

		FOR BHF USE					

LL1

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: 0052415

Facility Name: Warren Barr Lvg & Rehab Ctr

Address: 66 West Oak Street Chicago 60610
Number City Zip Code

County: Cook

Telephone Number: (312) 705-5100 Fax # (312) 705-5041

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2013

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

N/A

1	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	271	271	99,186	1
2				2
3				3
4				4
5				5
6				6
7	271	TOTALS	271	99,186

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	20,647	3,649	39,854	64,150
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	20,647	3,649	39,854	64,150

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.68%

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 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 8/1/2013

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

271

and days of care provided

30,251

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 Lvg & Rehab Ctr** # **0052415** 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	752,598	92,494	1,440	846,532		846,532		846,532			1
2	Food Purchase		659,834		659,834		659,834	(42,816)	617,018			2
3	Housekeeping	333,059	88,992		422,051		422,051	189	422,240			3
4	Laundry	39,460	29,209	92,031	160,700		160,700		160,700			4
5	Heat and Other Utilities			331,716	331,716		331,716	(14,607)	317,109			5
6	Maintenance	138,821	11,892	324,471	475,184		475,184	163,088	638,272			6
7	Other (specify):*											7
8	TOTAL General Services	1,263,938	882,421	749,658	2,896,017		2,896,017	105,854	3,001,871			8
	B. Health Care and Programs											
9	Medical Director			105,816	105,816		105,816		105,816			9
10	Nursing and Medical Records	6,349,916	137,685	297,267	6,784,868		6,784,868	48,535	6,833,403			10
10a	Therapy	229,299	220		229,519		229,519	(23,364)	206,155			10a
11	Activities	177,739	55,846		233,585		233,585		233,585			11
12	Social Services	447,701	143,577	2,708	593,986		593,986	188,465	782,451			12
13	CNA Training											13
14	Program Transportation			306,780	306,780		306,780	11	306,791			14
15	Other (specify):* Sitter, Escort Services			119,795	119,795		119,795	20,068	139,863			15
16	TOTAL Health Care and Programs	7,204,655	337,328	832,366	8,374,349		8,374,349	233,715	8,608,064			16
	C. General Administration											
17	Administrative	159,974		12,174	172,148		172,148	207,373	379,521			17
18	Directors Fees											18
19	Professional Services			335,213	335,213	(1,213)	334,000	(82,886)	251,114			19
20	Dues, Fees, Subscriptions & Promotions			163,976	163,976		163,976	(61,758)	102,218			20
21	Clerical & General Office Expenses	667,793	9,906	1,273,731	1,951,430		1,951,430	(787,901)	1,163,529			21
22	Employee Benefits & Payroll Taxes			2,308,687	2,308,687		2,308,687		2,308,687			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,188	16,188		16,188	3,729	19,917			24
25	Other Admin. Staff Transportation			20,451	20,451		20,451		20,451			25
26	Insurance-Prop.Liab.Malpractice			318,150	318,150		318,150	7,774	325,924			26
27	Other (specify):*							71,522	71,522			27
28	TOTAL General Administration	827,767	9,906	4,448,570	5,286,243	(1,213)	5,285,030	(642,148)	4,642,882			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,296,360	1,229,655	6,030,594	16,556,609	(1,213)	16,555,396	(302,579)	16,252,817			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							1,198,658	1,198,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			152,364	152,364		152,364	1,813,714	1,966,078			32
33	Real Estate Taxes			594,000	594,000	1,213	595,213	2,951	598,165			33
34	Rent-Facility & Grounds			2,229,602	2,229,602		2,229,602	(2,225,840)	3,762			34
35	Rent-Equipment & Vehicles			33,033	33,033		33,033	(19,286)	13,747			35
36	Other (specify):*			607,700	607,700		607,700	(607,700)				36
37	TOTAL Ownership			3,616,699	3,616,699	1,213	3,617,912	162,497	3,780,409			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	3,265,950	2,401,520	602,820	6,270,290		6,270,290		6,270,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			361,435	361,435		361,435		361,435			42
43	Other (specify):*			1,464,187	1,464,187		1,464,187	(1,464,187)				43
44	TOTAL Special Cost Centers	3,265,950	2,401,520	2,428,442	8,095,912		8,095,912	(1,464,187)	6,631,725			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	12,562,310	3,631,175	12,075,735	28,269,220		28,269,220	(1,604,269)	26,664,951			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	(18,338)	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	(293,462)	30		9
10	Interest and Other Investment Income	(9,133)	32		10
11	Discounts, Allowances, Rebates & Refunds	(43,651)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(372)	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	(31,318)	21		18
19	Entertainment	(10,911)	21		19
20	Contributions	(28,684)	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	(716,327)	21		24
25	Fund Raising, Advertising and Promotional	(25,092)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,621,165)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,798,453)		\$	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)	2,194,184		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,194,184		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,604,269)		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

