FOR BHF USE							

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0052779

Facility Name: St James Wellness Reh Villas

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

County: Will

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

HFS ID Number:

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

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	** Subject to the attached Accountants' Consulting Report*	
	(Print Name and Title)	
	(Firm Name & Address)	Marcum, LLP 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 Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,150	1,349	13,555	30,054	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,150	1,349	13,555	30,054	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.65%

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 4/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2014 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 9,464

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	332,668	70,591	22,999	426,258		426,258	531	426,789			1
2	Food Purchase		208,089		208,089		208,089	(95)	207,994			2
3	Housekeeping	135,846	105,583	2,455	243,884		243,884	974	244,858			3
4	Laundry	53,065	6,515		59,580		59,580		59,580			4
5	Heat and Other Utilities			184,853	184,853		184,853	(26,555)	158,298			5
6	Maintenance	92,816	2	257,330	350,148		350,148	4,051	354,199			6
7	Other (specify):*							2,651	2,651			7
8	**TOTAL General Services**	614,395	390,780	467,637	1,472,812		1,472,812	(18,443)	1,454,369			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,956,546	290,874	12,165	3,259,585		3,259,585	10,203	3,269,788			10
10a	Therapy	201,570		1,600	203,170		203,170		203,170			10a
11	Activities	128,549	10,795		139,344		139,344		139,344			11
12	Social Services	190,047			190,047		190,047	11,361	201,408			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,273	5,273			15
16	**TOTAL Health Care and Programs**	3,476,712	301,669	35,365	3,813,746		3,813,746	26,837	3,840,583			16
	C. General Administration											
17	Administrative	94,478			94,478		94,478	84,649	179,127			17
18	Directors Fees											18
19	Professional Services			461,305	461,305	(11)	461,294	(380,636)	80,658			19
20	Dues, Fees, Subscriptions & Promotions			114,645	114,645		114,645	(49,339)	65,306			20
21	Clerical & General Office Expenses	150,130	25,944	295,297	471,371		471,371	(127,019)	344,352			21
22	Employee Benefits & Payroll Taxes			718,621	718,621		718,621	(3,302)	715,319			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,157	1,157		1,157	545	1,702			24
25	Other Admin. Staff Transportation			2,649	2,649		2,649	492	3,141			25
26	Insurance-Prop.Liab.Malpractice			312,055	312,055		312,055	1,348	313,403			26
27	Other (specify):*							34,031	34,031			27
28	**TOTAL General Administration**	244,608	25,944	1,905,729	2,176,281	(11)	2,176,270	(439,231)	1,737,039			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,335,715	718,393	2,408,731	7,462,839	(11)	7,462,828	(430,837)	7,031,991			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.

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			81,323	81,323		81,323	478,151	559,474			30
31	Amortization of Pre-Op. & Org.			128	128		128	(128)				31
32	Interest			27,617	27,617		27,617	624,998	652,615			32
33	Real Estate Taxes			273,406	273,406	11	273,417	3,734	277,151			33
34	Rent-Facility & Grounds			1,126,278	1,126,278		1,126,278	(1,125,000)	1,278			34
35	Rent-Equipment & Vehicles			8,077	8,077		8,077	180	8,257			35
36	Other (specify):*											36
37	TOTAL Ownership			1,516,829	1,516,829	11	1,516,840	(18,065)	1,498,775			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		421,095	1,034,011	1,455,106		1,455,106	(30,914)	1,424,192			39
40	Barber and Beauty Shops			64	64		64		64			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,766	178,766		178,766		178,766			42
43	Other (specify):*			2,660,098	2,660,098		2,660,098	(2,660,098)				43
44	TOTAL Special Cost Centers		421,095	3,872,939	4,294,034		4,294,034	(2,691,012)	1,603,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,335,715	1,139,488	7,798,499	13,273,702		13,273,702	(3,139,914)	10,133,788			45

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(75)	02		4
5	Telephone, TV & Radio in Resident Rooms	(27,608)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(109,413)	30		9
10	Interest and Other Investment Income	(4,733)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	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	(902)	21		18
19	Entertainment				19
20	Contributions	(162)	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	(236,184)	21		24
25	Fund Raising, Advertising and Promotional	(46,234)	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	(2,696,070)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,121,473)		$	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)	(18,441)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (18,441)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,139,914)		37

