

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0053587</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																	
Facility Name: <u>Warren Barr Lincolnshire</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																																																																																	
Address: <u>150 Jamestown Lane</u> <u>Lincolnshire</u> <u>60069</u>																																																																																			
Number City Zip Code																																																																																			
County: <u>Lake</u>																																																																																			
Telephone Number: <u>(847) 883-9000</u> Fax # <u>(847) 883-9028</u>																																																																																			
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>5/1/2015</u></td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____		Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Date of Initial License for Current Owners: <u>5/1/2015</u>		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		Type of Ownership:		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____							In the event there are further questions about this report, please contact:		Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>		Email Address: _____	
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Facility Name & ID Number Warren Barr Lincolnshire

0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	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	<u>144</u>	Skilled (SNF)	<u>144</u>	<u>52,704</u>	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	<u>144</u>	TOTALS	<u>144</u>	<u>52,704</u>	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			<u>15,312</u>	<u>15,312</u>	8
9	SNF/PED					9
10	ICF	<u>14,622</u>	<u>12,720</u>		<u>27,342</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,622</u>	<u>12,720</u>	<u>15,312</u>	<u>42,654</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.93%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/2015 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 144 and days of care provided 11,324

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Warren Barr Lincolnshire** # **0053587** Report Period Beginning: **01/01/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	622,639	61,515	30,691	714,845		714,845		714,845			1
2	Food Purchase		200,844		200,844		200,844	(23,899)	176,945			2
3	Housekeeping		21,970	364,073	386,043		386,043	100	386,143			3
4	Laundry	85,404	30,593	21,724	137,721		137,721		137,721			4
5	Heat and Other Utilities			175,996	175,996		175,996	(14,403)	161,593			5
6	Maintenance	182,764	6,106	285,591	474,461		474,461	90,185	564,646			6
7	Other (specify):*											7
8	TOTAL General Services	890,807	321,028	878,075	2,089,910		2,089,910	51,983	2,141,893			8
	B. Health Care and Programs											
9	Medical Director			57,250	57,250		57,250		57,250			9
10	Nursing and Medical Records	4,369,662	141,734	72,648	4,584,044		4,584,044	(25,102)	4,558,942			10
10a	Therapy	140,426	266		140,692		140,692	(27,157)	113,535			10a
11	Activities	145,834	19,641	1,658	167,133		167,133		167,133			11
12	Social Services	167,946	42,165	41,323	251,434		251,434	32,924	284,358			12
13	CNA Training											13
14	Program Transportation			43,208	43,208		43,208	2	43,210			14
15	Other (specify):*			2,856	2,856		2,856	(689)	2,167			15
16	TOTAL Health Care and Programs	4,823,868	203,806	218,943	5,246,617		5,246,617	(20,022)	5,226,595			16
	C. General Administration											
17	Administrative	111,594		6,469	118,063		118,063	(105,557)	12,506			17
18	Directors Fees											18
19	Professional Services			282,241	282,241	(645)	281,596	(169,335)	112,261			19
20	Dues, Fees, Subscriptions & Promotions			129,195	129,195		129,195	(89,356)	39,839			20
21	Clerical & General Office Expenses	479,681	7,380	592,295	1,079,356		1,079,356	(211,362)	867,994			21
22	Employee Benefits & Payroll Taxes			945,156	945,156		945,156		945,156			22
23	Inservice Training & Education											23
24	Travel and Seminar			42,265	42,265		42,265	1,450	43,715			24
25	Other Admin. Staff Transportation			4,744	4,744		4,744		4,744			25
26	Insurance-Prop.Liab.Malpractice			143,600	143,600		143,600	2,255	145,855			26
27	Other (specify):*							26,233	26,233			27
28	TOTAL General Administration	591,275	7,380	2,145,965	2,744,620	(645)	2,743,975	(545,671)	2,198,304			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,305,950	532,214	3,242,983	10,081,147	(645)	10,080,502	(513,710)	9,566,792			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							107,947	107,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,932	69,932		69,932	381	70,313			32
33	Real Estate Taxes			162,000	162,000	645	162,645	1,568	164,213			33
34	Rent-Facility & Grounds			852,677	852,677		852,677	63	852,740			34
35	Rent-Equipment & Vehicles			15,396	15,396		15,396	53	15,449			35
36	Other (specify):*											36
37	TOTAL Ownership			1,100,005	1,100,005	645	1,100,650	110,013	1,210,662			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		811,429	1,448,861	2,260,290		2,260,290		2,260,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			259,852	259,852		259,852		259,852			42
43	Other (specify):*			897,520	897,520		897,520	(897,520)	(0)			43
44	TOTAL Special Cost Centers		811,429	2,606,233	3,417,662		3,417,662	(897,520)	2,520,142			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,305,950	1,343,643	6,949,221	14,598,814		14,598,814	(1,301,218)	13,297,596			45