Report Period Beginning:

Ending:

ID#

0052415

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Miscellaneous Income	\$ (697)	21	1
2	Patient Personal Items	(25,984)	10	2
3	Marketing	(95,618)	43	3
4	Bank Charges	(2,154)	21	4
5	Sequestration	(328,886)	21	5
6	Therapy Discounts	(23,364)	10A	6
7	Pharmacy Discounts	(8,781)	10	7
8	Amortization	(607,700)	36	8
9	Non-Allowable Auto Lease	(19,387)	35	9
10	Additional R&M	129,980	06	10
11	PAC Dues	(11,633)	20	11
12	Annual Report	(500)	20	12
13	Building Co - Bank Service Charge	(5,367)	21	13
14	Building Co - Amortization	(200,987)	36	14
15	Non-Allowable Expense	(1,368,569)	43	15
16	Non-Allowable Legal	(51,518)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,621,165)		49

ID#

0052415

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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	(44,023)		265		942							(42,816)	2
3	Housekeeping			189									189	3
4	Laundry													4
5	Heat and Other Utilities	(18,338)		829			2,902						(14,607)	5
6	Maintenance	129,980		11,004		18,853	3,250						163,088	6
7	Other (specify):*													7
8	TOTAL General Services	67,619		12,287		19,795	6,152						105,854	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34,765)				83,300							48,535	10
10a	Therapy	(23,364)											(23,364)	10a
11	Activities													11
12	Social Services					188,465							188,465	12
13	CNA Training													13
14	Program Transportation					11							11	14
15	Other (specify):*					20,068							20,068	15
16	TOTAL Health Care and Programs	(58,129)				291,844							233,715	16
	C. General Administration													
17	Administrative			17,104		190,268							207,373	17
18	Directors Fees													18
19	Professional Services	(51,518)		(21,119)	113	2,778	1,313	(14,453)					(82,886)	19
20	Fees, Subscriptions & Promotions	(65,909)		3,371		775	5						(61,758)	20
21	Clerical & General Office Expenses	(1,095,660)	5,367	299,538		2,813	41						(787,901)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,240		1,489							3,729	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,933		5,257	583						7,774	26
27	Other (specify):*			64,797		6,725							71,522	27
28	TOTAL General Administration	(1,213,087)	5,367	367,864	113	210,106	1,942	(14,453)					(642,148)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,203,597)	5,367	380,152	113	521,745	8,095	(14,453)					(302,579)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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	(293,462)	1,488,176	889	3,055								1,198,658	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,133)	1,815,223	14	1,107		6,502						1,813,714	32
33	Real Estate Taxes			1,571			1,380						2,951	33
34	Rent-Facility & Grounds		(2,226,000)	83,254		64	(83,157)						(2,225,840)	34
35	Rent-Equipment & Vehicles	(19,387)		101									(19,286)	35
36	Other (specify):*	(808,687)	200,987										(607,700)	36
37	TOTAL Ownership	(1,130,669)	1,278,386	85,829	4,162	64	(75,275)						162,497	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):*	(1,464,187)											(1,464,187)	43
44	TOTAL Special Cost Centers	(1,464,187)											(1,464,187)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,798,453)	1,283,753	465,981	4,275	521,808	(67,180)	(14,453)					(1,604,269)	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	34	Rent	\$ 2,226,000	FNR WB, LLC	100.00%	\$	(2,226,000)	1
2	V	32	Interest	44	FNR WB, LLC	100.00%	1,815,267	1,815,223	2
3	V	21	Bank Service		FNR WB, LLC	100.00%	5,367	5,367	3
4	V	30	Depreciation		FNR WB, LLC	100.00%	1,488,176	1,488,176	4
5	V	36	Amortization		FNR WB, LLC	100.00%	200,987	200,987	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			\$ 2,226,044			\$ 3,509,797	\$ * 1,283,753	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	<u>FOOD</u>	\$	<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>\$ 265</u>	<u>\$ 265</u>	15