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

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

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

St James Wellness Reh Villas

ID# 0052779

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted Living Expenses	$ (2,660,098)	43	1
2	Patient Clothing	(74)	10	2
3	Theft Loss	(1,025)	21	3
4	Collection Expense	(14,604)	21	4
5	Amortization	(128)	31	5
6	Building Company - Legal	(200)	19	6
7	Building Company - Misc. Admin. Expenses	(380)	21	7
8	PAC Dues	(5,295)	20	8
9	Chamber of Commerce Dues	(80)	20	9
10	Credit Card Processing	(5,536)	21	10
11	Capitalized R&M	(6,743)	06	11
12	Duplicated Expense	(1,907)	21	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
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**	(2,696,070)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

St James Wellness Reh Villas

ID# 0052779
Report Period Beginning: 01/01/20
Ending: 12/31/20

	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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			98	433								531	1
2	Food Purchase	(167)		72									(95)	2
3	Housekeeping			859	115								974	3
4	Laundry													4
5	Heat and Other Utilities	(27,608)		940	113								(26,555)	5
6	Maintenance	(6,743)		10,680	114								4,051	6
7	Other (specify):*			2,587	64								2,651	7
8	**TOTAL General Services**	(34,518)		15,236	839								(18,443)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(74)			25,155	(11,921)	(2,958)						10,203	10
10a	Therapy													10a
11	Activities													11
12	Social Services				11,361								11,361	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,273								5,273	15
16	**TOTAL Health Care and Programs**	(74)			41,789	(11,921)	(2,958)						26,837	16
	C. General Administration													
17	Administrative			12,298	72,351								84,649	17
18	Directors Fees													18
19	Professional Services	(200)	200	(285,071)	(95,565)								(380,636)	19
20	Fees, Subscriptions & Promotions	(51,771)		1,601	831								(49,339)	20
21	Clerical & General Office Expenses	(260,538)	380	95,377	37,785		(23)						(127,019)	21
22	Employee Benefits & Payroll Taxes			(3,302)									(3,302)	22
23	Inservice Training & Education													23
24	Travel and Seminar			261	284								545	24
25	Other Admin. Staff Transportation			492									492	25
26	Insurance-Prop.Liab.Malpractice			1,055	293								1,348	26
27	Other (specify):*			18,099	15,932								34,031	27
28	**TOTAL General Administration**	(312,509)	580	(159,190)	31,911		(23)						(439,231)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(347,101)	580	(143,954)	74,539	(11,921)	(2,981)						(430,837)	29

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	(109,413)	585,803	1,656	105								478,151	30
31	Amortization of Pre-Op. & Org.	(128)											(128)	31
32	Interest	(4,733)	623,718	5,918	95								624,998	32
33	Real Estate Taxes			3,294	440								3,734	33
34	Rent-Facility & Grounds		(1,125,000)										(1,125,000)	34
35	Rent-Equipment & Vehicles			180									180	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(114,274)	84,521	11,048	640								(18,065)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(30,914)						(30,914)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,660,098)											(2,660,098)	43
44	**TOTAL Special Cost Centers**	(2,660,098)					(30,914)						(2,691,012)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,121,473)	85,101	(132,906)	75,179	(11,921)	(33,895)						(3,139,914)	45

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	33	Real Estate Tax	273,406	St. James Property LLC		273,406		2
3	V	19	Legal		St. James Property LLC		200	200	3
4	V	21	Misc Admin Expense		St. James Property LLC		380	380	4
5	V	30	Depreciaton		St. James Property LLC		585,803	585,803	5
6	V	32	Interest		St. James Property LLC		623,718	623,718	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,398,406			$ 1,483,507	$ * 85,101	14

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	8.50%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	B & Z GRANDCHILDREN ACCUM TRUST	20.00%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	DANIEL ROTHNER ACCUM TRUST	9.00%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	KIMBERLY VALES ACCUM TRUST	9.00%	ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	RACHEL ROTHNER ACCUM TRUST	9.00%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	7
8	KATHRYN VALES ACCUM TRUST	9.00%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				8
9	WILLIAM ROTHNER ACCUM TRUST	9.00%	MAJOR HOSPITAL DYER	DYER, IN				9
10	N & S ROTHNER FAMILY TRUST	8.50%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