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

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				4
5	Telephone, TV & Radio in Resident Rooms	(16,386)	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	105,851	30		9
10	Interest and Other Investment Income	(3,670)	32		10
11	Discounts, Allowances, Rebates & Refunds	(23,619)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(586)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,164)	21		18
19	Entertainment	(7,684)	21		19
20	Contributions	(67,711)	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	(237,269)	21		24
25	Fund Raising, Advertising and Promotional	(23,324)	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	(993,398)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,268,960)		\$	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)	(32,257)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (32,257)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,301,217)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Personal Items	\$ (15,145)	10	1
2	Miscellaneous Income	(954)	21	2
3	Marketing	(46,909)	43	3
4	Bank Charges	(2,901)	21	4
5	Sequestration	(121,066)	21	5
6	Therapy Discount	(27,157)	10A	6
7	Annual Report	(250)	20	7
8	Non-Allowable Expense	(850,611)	43	8
9	Additional R&M	79,317	06	9
10	Sitter Expenses	(2,856)	15	10
11	Non-Allowable Legal	(4,865)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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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	(993,398)		49

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
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81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(24,205)		141		165							(23,899)	2
3	Housekeeping			100									100	3
4	Laundry													4
5	Heat and Other Utilities	(16,386)		441			1,542						(14,403)	5
6	Maintenance	79,317		5,847		3,294	1,727						90,185	6
7	Other (specify):*													7
8	TOTAL General Services	38,726		6,529		3,459	3,269						51,983	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,145)				(9,957)							(25,102)	10
10a	Therapy	(27,157)											(27,157)	10a
11	Activities													11
12	Social Services					32,924							32,924	12
13	CNA Training													13
14	Program Transportation					2							2	14
15	Other (specify):*	(2,856)				2,167							(689)	15
16	TOTAL Health Care and Programs	(45,158)				25,136							(20,022)	16
	C. General Administration													
17	Administrative			9,089		(114,646)							(105,557)	17
18	Directors Fees													18
19	Professional Services	(4,865)		(159,340)	60	485	698	(6,373)					(169,335)	19
20	Fees, Subscriptions & Promotions	(91,285)		1,791		135	2						(89,356)	20
21	Clerical & General Office Expenses	(371,039)		159,164		491	22						(211,362)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,190		260							1,450	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,027		918	310						2,255	26
27	Other (specify):*			34,431		(8,198)							26,233	27
28	TOTAL General Administration	(467,189)		47,352	60	(120,554)	1,032	(6,373)					(545,671)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(473,621)		53,882	60	(91,959)	4,301	(6,373)					(513,710)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	105,851		472	1,624								107,947	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,670)		8	588		3,455						381	32
33	Real Estate Taxes			835			733						1,568	33
34	Rent-Facility & Grounds			44,238		11	(44,186)						63	34
35	Rent-Equipment & Vehicles			53									53	35
36	Other (specify):*													36
37	TOTAL Ownership	102,181		45,606	2,212	11	(39,998)						110,013	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(897,520)											(897,520)	43
44	TOTAL Special Cost Centers	(897,520)											(897,520)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,268,960)		99,488	2,272	(91,948)	(35,696)	(6,373)					(1,301,218)	45

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.