16	V	3	<u>HOUSEKEEPING SUPPLIES</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>189</u>	<u>189</u>	16
17	V	5	<u>UTILITIES</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>829</u>	<u>829</u>	17
18	V	6	<u>GROUND & MAINTENANCE</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>8,271</u>	<u>8,271</u>	18
19	V	6	<u>MAINTENANCE SALARY</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>2,733</u>	<u>2,733</u>	19
20	V	17	<u>CFO SALARY</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>17,104</u>	<u>17,104</u>	20
21	V	19	<u>PROFESSIONAL FEES</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>38,881</u>	<u>38,881</u>	21
22	V	20	<u>FEES, SUBSCRIPTIONS</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>3,371</u>	<u>3,371</u>	22
23	V	21	<u>CLERICAL & GENERAL WAGES</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>259,417</u>	<u>259,417</u>	23
24	V	21	<u>CLERICAL & GENERAL OTHER COSTS</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>40,121</u>	<u>40,121</u>	24
25	V	24	<u>SEMINARS</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>2,240</u>	<u>2,240</u>	25
26	V	26	<u>INSURANCE</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>1,933</u>	<u>1,933</u>	26
27	V	27	<u>EMP. BEN.-GEN. ADMIN.</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>64,797</u>	<u>64,797</u>	27
28	V	30	<u>DEPRECIATION</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>889</u>	<u>889</u>	28
29	V	32	<u>INTEREST</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>14</u>	<u>14</u>	29
30	V	33	<u>REAL ESTATE TAXES</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>1,571</u>	<u>1,571</u>	30
31	V	34	<u>RENT</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>83,157</u>	<u>83,157</u>	31
32	V	34	<u>STORAGE</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>97</u>	<u>97</u>	32
33	V	35	<u>EQUIPMENT RENTAL</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>101</u>	<u>101</u>	33
34	V								34
35	V	17	<u>MANAGEMENT FEES</u>	<u>12,174</u>	<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>		<u>(12,174)</u>	35
36	V	19	<u>BOOKKEEPING FEES</u>	<u>60,000</u>	<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>		<u>(60,000)</u>	36
37	V	17	<u>MANAGEMENT FEES - YAIR ZUCKERMAN</u>		<u>Legacy Healthcare Financial Services</u>	<u>100.00%</u>	<u>12,174</u>	<u>12,174</u>	37
38	V								38
39	Total			\$ 72,174			\$ 538,155	\$ * 465,981	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%	\$ 113	\$ 113	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	3,055	3,055	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	1,107	1,107	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			\$			\$ 4,275	\$ * 4,275	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	2	<u>FOOD</u>	\$	<u>Progressive Healthcare Consulting</u>	100.00%	\$ 942	\$ 942	15
16	V	6	<u>MAINTENANCE SALARY</u>		<u>Progressive Healthcare Consulting</u>	100.00%	18,205	18,205	16
17	V	6	<u>BUILDING MAINTENANCE AND R&M</u>		<u>Progressive Healthcare Consulting</u>	100.00%	648	648	17
18	V	10	<u>MEDICAL AND NURSING SUPPLIES</u>		<u>Progressive Healthcare Consulting</u>	100.00%	252	252	18
19	V	10	<u>NURSING SALARIES</u>		<u>Progressive Healthcare Consulting</u>	100.00%	181,128	181,128	19
20	V	12	<u>ACTIVITIES PROGRAM</u>		<u>Progressive Healthcare Consulting</u>	100.00%	227	227	20
21	V	12	<u>CLERGY SALARY</u>		<u>Progressive Healthcare Consulting</u>	100.00%	3,288	3,288	21
22	V	12	<u>ADMISSIONS SALARY</u>		<u>Progressive Healthcare Consulting</u>	100.00%	184,950	184,950	22
23	V	14	<u>PATIENT TRANSPORTATION</u>		<u>Progressive Healthcare Consulting</u>	100.00%	11	11	23
24	V	15	<u>EMP. BEN.-NURSING</u>		<u>Progressive Healthcare Consulting</u>	100.00%	27,117	27,117	24