STATE OF ILLINOIS

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC		$ 98	$ 98	15
16	V	02	Food		Extended Care Consulting, LLC		72	72	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		859	859	17
18	V	05	Utilities		Extended Care Consulting, LLC		940	940	18
19	V	06	Maintenance		Extended Care Consulting, LLC		1,873	1,873	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	288,900	Extended Care Consulting, LLC		3,829	(285,071)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		1,601	1,601	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		8,432	8,432	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		261	261	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		492	492	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,055	1,055	26
27	V	30	Depreciation		Extended Care Consulting, LLC		1,656	1,656	27
28	V	32	Interest		Extended Care Consulting, LLC		5,918	5,918	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		3,294	3,294	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		180	180	30
31	V	06	Maintenance Salaries	5,380	Extended Care Consulting, LLC		14,187	8,807	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		2,587	2,587	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		12,298	12,298	33
34	V	21	Office and Clerical Salaries		Extended Care Consulting, LLC		86,945	86,945	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		18,099	18,099	35
36	V	22	Employee Benefits	3,302	Extended Care Consulting, LLC			(3,302)	36
37	V								37
38	V								38
39	Total			$ 297,582			$ 164,676	$ * (132,906)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 433	$ 433	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		115	115	16
17	V	5	Utilities		Extended Care Clinical, LLC		113	113	17
18	V	6	Maintenance		Extended Care Clinical, LLC		114	114	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		64	64	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		24,520	24,520	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		635	635	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		11,361	11,361	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		5,273	5,273	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		72,351	72,351	25
26	V	19	Professional Fees	96,570	Extended Care Clinical, LLC		1,005	(95,565)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC				27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		831	831	28
29	V	21	Office Salary		Extended Care Clinical, LLC		36,057	36,057	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		1,728	1,728	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		284	284	31
32	V	26	Insurance		Extended Care Clinical, LLC		293	293	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		15,932	15,932	33
34	V	30	Depreciation		Extended Care Clinical, LLC		105	105	34
35	V	32	Interest		Extended Care Clinical, LLC		95	95	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		440	440	36
37	V								37
38	V								38
39	Total			$ 96,570			$ 171,749	$ * 75,179	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	15,600	Vent Lease LLC		3,679	(11,921)	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			$ 15,600			$ 3,679	$ * (11,921)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 31,647	MAC Rx, LLC		$ 28,689	$ (2,958)	15
16	V	21	Clerical & General Office Expenses	249	MAC Rx, LLC		225	(23)	16
17	V	39	Ancillary	330,779	MAC Rx, LLC		299,865	(30,914)	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			$ 362,674			$ 328,779	$ * (33,895)	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 398,366	$ 398,366	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	398,366	CCS Employee Benefits Group			(398,366)	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			$ 398,366			$ 398,366	$ *	39

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Adam Vales	Relative	Clerical	0	See Attached	1.98	4.96%	Alloc Salary	$ 3,541	22-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,541		13

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

	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	1,219,947	38	$ 3,992	$	30,054	$ 98	1
2	02	Food	Patient Days	1,219,947	38	2,910		30,054	72	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		30,054	859	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		30,054	940	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		30,054	1,873	5
6	17	Administrative	Patient Days	1,219,947	38			30,054		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		30,054	3,829	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		30,054	1,601	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		30,054	8,432	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		30,054	261	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		30,054	492	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		30,054	1,055	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		30,054	1,656	13
14	32	Interest	Patient Days	1,219,947	38	240,208		30,054	5,918	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		30,054	3,294	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		30,054	180	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	30,054	14,187	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		30,054	2,587	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	30,054	12,298	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	30,054	86,945	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		30,054	18,099	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 164,676	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	30,054	$ 433	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		30,054	115	2
3	5	Utilities	Patient Days	603,308	20	2,264		30,054	113	3
4	6	Maintenance	Patient Days	603,308	20	2,283		30,054	114	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		30,054	64	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	30,054	24,520	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		30,054	635	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	30,054	11,361	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		30,054	5,273	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	30,054	72,351	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		30,054	1,005	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220				13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		30,054	831	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	30,054	36,057	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		30,054	1,728	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		30,054	284	17
18	26	Insurance	Patient Days	603,308	20	5,874		30,054	293	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		30,054	15,932	19
20	30	Depreciation	Patient Days	603,308	20	2,099		30,054	105	20
21	32	Interest	Patient Days	603,308	20	1,914		30,054	95	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		30,054	440	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 171,749	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						3,679	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					$	$		$ 3,679	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 28,689	1
2	21	Clerical & General Office Expense	Direct Allocation						225	2
3	39	Ancillary	Direct Allocation						299,865	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					$	$		$ 328,779	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