☐ 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)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* 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. ☒ 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	2	FOOD	\$	Legacy Healthcare Financial Services	100.00%	\$ 141	\$	141 15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	100		100 16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	441		441 17
18	V	6	GROUPS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	4,395		4,395 18
19	V	6	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100.00%	1,452		1,452 19
20	V	17	CFO SALARY		Legacy Healthcare Financial Services	100.00%	9,089		9,089 20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	20,660		20,660 21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,791		1,791 22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	137,845		137,845 23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	21,319		21,319 24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,190		1,190 25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,027		1,027 26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	34,431		34,431 27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	472		472 28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	8		8 29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	835		835 30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	44,186		44,186 31
32	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	52		52 32
33	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	53		53 33
34	V								34
35	V	19	BOOKKEEPING FEES	180,000	Legacy Healthcare Financial Services	100.00%			(180,000) 35
36	V	17	MANAGEMENT FEES	6,469	Legacy Healthcare Financial Services	100.00%			(6,469) 36
37	V	17	MANAGEMENT FEES - YAIR ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	6,469		6,469 37
38	V								38
39	Total			\$ 186,469			\$ 285,957	\$ *	99,488 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.

☒ 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	19	PROFESSIONAL FEES	\$	Legacy Real Properties	100.00%	\$ 60	\$ 60	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	1,624	1,624	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	588	588	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			\$			\$ 2,272	\$ * 2,272	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. ☒ 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	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 <u>FOOD</u>	\$	<u>Progressive Healthcare Consulting</u>	100.00%	\$ 165	\$ 165	15
16	V	6 <u>MAINTENANCE SALARY</u>		<u>Progressive Healthcare Consulting</u>	100.00%	3,180	3,180	16
17	V	6 <u>BUILDING MAINTENANCE AND R&M</u>		<u>Progressive Healthcare Consulting</u>	100.00%	113	113	17
18	V	10 <u>MEDICAL AND NURSING SUPPLIES</u>		<u>Progressive Healthcare Consulting</u>	100.00%	44	44	18
19	V	10 <u>NURSING SALARIES</u>		<u>Progressive Healthcare Consulting</u>	100.00%	31,642	31,642	19
20	V	12 <u>ACTIVITIES PROGRAM</u>		<u>Progressive Healthcare Consulting</u>	100.00%	40	40	20
21	V	12 <u>CLERGY SALARY</u>		<u>Progressive Healthcare Consulting</u>	100.00%	574	574	21
22	V	12 <u>ADMISSIONS SALARY</u>		<u>Progressive Healthcare Consulting</u>	100.00%	32,310	32,310	22
23	V	14 <u>PATIENT TRANSPORTATION</u>		<u>Progressive Healthcare Consulting</u>	100.00%	2	2	23
24	V	15 <u>EMP. BEN.-NURSING</u>		<u>Progressive Healthcare Consulting</u>	100.00%	4,737	4,737	24
25	V	17 <u>ADMIN SALARY- NON OWNER</u>		<u>Progressive Healthcare Consulting</u>	100.00%	33,239	33,239	25
26	V	19 <u>PROFESSIONAL FEES</u>		<u>Progressive Healthcare Consulting</u>	100.00%	485	485	26
27	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>Progressive Healthcare Consulting</u>	100.00%	135	135	27
28	V	21 <u>CLERICAL & GENERAL</u>		<u>Progressive Healthcare Consulting</u>	100.00%	491	491	28
29	V	24 <u>SEMINARS</u>		<u>Progressive Healthcare Consulting</u>	100.00%	260	260	29
30	V	27 <u>EMP. BEN.-NURSING</u>		<u>Progressive Healthcare Consulting</u>	100.00%	9,813	9,813	30
31	V	26 <u>INSURANCE</u>		<u>Progressive Healthcare Consulting</u>	100.00%	918	918	31
32	V	34 <u>STORAGE RENTAL</u>		<u>Progressive Healthcare Consulting</u>	100.00%	11	11	32
33	V							33
34	V	10 <u>NURSING SALARIES</u>	41,643	<u>Progressive Healthcare Consulting</u>	100.00%		(41,643)	34
35	V	17 <u>ADMINISTRATIVE</u>	147,885	<u>Progressive Healthcare Consulting</u>	100.00%		(147,885)	35
36	V	15 <u>PAYROLL TAXES - NURSING</u>	2,570	<u>Progressive Healthcare Consulting</u>	100.00%		(2,570)	36
37	V	27 <u>PAYROLL TAXES - OTHER</u>	18,011	<u>Progressive Healthcare Consulting</u>	100.00%		(18,011)	37
38	V							38
39	Total		\$ 210,109			\$ 118,161	\$ * (91,948)	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.