25	V	17	<u>ADMIN SALARY- NON OWNER</u>		<u>Progressive Healthcare Consulting</u>	100.00%	190,268	190,268	25
26	V	19	<u>PROFESSIONAL FEES</u>		<u>Progressive Healthcare Consulting</u>	100.00%	2,778	2,778	26
27	V	20	<u>FEES, SUBSCRIPTIONS</u>		<u>Progressive Healthcare Consulting</u>	100.00%	775	775	27
28	V	21	<u>CLERICAL & GENERAL</u>		<u>Progressive Healthcare Consulting</u>	100.00%	2,813	2,813	28
29	V	24	<u>SEMINARS</u>		<u>Progressive Healthcare Consulting</u>	100.00%	1,489	1,489	29
30	V	27	<u>EMP. BEN.-NON-NURSING</u>		<u>Progressive Healthcare Consulting</u>	100.00%	56,174	56,174	30
31	V	26	<u>INSURANCE</u>		<u>Progressive Healthcare Consulting</u>	100.00%	5,257	5,257	31
32	V	34	<u>STORAGE RENTAL</u>		<u>Progressive Healthcare Consulting</u>	100.00%	64	64	32
33	V								33
34	V								34
35	V	10	<u>NURSING</u>	98,079	<u>Progressive Healthcare Consulting</u>	100.00%		(98,079)	35
36	V	15	<u>PAYROLL TAXES - NURSING</u>	7,049	<u>Progressive Healthcare Consulting</u>	100.00%		(7,049)	36
37	V	27	<u>PAYROLL TAXES - NON-NURSING</u>	49,449	<u>Progressive Healthcare Consulting</u>	100.00%		(49,449)	37
38	V								38
39	Total			\$ 154,577			\$ 676,385	\$ * 521,808	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%	\$ 2,902	\$ 2,902	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	3,250	3,250	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	1,313	1,313	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	5	5	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	41	41	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	583	583	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	6,502	6,502	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	1,380	1,380	22
23	V								23
24	V	34	RENT	83,157	CF ST. LOUIS, LLC	100.00%		(83,157)	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			\$ 83,157			\$ 15,977	\$ * (67,180)	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	\$ 60,223	ProPay HR LLC	24.00%	\$ 45,770	\$ (14,453)	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			\$ 60,223			\$ 45,770	\$ * (14,453)	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	NETZACH INVESTMENTS, LLC	10.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	FNR WB, LLC		BUILDING CO	1
2	EREZ BAVER	2.50%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3	CHAIM RAJCHENBACH	28.52%	CARLTON SKILED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPING	3
4	MENACHEM SHABAT	28.52%	CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	4
5	RONALD SHABAT	10.38%	ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	5
6	YAIR ZUCKERMAN	2.09%	EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	6
7	SUSAN FRIEDMAN	5.00%	GROVE OF FOX VALLEY	AURORA	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	7
8	RAJCHENBACH FAMILY TRUST	6.69%	LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	8
9	YOSEPH & NAOMI RAJCHENBACH	0.44%	GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	LINCOLNSHIRE ASSISTED LIVING	LINCOLNSHIRE	ASSISTED LIVING	9
10	AVROHOM & CHANA RAJCHENBACH	0.44%	LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR LLC	EVANSTON	PAYROLL PROCESSING	10
11	SHLOMO ZALMAIN BUSEL & CHAVA BUSEL	0.44%	LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	11
12	PINCHAS & NAHAMA SCHWARTZ	0.44%	LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				12
13	ROSS BOTTNER	2.61%	AVANTARA LONG GROVE	LONG GROVE				13
14	JACK RAJCHENBACH	1.95%	SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				14
15			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				15
16			WARREN BARR NORTH SHORE	HIGHLAND PARK				16
17			AVANTARA PARK RIDGE	PARK RIDGE				17
18			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				18
19			WARREN BARR SOUTH LOOP	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