	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			$	$		$ 398,366	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					$	$		$ 398,366	25

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage			$	$ 10,575,378			$ 517,951	1
2	First Bank		X	Note Payable				3,399,902			105,768	2
3												3
4												4
5												5
	Working Capital											
6	Bak Leumi		X	Line of Credit				448,194			27,617	6
7												7
8												8
9	TOTAL Facility Related						$	$ 14,423,474			$ 651,336	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,733)	10
11	Alloc from Extended Care Consulting										5,918	11
12	Alloc from Extended Care Clinical										95	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,280	14
15	TOTALS (line 9+line14)						$	$ 14,423,474			$ 652,616	15

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	402,770	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.)	$	285,474	2
3. Under or (over) accrual (line 2 minus line 1).	$	(117,296)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	394,436	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.)	$	11	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ______ For ______ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	277,151	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	231,212	8
	2016	294,778	9
	2017	294,533	10
	2018	284,340	11
	2019	281,740	12

2020 Accrual = Full tax bills $375,654 x 1.05 = $394,436
Allocated from Extended Care Consulting $3294
Allocated from Extended Care Clinical $440
*Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Reh Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 338,494.46	$ 253,870.85
2.	23-15-02-400-023-0000	Long Term Care Property	$ 37,159.32	$ 27,869.49
3.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 3,293.80
4.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 440.10
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 769,979.16	$ 285,474.24

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St James Wellness Reh Villas COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,747 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 - 31,358 square feet

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	215,779	2014	$ 230,690	1
2	Allocated from Care Center Building			15,529	2
3	TOTALS	215,779		$ 246,219	3

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 585,803	35	$ 359,061	$ (226,742)	$ 2,714,465	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	146,469		20	7,149	7,149	49,477	9
10	Various			2015	518,772		20	25,939	25,939	169,107	10
11	Various			2016	66,518		20	3,326	3,326	16,018	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		77,241	1,199		1,199		54,502	68
69	Financial Statement Depreciation			81,323			(81,323)		69
70	TOTAL (lines 4 thru 69)		$ 13,376,146	$ 668,325		$ 396,674	$ (271,651)	$ 3,003,569	70