☒ 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	5	UTILITIES	\$	CF ST. LOUIS, LLC	100.00%	\$ 1,542	\$ 1,542	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,727	1,727	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	698	698	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	22	22	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	310	310	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	3,455	3,455	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	733	733	22
23	V								23
24	V	34	RENT	44,186	CF ST. LOUIS, LLC	100.00%		(44,186)	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			\$ 44,186			\$ 8,490	\$ * (35,696)	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.

☒ 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	19	Payroll Services	\$ 26,554	ProPay HR LLC	24.00%	\$ 20,181	\$ (6,373)	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			\$ 26,554			\$ 20,181	\$ * (6,373)	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.

☐ 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.

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.

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.

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.

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	YAIR ZUCKERMAN	10.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	1
2	MENACHEM SHABAT	3.10%	BETHANY TERRACE	MORTON GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEP	2
3	MENACHEM & AHUVA SHABAT DESCENDANTS	27.95%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4	CHAIM RAJCHENBACH	7.76%	ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5	GPN FAMILY TRUST	23.29%	EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6	DAVID M. FRIEDMAN	4.90%	GROVE OF FOX VALLEY	AURORA	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7	RONALD SHABAT	10.00%	LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8	THE RAJCHENBACH 2015 FAMILY TRUST	10.00%	GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	LINCOLNSHIRE ASSISTED LIV	LINCOLNSHIRE	ASSISTED LIVING	8
9	ROSS BOTTNER	3.00%	LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	9
10			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR LLC	EVANSTON	PAYROLL SERVICES	10
11			CHALET SKILLED NURSING FACILITY LLC	CHICAGO				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR LIVING AND REHAB	CHICAGO				19
20			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT				20
21			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				21
22			CLARK SKILLED NURSING FACILITY	CHICAGO				22
23			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				23
24			AZRIA MONTCLAIR	OMAHA, NE				24
25			AZRIA OLATHE	OLATHE, KS				25
26								26
27								27
28								28
29								29
30								30

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 Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yair Zuckerman	Owner	Administrative	10.00%	See Attached	1.62	3.24%	Mgmt Fee	\$ 6,469	17-3	1
2	Ross Bottner	Owner	Administrative	3.00%	See Attached	1.29	3.23%	Alloc Salary	6,469	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 12,938		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 Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Legacy Healthcare Financial Services
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	FOOD	AVAIL. BED DAYS	1,629,488	29	\$ 4,354	\$	52,704	\$ 141	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,629,488	29	3,107		52,704	100	2
3	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	13,622		52,704	441	3
4	6	GROUND & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	135,883		52,704	4,395	4
5	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,629,488	29	44,897	44,897	52,704	1,452	5
6	17	CFO SALARY	AVAIL. BED DAYS	1,629,488	29	281,003	281,003	52,704	9,089	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	638,760		52,704	20,660	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	55,387		52,704	1,791	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,629,488	29	4,261,866	4,261,866	52,704	137,845	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,629,488	29	659,124		52,704	21,319	10
11	24	SEMINARS	AVAIL. BED DAYS	1,629,488	29	36,800		52,704	1,190	11
12	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	31,752		52,704	1,027	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,629,488	29	1,064,526		52,704	34,431	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	14,600		52,704	472	14
15	32	INTEREST	AVAIL. BED DAYS	1,629,488	29	234		52,704	8	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	25,813		52,704	835	16
17	34	RENT	AVAIL. BED DAYS	1,629,488	29	1,366,146		52,704	44,186	17
18	34	STORAGE	AVAIL. BED DAYS	1,629,488	29	1,600		52,704	52	18
19	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,629,488	29	1,654		52,704	53	19
20										20
21	17	MANAGEMENT FEES- Y. ZUC	AVG HOURS WKD	50	29	200,000		0.69	6,469	21
22										22
23										23
24										24
25	TOTALS					\$ 8,841,129	\$ 4,587,766		\$ 285,957	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Legacy Real Properties
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	\$ 1,852	\$	52,704	\$ 60	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	50,196		52,704	1,624	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	18,179		52,704	588	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					\$ 70,227	\$		\$ 2,272	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Progressive Healthcare Consulting
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation		
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6		
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units			
1	2	FOOD	AVAIL. BED DAYS	1,167,679	20	\$ 11,123	\$	17,280	\$ 165	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	214,912	214,912	17,280	3,180	2
3	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	1,167,679	20	7,646		17,280	113	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	2,971		17,280	44	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	2,138,189	2,138,189	17,280	31,642	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	2,679		17,280	40	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	38,812	38,812	17,280	574	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	2,183,313	2,183,313	17,280	32,310	8
9	14	PATIENT TRANSPORTATION	AVAIL. BED DAYS	1,167,679	20	128		17,280	2	9
10	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	320,111		17,280	4,737	10
11	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	2,246,090	2,246,090	17,280	33,239	11
12	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	32,793		17,280	485	12
13	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	9,154		17,280	135	13
14	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	33,203		17,280	491	14
15	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	17,580		17,280	260	15
16	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	663,131		17,280	9,813	16
17	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	62,063		17,280	918	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,167,679	20	750		17,280	11	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,984,649	\$ 6,821,317		\$ 118,161	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	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	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	\$ 47,675	\$	52,704	\$ 1,542	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	53,400		52,704	1,727	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	21,572		52,704	698	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	76		52,704	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,629,488	29	678		52,704	22	5
6	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	9,585		52,704	310	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	106,824		52,704	3,455	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	22,674		52,704	733	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					\$ 262,484	\$		\$ 8,490	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ProPay HR LLC
Street Address 2201 W. Main Street
City / State / Zip Code Evanston, IL 60202
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	19	Payroll Services	Direct			\$	\$		\$ 20,181	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					\$	\$		\$ 20,181	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Warren Barr Lincolnshire # 0053587 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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							\$		\$			\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X	CapEx				2,826,577				69,932	6
7	Allocated from Legacy HC	X										8	7
8	See Supplemental Schedule				-							4,043	8
9	TOTAL Facility Related						\$	2,826,577			\$	73,983	9
	B. Non-Facility Related*												
10	Interest Income		X									(3,670)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(3,670)	14
15	TOTALS (line 9+line14)						\$	2,826,577			\$	70,314	15