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	Adminstrative	2.09%	See Attached	3.04	6.08%	Mgmt Fee	\$ 12,174	17-3	1
2	Ross Bottner	Owner	Administrative	2.61%	See Attached	2.43	6.08%	Alloc Salary	12,174	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	\$ 24,348		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 Lvg & Rehab Ctr # 0052415 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 Lvg & Rehab Ctr # 0052415 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	\$	99,186	\$ 265	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,629,488	29	3,107		99,186	189	2
3	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	13,622		99,186	829	3
4	6	GROUND & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	135,883		99,186	8,271	4
5	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,629,488	29	44,897	44,897	99,186	2,733	5
6	17	CFO SALARY	AVAIL. BED DAYS	1,629,488	29	281,003	281,003	99,186	17,104	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	638,760		99,186	38,881	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	55,387		99,186	3,371	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,629,488	29	4,261,866	4,261,866	99,186	259,417	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,629,488	29	659,124		99,186	40,121	10
11	24	SEMINARS	AVAIL. BED DAYS	1,629,488	29	36,800		99,186	2,240	11
12	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	31,752		99,186	1,933	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,629,488	29	1,064,526		99,186	64,797	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	14,600		99,186	889	14
15	32	INTEREST	AVAIL. BED DAYS	1,629,488	29	234		99,186	14	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	25,813		99,186	1,571	16
17	34	RENT	AVAIL. BED DAYS	1,629,488	29	1,366,146		99,186	83,157	17
18	34	STORAGE	AVAIL. BED DAYS	1,629,488	29	1,600		99,186	97	18
19	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,629,488	29	1,654		99,186	101	19
20									0	20
21	17	MANAGEMENT FEES- Y. ZUC	AVG HOURS WKD	50	29	200,000		3.13	12,174	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 8,841,129	\$ 4,587,766		\$ 538,155	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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		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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	\$ 1,852	\$	99,186	\$ 113	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	50,196		99,186	3,055	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	18,179		99,186	1,107	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	\$		\$ 4,275	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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	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	1,167,679	21	\$ 11,123	\$	98,915	\$ 942	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	21	214,912	214,912	98,915	18,205	2
3	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	1,167,679	21	7,646		98,915	648	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	21	2,971		98,915	252	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	21	2,138,189	2,138,189	98,915	181,128	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	21	2,679		98,915	227	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	21	38,812	38,812	98,915	3,288	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	21	2,183,313	2,183,313	98,915	184,950	8
9	14	PATIENT TRANSPORTATION	AVAIL. BED DAYS	1,167,679	21	128		98,915	11	9
10	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	21	320,111		98,915	27,117	10
11	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	21	2,246,090	2,246,090	98,915	190,268	11
12	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	21	32,793		98,915	2,778	12
13	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	21	9,154		98,915	775	13
14	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	21	33,203		98,915	2,813	14
15	24	SEMINARS	AVAIL. BED DAYS	1,167,679	21	17,580		98,915	1,489	15
16	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,167,679	21	663,131		98,915	56,174	16
17	26	INSURANCE	AVAIL. BED DAYS	1,167,679	21	62,063		98,915	5,257	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,167,679	21	750		98,915	64	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,984,649	\$ 6,821,317		\$ 676,385	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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	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	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	\$ 47,675	\$	99,186	\$ 2,902	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	53,400		99,186	3,250	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	21,572		99,186	1,313	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	76		99,186	5	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,629,488	29	678		99,186	41	5
6	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	9,585		99,186	583	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	106,824		99,186	6,502	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	22,674		99,186	1,380	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	\$		\$ 15,977	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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		\$	\$		\$ 45,770	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				\$	\$		\$ 45,770	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 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 Lvg & Rehab Ctr # 0052415 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