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 13,376,146	$ 668,325		$ 396,674	$ (271,651)	$ 3,003,569	1
2	Retractable Pit Ladders In Elevator	2017	14,058		20	703	703	2,812	2
3	Exterior Steel Door Replacement	2017	3,900		20	195	195	780	3
4	Repair Failing Storm Structure	2017	4,675		20	234	234	916	4
5	Replacement Of Thermostatic Mixing Valve	2017	5,320		20	266	266	998	5
6	Replace 4 Condenser Fan Motors & Blades On Chiller	2017	4,473		20	224	224	839	6
7	Rebuilt Chiller Pump	2017	3,765		20	188	188	706	7
8	Roof/Siding/Sofit & Fascial Replacement	2017	56,786		20	2,839	2,839	10,174	8
9	Hallway Ceiling Replacement	2017	87,900		20	4,395	4,395	15,016	9
10	Lvt Flooring Installation - Dining Room	2017	25,851		20	1,293	1,293	13,788	10
11	New Sump Pump In Elevator Shaft	2017	4,450		20	223	223	742	11
12	Ats Em Service - Wireless Update	2017	9,360		20	468	468	1,521	12
13	Hvac	2017	104,664		20	5,233	5,233	16,572	13
14	Domestic Water Heaters - Manor Building'	2017	163,471		20	8,174	8,174	25,883	14
15	Dry Sprinkler Repair - Pipe Replacement, Wet System Leak	2017	4,048		20	202	202	759	15
16	Fire Damper Repair - Replace Actuators	2017	2,789		20	139	139	488	16
17	Wet Sprinkler System - Repair Main Drain Valve	2017	2,678		20	134	134	513	17
18	Wet Sprinkler System - Install Sidewall Heads In End Hallway 10(	2017	2,622		20	131	131	502	18
19	Replace Thermostat Cable	2018	3,539		20	177	177	531	19
20	Replace Control Relay For Door Holders	2018	3,286		20	164	164	493	20
21	Exit Devices And Air Curtain Units	2018	9,334		20	467	467	2,178	21
22	New Windows - 2Nd Floor North Wing Hallway	2018	5,100		20	255	255	701	22
23	Floor Sink Replacement	2018	2,640		20	132	132	363	23
24	Entrance Canopy	2018	5,245		20	262	262	699	24
25	Replace Daytank Controller	2018	4,022		20	201	201	536	25
26	New 10 Ton Rooftop Unit	2018	14,500		20	725	725	1,873	26
27	Air Compressor	2018	3,880		20	194	194	485	27
28	Roof Repairs	2018	6,700		20	335	335	810	28
29	4 Studios: Flooring, Cabinets, Counter, Plumbing, Paint, Electric	2018	49,000		20	2,450	2,450	5,921	29
30	Heat Exchanger	2018	14,639		20	732	732	1,708	30
31	Basement Level Drain Cleanout	2018	2,790		20	140	140	303	31
32	Repair Air Handler Leaking Pipe	2018	4,449		20	222	222	611	32
33	Install Evaporator Coil	2018	2,736		20	137	137	388	33
34	TOTAL (lines 1 thru 33)		$ 14,008,816	$ 668,325		$ 428,308	$ (240,017)	$ 3,114,178	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 14,008,816	$ 668,325		$ 428,308	$ (240,017)	$ 3,114,178	1
2	Repair Control System	2018	2,541		20	127	127	360	2
3	Repair Water Softeners	2018	6,762		20	338	338	761	3
4	Repair Air Compressor	2018	3,946		20	197	197	444	4
5	Repair Boilers & Chillers	2018	4,031		20	202	202	454	5
6	Repair Air Handler Leaking Pipe	2018	3,924		20	196	196	425	6
7	Repair Ceiling Leaking Air Unit	2018	3,096		20	155	155	336	7
8	Repair Air Handler & Mua Dual Temp Valve In 1300 Wing	2018	5,043		20	252	252	525	8
9	Replace 4 Wired Smoke Detectors In Rms 119 & 219	2018	2,841		20	142	142	414	9
10	Fire Alarm System Modifications	2018	3,412		20	171	171	484	10
11	Sprinkler Head	2018	2,975		20	149	149	397	11
12	Heat Exchanger	2019	22,996		20	1,150	1,150	2,300	12
13	New Roofing System	2019	22,173		20	1,109	1,109	1,201	13
14	Shingle & Flat Roof Repairs	2019	4,229		20	211	211	422	14
15	Boiler Repair - Switches & Thermostat	2019	5,168		20	258	258	516	15
16	Install Chiller Isolation Valves	2019	4,829		20	241	241	482	16
17	Repair To Air Dampers In Generator Room	2019	2,548		20	127	127	254	17
18	New Motor ,Valves & Blower Wheels	2019	2,889		20	144	144	288	18
19	New Valves & Trim On Fire Alarm System	2019	3,584		20	179	179	358	19
20	Soffit Fascia Repair,Replace / Repair Damaged Stucco Under Car	2019	3,250		20	163	163	163	20
21	Fire Alarm - Dry Valve Repairs	2019	3,147		20	157	157	157	21
22	New Phone System	2020	15,380		20	769	769	769	22
23	Boiler Repairs - Fan/Coil Cabinets Not Heating	2020	3,596		20	180	180	180	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)		$ 14,141,176	$ 668,325		$ 434,925	$ (233,400)	$ 3,125,868	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 14,141,176	$ 668,325		$ 434,925	$ (233,400)	$ 3,125,868	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 14,141,176	$ 668,325		$ 434,925	$ (233,400)	$ 3,125,868	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 14,141,176	$ 668,325		$ 434,925	$ (233,400)	$ 3,125,868	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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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)		$ 14,141,176	$ 668,325		$ 434,925	$ (233,400)	$ 3,125,868	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2,522	65	35	65		1,183	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	5,913	131	35	131		1,768	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	18,878	484	35	484		8,854	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	15,594		20			15,594	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	18,378		20			18,378	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	913		20			913	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	165	8	20	8		99	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,581	79	20	79		553	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	260	13	20	13		168	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,026	51	20	51		257	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	1,780	89	20	89		356	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	816	41	20	41		122	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	307	15	20	15		31	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	82	4	20	4		4	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,084		20			2,084	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,455		20			2,455	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	122		20			122	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	22	1	20	1		13	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	205	10	20	10		72	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	35	2	20	2		22	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	137	7	20	7		34	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	238	12	20	12		48	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	109	5	20	5		16	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	41	2	20	2		4	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	11	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 73,674	$ 1,020		$ 1,020	$	$ 53,151	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 73,674	$ 1,020		$ 1,020	$	$ 53,151	1
2									2
3									3
4	Leasehold Improvements:								4
5	Allocated from Extended Care Consulting	2007	113	6	20	6		79	5
6	Allocated from Extended Care Consulting	2009	68	3	20	3		41	6
7	Allocated from Extended Care Consulting	2010	665	33	20	33		366	7
8	Allocated from Extended Care Consulting	2011	239	12	20	12		120	8
9	Allocated from Extended Care Consulting	2012	79	4	20	4		35	9
10	Allocated from Extended Care Consulting	2014	1,093	55	20	55		382	10
11	Allocated from Extended Care Consulting	2016	1,310	66	20	66		328	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)		$ 77,241	$ 1,199		$ 1,199	$	$ 54,502	34