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

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

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

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

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	Allocated from Legacy Real Pro	X					\$					\$ 588	8
9	Allocated from CF St. Louis	X										3,455	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											4,043	14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincolnshire COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053587

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-15-200-062</u>	<u>Long Term Care Facility</u>	\$ <u>166,492.26</u>	\$ <u>166,492.26</u>
2. <u>10-35-104-076-0000</u>	<u>Home Office Allocation</u>	\$ <u>40,927.41</u>	\$ <u>1,323.75</u>
3. <u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>440,762.19</u>	\$ <u>4,328.41</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>648,181.86</u></u>	\$ <u><u>172,144.42</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEWarren Barr LincolnshireCOUNTYLake

FACILITY IDPH LICENSE NUMBER0053587

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	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.

A. Square Feet: 62,477

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

E. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	Allocated from Legacy Real Properties			\$ 2,646	1
2					2
3	TOTALS			\$ 2,646	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
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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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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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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)		74,608	1,187		3,353	2,166	13,856	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 74,608	\$ 1,187		\$ 3,353	\$ 2,166	\$ 13,856	70

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 74,608	\$ 1,187		\$ 3,353	\$ 2,166	\$ 13,856	1
2	Kitchen - Millwork/Countertop/Cabinet	2015	25,783		20	752	752	2,041	2
3	Resident Rm/Dining/Hallways - Wall Sconces/Light Fixtures	2015	20,930		20	610	610	1,483	3
4	Resident Rooms - Power Outlets/Cables/Plates	2015	4,200		20	123	123	280	4
5	Resident Rooms - Carpet/Flooring	2015	4,300		20	125	125	287	5
6	Tile In Riviera Wing	2015	6,400		20	187	187	427	6
7	Resident Room Carpet	2015	31,058		20	906	906	2,071	7
8	Wood/Fire Rated Door & Hinges For Corridor	2015	10,953		20	319	319	730	8
9	Glass Door	2015	7,730		20	225	225	515	9
10	Resident Room Flooring	2015	14,057		20	410	410	937	10
11	Cape Cod Unit Tile	2015	7,715		20	225	225	514	11
12	Double Egress Fire Doors	2015	2,992		20	87	87	199	12
13	Corridors Carpet/Flooring	2015	9,096		20	265	265	569	13
14	Cape Cod Unit Drapery/Curtains	2015	12,109		20	353	353	706	14
15	Cape Cod Unit Wallcovering	2015	3,102		20	90	90	181	15
16	Cape Cod Unit Glass Mount Bracket	2015	4,052		20	118	118	236	16
17	Cape Cod Unit Double Doors	2015	7,730		20	225	225	451	17
18	Corridor Signage	2015	3,855		20	112	112	305	18
19	Cape Cod Unit - New Frames/Doors	2015	3,647		20	106	106	198	19
20	New Compressor For Chiller	2015	8,897		20	259	259	556	20
21	Install Door Controls	2015	20,150		20	588	588	1,343	21
22	Drapery - Coventry/Palm Beach Wings	2015	6,000		20	175	175	325	22