Ending: 12/31/16

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 Lvg & Rehab Ctr # 0052415 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	The Private Bank		X	Mortgage			\$	37,101,877			\$	1,545,541	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X					2,514,860				152,364	6
7	CapEX		X	Line of Credit				4,810,644				269,727	7
8	See Supplemental Schedule				-							7,623	8
9	TOTAL Facility Related						\$	44,427,381			\$	1,975,255	9
	B. Non-Facility Related*												
10	Interest Income		X									(9,133)	10
11	Interest Income - Bldg Co.		X									(44)	11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(9,177)	14
15	TOTALS (line 9+line14)						\$	44,427,381			\$	1,966,078	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 HC	X					\$	\$			\$ 14	8	
9	Allocated from Legacy Real Pro	X									1,107	9	
10	Allocated from CF St. Louis	X									6,502	10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										7,623	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

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

FACILITY NAME	<u>Warren Barr Lvg & Rehab Ctr</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0052415</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-6300	FAX #:	(847) 236-6301

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.

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lvg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052415

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)
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:

130,152

B. General Construction Type:

Exterior Concrete

Frame Steel

Number of Stories

9

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).

None

F. 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	Facility						\$ 4,000,000	
2	Allocated from Legacy Real Properties						4,980	
3	TOTALS						\$ 4,004,980	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	271		2013	1976	\$ 30,630,000	\$ 1,488,176	39	\$ 785,385	\$ (702,791)	\$ 2,044,513	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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10											10
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31											31
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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
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66									66
67									67
68	Related Party Allocations (Page 12I)		140,410	2,234		6,311	4,077	26,076	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 30,770,410	\$ 1,490,410		\$ 791,696	\$ (698,714)	\$ 2,070,589	70

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 30,770,410	\$ 1,490,410		\$ 791,696	\$ (698,714)	\$ 2,070,589	1
2	<u>Fence</u>	2013	2,600		20	130	130	520	2
3	<u>Chrome Faucet And Pop Up Handle</u>	2013	3,233		20	162	162	647	3
4	<u>Custom Wall Sconce</u>	2013	10,150		20	508	508	2,030	4
5	<u>7Th Floor Bathroom Flooring</u>	2013	6,400		20	320	320	1,280	5
6	<u>7Th Floor Sprinkler System</u>	2013	30,108		20	1,505	1,505	6,022	6
7	<u>6Th Floor Nurse Call System</u>	2013	26,000		20	1,300	1,300	5,200	7
8	<u>Electrical Wiring On 7Th Floor</u>	2013	5,000		20	250	250	1,000	8
9	<u>3Rd,4Th,7Th Floor - Demolition, Repaired Walls, New Drop Ceilings</u>	2013	30,000		20	1,500	1,500	6,000	9
10	<u>7Th Floor - Electric Work, Woodwork</u>	2013	25,000		20	1,250	1,250	5,000	10
11	<u>7Th Floor - Replaced Doors And Locks, Tiling</u>	2013	30,000		20	1,500	1,500	6,000	11
12	<u>Cafeteria, Resid Rooms, Bathrooms, Corridors - Wallpapers</u>	2013	2,650		20	133	133	530	12
13	<u>Handrails</u>	2013	3,279		20	164	164	656	13
14	<u>Chrome Faucet</u>	2013	3,725		20	186	186	745	14
15	<u>7Th Floor Lighting</u>	2013	4,450		20	223	223	890	15
16	<u>7Th Floor Wallcoverings</u>	2013	5,991		20	300	300	1,198	16
17	<u>Boiler Repair</u>	2013	6,153		20	308	308	1,231	17
18	<u>7Th Floor Doors</u>	2013	6,347		20	317	317	1,269	18
19	<u>Cubicle Curtains</u>	2013	15,851		20	793	793	3,170	19
20	<u>7Th Floor Wallcoverings</u>	2013	7,958		20	398	398	1,592	20
21	<u>Corridor - Carpeting Tile</u>	2013	9,226		20	461	461	1,845	21
22	<u>Bathroom Tilings</u>	2013	13,465		20	673	673	2,693	22
23	<u>7Th Floor Shower Room Tiling</u>	2013	13,493		20	675	675	2,699	23
24	<u>7Th Floor Fire Dampers</u>	2013	25,320		20	1,266	1,266	5,064	24
25	<u>6Th Floor - Priming And Painting, Plumbing, Drop Ceiling, Walls</u>	2013	30,000		20	1,500	1,500	6,000	25
26	<u>Wood Doors</u>	2013	10,211		20	511	511	2,042	26
27	<u>7Th Floor - Countertops, Ceramic Tiling</u>	2013	50,000		20	2,500	2,500	10,000	27
28	<u>6Th Floor Nurse Call System</u>	2013	11,800		20	590	590	2,360	28
29	<u>6Th Floor Wallcoverings</u>	2013	8,346		20	417	417	1,669	29
30	<u>Handrails</u>	2013	4,109		20	205	205	822	30
31	<u>Shower Room Tiling</u>	2013	5,044		20	252	252	1,009	31
32	<u>Corridors And Common Areas - Carpeting</u>	2013	9,310		20	466	466	1,862	32
33	<u>Common Area Carpeting</u>	2013	10,290		20	515	515	2,058	33
34	TOTAL (lines 1 thru 33)		\$ 31,195,919	\$ 1,490,410		\$ 812,971	\$ (677,439)	\$ 2,155,690	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