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 1,250,191	$ 562	$ 123,680	$ 123,118	10	$ 874,622	71
72	Current Year Purchases	8,696		870	870	10	870	72
73	Fully Depreciated Assets	162,186				10	162,186	73
74								74
75	TOTALS	$ 1,421,073	$ 562	$ 124,550	$ 123,988		$ 1,037,678	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	$ 2,559	$	$	$	5	$ 2,559	76
77		Alloc. Extended Care Consulting	2014	627				5	627	77
78										78
79										79
80	TOTALS			$ 3,186	$	$	$		$ 3,186	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)	$ 15,811,654	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 668,887	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 559,474	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (109,413)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,166,731	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 BEDRO(	$ 43,700	$	$	86
87	REMODLING ROOMS (1 STUDIO, 3 1-	63,500			87
88	REMODLING ROOMS (2 STUDIOS) - 2	25,000			88
89	Land/Building/FFE 2014 - 2014	7,764,972			89
90	Amenity Mall - Assisted Living Portion - :	164,296			90
91	TOTALS	$ 8,061,468	$	$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off-Site Storage Rental				1,278			5
6								6
7	TOTAL				$ 1,278 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 8,257 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 430,882	$		$ 430,882	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			170,268			170,268	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			431,009			431,009	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				346,659		346,659	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					1,852	74,436		76,288	13
14	TOTAL			$		$ 1,034,011	$ 421,095		$ 1,455,106	14