23	Dining Area/Guest Room - Valance/Rods/Divider Panels	2015	33,300		20	971	971	2,636	23
24	Bathroom/Resident Rooms - Dividers/Doors	2015	17,820		20	520	520	1,411	24
25	Resident Rooms/Corridors - Painting	2015	16,900		20	493	493	1,197	25
26	Cape Cod Unit Wallcovering	2015	5,603		20	163	163	350	26
27	East Wing - Primer/Tile	2015	30,947		20	903	903	2,450	27
28	Dining Room, Hallway, Gym & Library - Painted Ceiling/Walls	2016	9,850		20	493	493	493	28
29	Hallways - Tiles & Carpet	2016	6,392		20	320	320	320	29
30	Cape Cod -Installed Roller Shades	2016	5,580		20	279	279	279	30
31	Wireless Access Point	2016	58,169		20	2,908	2,908	2,908	31
32	Security Cameras	2016	25,993		20	1,300	1,300	1,300	32
33	Hallways - Vinyl Tiles, Carpet	2016	4,100		20	205	205	205	33
34	TOTAL (lines 1 thru 33)		\$ 504,018	\$ 1,187		\$ 18,171	\$ 16,984	\$ 41,759	34

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 504,018	\$ 1,187		\$ 18,171	\$ 16,984	\$ 41,759	1
2	Repaired Boiler	2016	2,732		20	137	137	137	2
3	Painted Resident Rooms/Bathrooms/Kitchen/Lounge/Office	2016	9,160		20	458	458	458	3
4	Installed Nurse Stations, Counters, Cabinets	2016	23,460		20	1,173	1,173	1,173	4
5	Tuscany Wing - Drywall & Nurses Station Repair	2016	2,633		20	132	132	132	5
6	Painted Dining Room And Hallways	2016	25,200		20	1,260	1,260	1,260	6
7	Architectural Fees - Wing Conversion	2016	12,000		20	600	600	600	7
8	Exterior Signage	2016	14,135		20	707	707	707	8
9	Tuscany/Barcelona Wing - Carpeting	2016	19,655		20	983	983	983	9
10	Unit Melbourne - Carpeting	2016	3,995		20	200	200	200	10
11	Painted 8 Regular And 4 Double Rooms	2016	11,957		20	598	598	598	11
12	Chiller Hook Up	2016	2,590		20	130	130	130	12
13	Repair Leaks In 4-Rtu Hydronic Coils	2016	6,646		20	332	332	332	13
14	Landscaping Including Shrubs & Ground Cover	2016	8,749		20	437	437	437	14
15	Installation Of Wiring For Kiosk, Nurse Station, And Speaker Loc	2016	4,496		20	524	524	824	15
16	Replaced Garbage Disposal	2016	3,250		20	379	379	379	16
17	Repaired Generator	2016	2,934		20	342	342	391	17
18	Repaired Pump	2016	4,902		20	327	327	327	18
19	Installed Light Fixtures For Melbourne, Tuscany & Sydney Wings	2016	3,853		20	502	502	860	19
20	Demolition Of 9 Fixtures & Can Lights For Nurse Stations	2016	3,610		20	182	182	234	20
21	Insulated Chilled Water Pipes/Mechanical Room Pipes	2016	10,875		20	544	544	544	21
22	Repaired Pump	2016	4,902		20	245	245	245	22
23	Removed And Replaced Garbage Disposal	2016	2,650		20	133	133	133	23
24	Repaired Fire Alarm System	2016	3,124		20	156	156	156	24
25	Repaired Valves On Boiler	2016	3,033		20	152	152	152	25
26	Cape Cod Unit - Demo/Carpentry/Drywall/Electical/Tiling.Paintin	2016	334,638		20	16,732	16,732	16,732	26
27	West Wing - Installed Nurse Station/Work Hub	2016	28,688		20	1,434	1,434	1,434	27
28	Installed New Chiller	2016	168,000		20	8,400	8,400	8,400	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,225,884	\$ 1,187		\$ 55,368	\$ 54,181	\$ 79,715	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,225,884	\$ 1,187		\$ 55,368	\$ 54,181	\$ 79,715	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,225,884	\$ 1,187		\$ 55,368	\$ 54,181	\$ 79,715	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$1,225,884	\$1,187		\$55,368	\$54,181	\$79,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,225,884	\$1,187		\$55,368	\$54,181	\$79,715	34