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		\$ 31,195,919	\$ 1,490,410		\$ 812,971	\$ (677,439)	\$ 2,155,690	1
2	6Th Floor - Demolition, Rough Carpentry	2013	40,000		20	2,000	2,000	8,000	2
3	7Th Floor Patient Rooms, Corridors, Offices - Painting	2013	51,315		20	2,566	2,566	10,263	3
4	7Th Floor Shower Room, Dining Room - Flooring, Countertop, Hy	2013	69,110		20	3,456	3,456	13,822	4
5	Alley Lighting	2013	2,585		20	129	129	517	5
6	7Th Floor Handrail	2013	3,165		20	158	158	633	6
7	6Th Floor Resident Room Ceiling Lights	2013	3,599		20	180	180	720	7
8	6Th And 7Th Floor Tiling And Wall Base	2013	3,940		20	197	197	788	8
9	6Th Floor Light Fixtures	2013	4,360		20	218	218	872	9
10	Repaired Doors	2013	5,400		20	270	270	1,080	10
11	6Th Floor Handrail	2013	5,709		20	285	285	1,142	11
12	Shower Room Tiling	2013	12,300		20	615	615	2,460	12
13	6Th Floor Sprinklers	2013	17,000		20	850	850	3,400	13
14	Shower Room Tiling	2013	17,835		20	892	892	3,567	14
15	7Th Floor - Construction	2013	30,000		20	1,500	1,500	6,000	15
16	Shower Room Tiling	2013	33,153		20	1,658	1,658	6,631	16
17	7Th Floor Electrical Work	2013	45,000		20	2,250	2,250	9,000	17
18	6Th Floor Wallcoverings	2013	6,012		20	301	301	902	18
19	Wall Sconce	2013	6,983		20	349	349	1,047	19
20	6Th Floor - Wallpaper, Ceiling, Walls, Tiling	2013	55,000		20	2,750	2,750	8,250	20
21	Security Cameras	2013	39,153		20	1,958	1,958	5,873	21
22	Shower Room Grab Bars	2013	2,607		20	130	130	391	22
23	Installed New Wood Doors	2013	31,801		20	1,590	1,590	4,770	23
24	Lower Level Shades	2013	10,238		20	512	512	1,536	24
25	Lower Level Shades	2013	12,561		20	628	628	1,884	25
26	Landscaping- Installed Upper Terrace For Lower Patio	2014	19,902		20	995	995	2,985	26
27	6Th Floor Nurse Call System	2014	25,053		20	1,253	1,253	3,758	27
28	6Th Floor - Prime And Paint, Flooring, Doors, Plumbing	2014	70,000		20	3,500	3,500	10,500	28
29	Elevator Repairs	2014	3,463		20	173	173	519	29
30	Boiler Repair	2014	6,804		20	340	340	1,021	30
31	6Th Floor And Garage Sprinkler Repair	2014	23,902		20	1,195	1,195	3,585	31
32	6Th Floor - Electric Work, Nurse Station, Flooring	2014	175,750		20	8,788	8,788	26,363	32
33	Repaired Condenser	2014	4,975		20	249	249	746	33
34	TOTAL (lines 1 thru 33)		\$ 32,034,593	\$ 1,490,410		\$ 854,905	\$ (635,505)	\$ 2,298,715	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

