	177	177	2
3	Replace Control Relay For Door Holders	2018	3,286		20	164	164	164	3
4	Exit Devices And Air Curtain Units	2018	18,667		20	389	389	389	4
5	New Windows - 2Nd Floor North Wing Hallway	2018	5,100		20	191	191	191	5
6	Floor Sink Replacement	2018	2,640		20	99	99	99	6
7	Entrance Canopy	2018	5,245		20	181	181	181	7
8	Replace Daytank Controller	2018	4,022		20	134	134	134	8
9	New 10 Ton Rooftop Unit	2018	14,500		20	423	423	423	9
10	Air Compressor	2018	3,880		20	97	97	97	10
11	Roof Repairs	2018	6,700		20	140	140	140	11
12	4 Studios: Flooring, Cabinets, Counters, Plumbing, Paint, Electric	2018	49,000		20	1,021	1,021	1,021	12
13	Heat Exchanger	2018	14,639		20	244	244	244	13
14	Basement Level Drain Cleanout	2018	2,790		20	23	23	23	14
15	Repair Air Handler Leaking Pipe	2018	4,449		20	222	222	222	15
16	Install Evaporator Coil	2018	2,736		20	137	137	137	16
17	Repair Control System	2018	2,541		20	127	127	127	17
18	Repair Water Softeners	2018	6,762		20	338	338	338	18
19	Repair Air Compressor	2018	3,946		20	197	197	197	19
20	Repair Boilers & Chiller	2018	4,031		20	202	202	202	20
21	Repair Air Handler Leaking Pipe	2018	3,924		20	196	196	196	21
22	Repair Ceiling Leaking Air Unit	2018	3,096		20	155	155	155	22
23	Repair Air Handler And Mua Dual Temp Valve In 1300 Wing	2018	5,043		20	252	252	252	23
24	Replace 4 Wired Smoke Detectors In Rms 119 & 219	2018	2,841		20	142	142	142	24
25	Fire Alarm System Modifications	2018	3,412		20	171	171	171	25
26	Sprinkler Head	2018	2,975		20	149	149	149	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,119,645	$ 1,306,160		$ 439,544	$ (866,616)	$ 2,245,919	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 14,119,645	$ 1,306,160		$ 439,544	$ (866,616)	$ 2,245,919	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,119,645	$ 1,306,160		$ 439,544	$ (866,616)	$ 2,245,919	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 14,119,645	$ 1,306,160		$ 439,544	$ (866,616)	$ 2,245,919	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 14,119,645	$ 1,306,160		$ 439,544	$ (866,616)	$ 2,245,919	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	18,628	478	39	478		7,781	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	5,834	129	35	129		1,486	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,408	62	35	62		1,006	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	15,388		20			15,388	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	18,134		20			18,134	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	901		20			901	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	163	8	20	8		81	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,560	78	20	78		390	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	256	13	20	13		111	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,013	51	20	51		152	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	1,756	88	20	88		176	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	805	40	20	40		40	16
17	Allocated from Extended Care Clinical - Care Center Bldg	2002	1,989		20			1,989	17
18	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,344		20			2,344	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2005	116		20			116	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2009	21	1	20	1		11	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2014	195	10	20	10		49	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2015	33	2	20	2		14	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2016	131	7	20	7		20	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2017	227	11	20	11		23	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2018	104	5	20	5		5	25
26	Allocated from Extended Care Consulting	2007	112	6	20	6		67	26
27	Allocated from Extended Care Consulting	2009	67	3	20	3		34	27
28	Allocated from Extended Care Consulting	2010	656	33	20	33		295	28
29	Allocated from Extended Care Consulting	2011	236	12	20	12		95	29
30	Allocated from Extended Care Consulting	2012	78	4	20	4		27	30
31	Allocated from Extended Care Consulting	2014	1,078	54	20	54		270	31
32	Allocated from Extended Care Consulting	2016	1,293	65	20	65		194	32
33									33
34	TOTAL (lines 1 thru 33)		$ 75,526	$ 1,160		$ 1,160	$	$ 51,198	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 75,526	$ 1,160		$ 1,160	$	$ 51,198	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 75,526	$ 1,160		$ 1,160	$	$ 51,198	34