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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
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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.

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from Legacy Real Properties	2009	20,502	761	30	683	(78)	5,125	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Legacy HC Financial Services	2012	922	20	20	46	26	231	9
10 Allocated from Legacy HC Financial Services	2013	2,950	65	20	147	82	590	10
11 Allocated from Legacy HC Financial Services	2014	288	6	20	14	8	43	11
12 Allocated from Legacy HC Financial Services	2015	397	9	20	20	11	40	12
13								13
14 Allocated from Legacy Real Properties	2009	11,643	188	20	582	394	3,929	14
15 Allocated from Legacy Real Properties	2010	3,540	57	20	142	85	921	15
16 Allocated from Legacy Real Properties	2011	5,032	81	20	252	171	1,510	16
17								17
18 Allocated from CF St. Louis LLC	2016	29,334		20	1,467	1,467	1,467	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)		\$ 74,608	\$ 1,187		\$ 3,353	\$ 2,166	\$ 13,856	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$74,608	\$1,187		\$3,353	\$2,166	\$13,856	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$74,608	\$1,187		\$3,353	\$2,166	\$13,856	34

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

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	\$327,722	\$816	\$19,607	\$18,791	10	\$49,494	71
72	Current Year Purchases	329,703	92	32,971	32,879	10	32,971	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$657,425	\$908	\$52,577	\$51,669		\$82,465	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,885,955	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,095	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$107,946	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$105,851	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$162,180	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	Assisted Living Addition - 2016	\$53,025	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$53,025	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$192,702	92
93			93
94			94
95		\$192,702	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: Cambridge Realty
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

NO
- If NO, see instructions.

		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:		144		\$ 851,649			3
4	Additions							4
5	Offsite Storage				1,028			5
6	Alloc Legacy/Progressive HC				63			6
7	TOTAL		144		\$ 852,740			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: *

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: \$ 15,449Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

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

Fiscal Year Ending

Annual Rent

12. /2017\$

13. /2018\$

14. /2019\$

* 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.