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

Facility Name & ID Number St James Wellness Reh Villas # 0052779 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 1,190,484	$ 1,191,496	1
2	Cash-Patient Deposits	20,939	20,939	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,941,589	3,941,589	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136,554	136,554	6
7	Other Prepaid Expenses	9,994	9,994	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	2,385	2,385	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,301,945	$ 5,302,957	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	1,147,536	1,768,154	15
16	Equipment, at Historical Cost	37,234	1,893,242	16
17	Accumulated Depreciation (book methods)	(507,120)	(7,505,759)	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	2,773,248	2,773,248	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,450,898	$ 20,147,566	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,752,843	$ 25,450,523	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,761,624	$ 2,308,623	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,169	22,169	28
29	Short-Term Notes Payable	448,194	448,194	29
30	Accrued Salaries Payable	269,873	269,873	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,761	12,761	31
32	Accrued Real Estate Taxes(Sch.IX-B)	394,436	394,436	32
33	Accrued Interest Payable		45,804	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,369,673	2,369,673	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,278,730	$ 5,871,533	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,399,902	39
40	Mortgage Payable		10,575,378	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	215,000	7,690,995	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 215,000	$ 21,666,275	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,493,730	$ 27,537,808	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,259,113	$ (2,087,285)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,752,843	$ 25,450,523	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,222,881	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,222,881	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,036,232	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,036,232	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)**	$ 2,259,113	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,657,502	1
2	Discounts and Allowances for all Levels	(5,424,610)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,232,892	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,972,631	6
7	Oxygen	1,684	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,974,315	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	75	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	344,737	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	98,332	19
20	Radiology and X-Ray	6,143	20
21	Other Medical Services	79,759	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 529,046	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,733	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,733	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	3,568,948	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,568,948	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,309,934	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,472,812	31
32	Health Care	3,813,746	32
33	General Administration	2,176,281	33
	B. Capital Expense		
34	Ownership	1,516,829	34
	C. Ancillary Expense		
35	Special Cost Centers	4,115,268	35
36	Provider Participation Fee	178,766	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,273,702	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,036,232	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,036,232	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,848,179	44
45	Private Pay - Net Inpatient Revenue	594,138	45
46	Medicare - Net Inpatient Revenue	1,197,017	46
47	Other-(specify) Hospice	278,834	47
48	Other-(specify) Insurance	314,724	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,232,892	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,621	3,198	$ 144,570	$ 45.21	1
2	Assistant Director of Nursing	138	148	5,149	34.79	2
3	Registered Nurses	5,675	6,386	225,331	35.29	3
4	Licensed Practical Nurses	34,689	37,676	1,246,586	33.09	4
5	CNAs & Orderlies	68,238	72,658	1,189,612	16.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,177	6,565	201,570	30.70	8
9	Activity Director	1,260	1,451	32,178	22.18	9
10	Activity Assistants	7,083	7,800	96,371	12.36	10
11	Social Service Workers	7,594	8,502	190,047	22.35	11
12	Dietician					12
13	Food Service Supervisor	1,781	2,022	40,835	20.20	13
14	Head Cook	6,486	7,384	113,831	15.42	14
15	Cook Helpers/Assistants	14,000	15,166	178,002	11.74	15
16	Dishwashers					16
17	Maintenance Workers	4,156	4,663	92,816	19.90	17
18	Housekeepers	11,267	12,143	135,846	11.19	18
19	Laundry	4,766	5,195	53,065	10.21	19
20	Administrator	2,070	2,193	94,478	43.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,887	7,390	150,130	20.32	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	2,392	2,680	50,830	18.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,642	6,118	94,468	15.44	33
34	TOTAL (lines 1 - 33)	189,922	209,338	$ 4,335,715 *	$ 20.71	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	450	$ 22,999	01-03	35
36	Medical Director	Monthly	21,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,872	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	33	1,600	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)	483	$ 53,071		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	83	4,273	10-03	51
52	Certified Nurse Assistants/Aides	38	1,020	10-03	52
53	TOTAL (lines 50 - 52)	121	$ 5,293		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Petty (1/1/20-10/23/20)	Administrator	0	$ 78,952
Tamar Dobbins (10/19/20-12/31/20)	Administrator	0	15,526
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,478

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
Marcum LLP	Accounting	$ 14,935
Extended Care Consulting	Home Office Expense	288,900
Extended Care Clinical	Home Office Expense	96,570
Personnel Planners, Inc.	Unemployment Consultant	1,020
Newmark Knight Frank	Real Estate Advisory	2,628
Paycor Payroll Services	Payroll Services	19,272
Navex Global	Risk & Compliance Mgmt	262
West Fork Advisory	Due Diligence Consulting	9,242
Pinnacle Quality	Customer Satisfacition	516
Red Eyed Moose	Healthcare IT Support	1,372
See Attached	Legal	4,878
See Supplemental Schedule		21,709
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 461,304

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,272
Unemployment Compensation Insurance	69,852
FICA Taxes	331,682
Employee Health Insurance	214,791
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	245
Other Employee Welfare	10,477
TOTAL (agree to Schedule V, line 22, col.8)	$ 715,319

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	$ 3,227
Advertising: Employee Recruitment	40,982
Health Care Worker Background Check (Indicate # of checks performed 264)	2,642
Patient Background Checks	
Dues & Subscriptions	14,138
Licenses & Fees	1,885
See Supplemental Schedule	2,432
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,306

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,157
See Supplemental Schedule	545
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,702

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $10,591**

(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. $ **45,832** 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. $ **178,766**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **75**

(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