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,331,449	$ 554	$ 144,664	$ 144,110	10	$ 698,805	71
72	Current Year Purchases	5,100		383	383	10	383	72
73	Fully Depreciated Assets	74,729				10	74,729	73
74								74
75	TOTALS	$ 1,411,278	$ 554	$ 145,047	$ 144,493		$ 773,917	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		Alloc. Extended Care Clinical	2012	$ 2,443	$	$	$	5	$ 2,443	76
77		Alloc. Extended Care Consulting	2014	619	124	124		5	619	77
78										78
79										79
80	TOTALS			$ 3,062	$ 124	$ 124	$		$ 3,062	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)	$ 15,779,940	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,306,838	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 584,715	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (722,123)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,022,898	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	REMODELING OF THREE BEDROO	$ 43,700	$	$	86
87	Land - 2014 - 2014	127,928			87
88	Building - 2014 - 2014	6,972,854			88
89	Furniture and Fixtures - 2014 - 2014	664,190			89
90	Amenity Mall - Assisted Living Portion - 2(	164,296			90
91	TOTALS	$ 7,972,968	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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				1,416			5
6								6
7	TOTAL				$ 1,416 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,306 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 417,472	$		$ 417,472	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			96,410			96,410	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			452,085			452,085	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				295,086		295,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					381	59,134		59,515	13
14	TOTAL			$		$ 966,348	$ 354,220		$ 1,320,568	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,468	$ (20,948)	1
2	Cash-Patient Deposits	11,258	11,258	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,978,388	1,978,388	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,375	79,375	6
7	Other Prepaid Expenses	5,990	5,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	587	587	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,078,066	$ 2,054,650	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	1,008,664	1,629,282	15
16	Equipment, at Historical Cost	37,234	1,893,242	16
17	Accumulated Depreciation (book methods)	(252,750)	(5,792,011)	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	2,589,543	17,476	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,382,691	$ 18,966,670	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,460,757	$ 21,021,320	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 655,731	$ 555,733	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,250	9,250	28
29	Short-Term Notes Payable	2,023,121	2,204,513	29
30	Accrued Salaries Payable	208,690	208,690	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,841	8,841	31
32	Accrued Real Estate Taxes(Sch.IX-B)	412,346	412,346	32
33	Accrued Interest Payable		56,659	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	10,234	25,234	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,328,213	$ 3,481,266	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,380,000	39
40	Mortgage Payable		15,519,384	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	467,301	833,301	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 467,301	$ 19,732,685	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,795,514	$ 23,213,951	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,665,243	$ (2,192,631)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,460,757	$ 21,021,320	48

*(See instructions.)

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,172,510	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,172,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(507,267)	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)**	$ (507,267)	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)**	$ 1,665,243	24 *

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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 9,572,910	1
2	Discounts and Allowances for all Levels	(4,529,480)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,043,430	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,346,593	6
7	Oxygen	811	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,347,404	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	325	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	288,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,387	19
20	Radiology and X-Ray	7,203	20
21	Other Medical Services	93,799	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 420,354	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,105	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,105	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	2,102,033	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,102,033	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,925,326	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,357,065	31
32	Health Care	3,182,987	32
33	General Administration	2,286,338	33
	B. Capital Expense		
34	Ownership	1,511,811	34
	C. Ancillary Expense		
35	Special Cost Centers	3,887,049	35
36	Provider Participation Fee	207,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,432,593	40
41	**Income before Income Taxes (line 30 minus line 40)****	(507,267)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (507,267)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,016,072	44
45	Private Pay - Net Inpatient Revenue	1,096,820	45
46	Medicare - Net Inpatient Revenue	512,511	46
47	Other-(specify) Hospice	295,038	47
48	Other-(specify) Insurance	122,989	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,043,430	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 Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,667	3,090	$ 134,306	$ 43.46	1
2	Assistant Director of Nursing	830	933	30,858	33.07	2
3	Registered Nurses	13,823	15,329	502,975	32.81	3
4	Licensed Practical Nurses	25,615	28,187	785,328	27.86	4
5	CNAs & Orderlies	64,972	70,179	924,863	13.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,886	6,509	125,214	19.24	8
9	Activity Director	1,340	1,557	34,301	22.03	9
10	Activity Assistants	9,509	10,320	122,180	11.84	10
11	Social Service Workers	6,006	6,509	160,163	24.61	11
12	Dietician					12
13	Food Service Supervisor	1,566	2,026	44,148	21.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,377	22,336	272,929	12.22	15
16	Dishwashers					16
17	Maintenance Workers	3,802	4,086	117,733	28.81	17
18	Housekeepers	15,241	16,705	154,276	9.24	18
19	Laundry	3,329	3,627	36,976	10.19	19
20	Administrator	1,957	2,125	76,734	36.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,576	7,075	131,303	18.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,357	2,592	42,665	16.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,288	2,593	38,778	14.95	33
34	TOTAL (lines 1 - 33)	187,141	205,778	$ 3,735,730 *	$ 18.15	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	582	$ 21,144	01-03	35
36	Medical Director	Monthly	23,550	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,782	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	236	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	587	$ 52,712		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

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Davey	Administrator	0	$ 33,064
Sandra Erickson	Administrator	0	8,585
Robert Petty	Administrator	0	35,085
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,734

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
Extended Care Consulting	Home Office Expense	$ 288,900
Extended Care Clinical	Home Office Expense	96,570
Marcum LLP	Accounting	22,850
Personnel Planners	Unemployment Consulting	1,367
See Attached	Legal Fees	3,370
Ability Network	Medicare Billing	5,265
Achieve Accreditation	Accreditation	17,455
National Datacare Corp	Resident Fund Processing	659
Paycor	Payroll Services	21,716
Bylmas	Tax Credit Services	9,334
Plant Moran	Accounting	212
See Supplemental Schedule		3,633
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 471,331

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,719
Unemployment Compensation Insurance	103,585
FICA Taxes	285,783
Employee Health Insurance	165,174
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	495
Other Employee Benefits	3,114
Holiday Expense	2,084
TOTAL (agree to Schedule V, line 22, col.8)	$ 644,954

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,860
Advertising: Employee Recruitment	25,839
Health Care Worker Background Check	
(Indicate # of checks performed)	1,973
Patient Background Checks	
Dues & Subscriptions	13,164
Licenses & Fees	3,106
Allocated from Extended Care Consulting	1,309
Allocated from Extended Care Clinical	739
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,222
Allocated from Extended Care Consulting	248
Allocated from Extended Care Clinical	601
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,071

**See instructions.

Facility Name & ID Number St James Wellness Rehab Villas # 0052779 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **HCCI $14,748**

(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. $ **55,228** 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. $ **207,343**
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. $ **325**

(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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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