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

☒ 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	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 556,205	\$		\$ 556,205	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			135,509			135,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			614,889			614,889	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				650,354		650,354	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					142,258	161,075		303,333	13
14	TOTAL			\$		\$ 1,448,861	\$ 811,429		\$ 2,260,290	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,639,247		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,726		6
7	Other Prepaid Expenses	48,083		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	815,125		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,531,181	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	782,067		15
16	Equipment, at Historical Cost	986,964		16
17	Accumulated Depreciation (book methods)	(39,802)		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): <u>See Attached Schedule</u>	243,771		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,973,000	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,504,181	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,500,228	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,826,577		29
30	Accrued Salaries Payable	108,388		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,940		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	189,937		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,634,070	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	904,978		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 904,978	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,539,048	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,034,867)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,504,181	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (717,732)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (717,734)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(317,133)	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)	\$ (317,133)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,034,867)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,496,224	1
2	Discounts and Allowances for all Levels	(7,629,857)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,866,367	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,564,923	6
7	Oxygen	181	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,565,104	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	627,700	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	138,941	19
20	Radiology and X-Ray	10,385	20
21	Other Medical Services	17,784	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 794,810	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,670	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,670	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	51,730	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 51,730	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,281,681	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,089,910	31
32	Health Care	5,246,617	32
33	General Administration	2,744,620	33
	B. Capital Expense		
34	Ownership	1,100,005	34
	C. Ancillary Expense		
35	Special Cost Centers	3,157,810	35
36	Provider Participation Fee	259,852	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,598,814	40
41	Income before Income Taxes (line 30 minus line 40)**	(317,133)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (317,133)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Various</u>	6,872,716	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,872,716	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,214	3,494	\$ 209,442	\$ 59.94	1
2	Assistant Director of Nursing	1,254	1,363	61,803	45.34	2
3	Registered Nurses	40,737	44,279	1,463,605	33.05	3
4	Licensed Practical Nurses	25,878	28,128	763,055	27.13	4
5	CNAs & Orderlies	107,401	116,741	1,835,171	15.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,456	9,192	140,426	15.28	8
9	Activity Director	2,707	2,942	51,234	17.41	9
10	Activity Assistants	7,453	8,101	94,600	11.68	10
11	Social Service Workers	7,203	7,830	156,653	20.01	11
12	Dietician					12
13	Food Service Supervisor	3,920	4,261	106,061	24.89	13
14	Head Cook	9,337	10,149	153,820	15.16	14
15	Cook Helpers/Assistants	28,990	31,511	362,758	11.51	15
16	Dishwashers					16
17	Maintenance Workers	7,835	8,516	182,764	21.46	17
18	Housekeepers					18
19	Laundry	7,499	8,151	85,404	10.48	19
20	Administrator	2,189	2,379	97,334	40.91	20
21	Assistant Administrator	382	415	14,260	34.36	21
22	Other Administrative					22
23	Office Manager	1,205	1,310	25,536	19.49	23
24	Clerical	25,596	27,821	454,145	16.32	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	1,009	1,097	21,231	19.35	31
32	Other Health Care(specify)					32
33	Other(specify)	1,594	1,733	26,648	15.38	33
34	TOTAL (lines 1 - 33)	293,859	319,413	\$ 6,305,950 *	\$ 19.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 30,691	01-03	35
36	Medical Director	Monthly	57,250	09-03	36
37	Medical Records Consultant	Monthly	3,200	10-03	37
38	Nurse Consultant	Monthly	53,176	10-03	38
39	Pharmacist Consultant	Monthly	14,982	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,658	11-03	44
45	Social Service Consultant	Monthly	41,323	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	1,250	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 203,530		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2	40	10-03	52
53	TOTAL (lines 50 - 52)	2	\$ 40		53

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Warren Barr Lincolnshire

0053587

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Carrasco	Administrator	0.00%	\$ 52,408
Josh Graber	Administrator	0.00%	44,926
Ryan Gapsis	Assistant Admin	0.00%	2,472
Meir Sharp	Assistant Admin	0.00%	11,788
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,593

B. Administrative - Other

Description	Amount
Management Fees - Yair Zuckerman	\$ 6,469
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 6,469

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	\$ 22,000
Achieve Accreditation	Joint Commission Consult	7,549
Julie Tolbert	Notary Services	160
Lexis Nexis	Data Processing	2,342
ProPay HR LLC	Payroll Services	26,554
Personnel Planners	Unemployment Tax Consult	1,767
Cukierski & Kowal, LLC	DOL Audit	324
Lighthouse Services Inc.	Compliance	353
Shkop Financial Services	Financial Consultant	141
Michigan Peer Review	Peer Review	590
See Attached	Legal	34,922
See Supplemental Schedule		185,538
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 282,241

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 168,489
Unemployment Compensation Insurance	88,774
FICA Taxes	482,405
Employee Health Insurance	144,346
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	9,811
Employee Physical Exams	15,327
Other Employee Benefits	36,003
TOTAL (agree to Schedule V, line 22, col.8)	\$ 945,155

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,090
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 557)	5,566
Patient Background Checks	
Dues and Subscriptions	7,893
License and Permits	21,361
Allocated from Legacy HC	1,791
Allocated from Progressive HC	135
See Supplemental Schedule	2
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 39,838

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	42,265
Allocated from Legacy HC	1,190
Allocated from Progressive HC	260
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 43,715

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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?
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,698 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. \$ 259,852
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 benefit on Schedule V. \$ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? N/A 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- 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