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 12C, Carried Forward		\$ 32,034,593	\$ 1,490,410		\$ 854,905	\$ (635,505)	\$ 2,298,715	1
2	Paging Sytem	2014	3,622		20	181	181	543	2
3	Repaired Dry Valve And Pipes	2014	10,826		20	541	541	1,624	3
4	Sprinkler Repair	2014	8,228		20	411	411	1,234	4
5	Door Repairs - Egress Locks	2014	3,888		20	194	194	583	5
6	5Th-9Th Floor Fire Dampers	2014	17,308		20	865	865	2,596	6
7	Signage	2014	6,715		20	336	336	1,007	7
8	2Nd Floor Hydronic Pipe Repair	2014	4,549		20	227	227	682	8
9	Repaired Pump For Chiller	2014	18,989		20	949	949	2,848	9
10	Door And Frame	2014	35,368		20	1,768	1,768	5,305	10
11	Heating/Cooling Unit Repair	2014	4,069		20	203	203	610	11
12	Fire Pump Anunciator	2014	4,311		20	216	216	647	12
13	Fire Dampers In Bathroom	2014	8,652		20	433	433	1,298	13
14	Repaired Colvent Plate Exchangers And Seals	2014	12,616		20	631	631	1,892	14
15	Anunciator System	2014	16,120		20	806	806	2,418	15
16	5Th Floor Tiling	2014	69,501		20	3,475	3,475	10,425	16
17	Heating/Cooling Unit Repair	2014	12,091		20	605	605	1,814	17
18	Replaced Hot Water Heater	2014	16,463		20	823	823	2,470	18
19	Glass Mount Bracket	2014	4,226		20	211	211	634	19
20	Doors	2014	8,382		20	419	419	1,257	20
21	5Th Floor Shower Room And Spa Tiling	2014	3,248		20	162	162	487	21
22	Handrails For Common Corridors	2014	7,198		20	360	360	1,080	22
23	5Th Floor Resident Rooms Light Fixtures	2014	6,968		20	348	348	1,045	23
24	5Th Floor Corridors Floor Covering	2014	9,254		20	463	463	1,388	24
25	6Th Floor Resident Rooms Wallpaper	2014	6,546		20	327	327	982	25
26	6Th Floor Corridors Wallpaper	2014	6,015		20	301	301	902	26
27	3Rd And 4Th Floor Corridors And Resident Rooms Painting	2014	3,500		20	175	175	525	27
28	Wood Doors For Corridors And Resident Rooms	2014	21,042		20	1,052	1,052	3,156	28
29	6Th Floor Common Area And Nurse Station - Fire Dampers	2014	22,570		20	1,128	1,128	3,385	29
30	Generator For 5Th Floor	2014	12,971		20	649	649	1,946	30
31	5Th Floor Corridors, Resid Rm & Bath, Lounge & Dining Rm	2014			20				31
32	Installed Fire Alarm System	2015	5,880		20	294	294	588	32
33	6Th And 7Th Floor Doors	2015	3,450		20	173	173	345	33
34	TOTAL (lines 1 thru 33)		\$ 32,409,159	\$ 1,490,410		\$ 873,633	\$ (616,777)	\$ 2,354,433	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

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 12D, Carried Forward		\$ 32,409,159	\$ 1,490,410		\$ 873,633	\$ (616,777)	\$ 2,354,433	1
2	Installed Fan Coil Unit For Resident Room	2015	2,999		20	150	150	300	2
3	6Th Floor Nurse Call System - Demo/Lights/Ceiling Mount	2015	31,775		20	1,589	1,589	3,178	3
4	Repaired Wiring For Phones	2015	2,654		20	133	133	265	4
5	Rewired Phones And Computers To Resident Rooms	2015	5,636		20	282	282	564	5
6	Replaced Sprinkler Valve	2015	2,705		20	135	135	270	6
7	Installed Fan Coil Unit	2015	3,915		20	196	196	392	7
8	Repaired Cooling Tower	2015	5,478		20	274	274	548	8
9	Repaired Air Handler On 2Nd Floor	2015	3,814		20	191	191	381	9
10	2Nd Floor Blinds	2015	3,920		20	196	196	392	10
11	Repaired 2Nd Fl Air Handler	2015	4,140		20	207	207	414	11
12	Rewired Cable From 2Nd Fl Med Rec Rm To Office	2015	3,180		20	159	159	318	12
13	Repaired 9Th Floor Pipes	2015	5,263		20	263	263	526	13
14	Repaired Insulation On 1St, 8Th And 9Th Floor	2015	6,633		20	332	332	663	14
15	Repaired 2 Passenger Elevator	2015	18,000		20	900	900	1,800	15
16	Removed And Installed New Windows In Facility	2015	13,750		20	688	688	1,375	16
17	Installed Fire Dampers On 9Th Floor	2015	6,680		20	334	334	668	17
18	8Th Floor - Drywall/Patchwork/Paint	2015	6,500		20	325	325	650	18
19	Installed Air Compressor And Air Dyer In Boiler Room	2015	14,154		20	708	708	1,415	19
20	Fire Alarm System On 1St Floor	2015	5,475		20	274	274	548	20
21	Installed New Air Handlers/Water Lines For Pipe Insulation	2015	2,787		20	139	139	279	21
22	Installed Door For Garage	2015	4,936		20	247	247	494	22
23	Paint Hallway Doors And 25 Resident Rooms	2015	22,870		20	1,144	1,144	2,287	23
24	Repaired Dampers On 3Rd And 4Th Floor	2015	4,972		20	249	249	497	24
25	Repaired Elevators	2015	3,930		20	197	197	393	25
26	1St Floor Fire Alarm System	2015	6,025		20	301	301	603	26
27	Fire Alarm In Elevator	2015	6,419		20	321	321	642	27
28	8Th Floor - Tiling/Trim Moldings/Lights/Ceiling Paint	2015	9,543		20	477	477	954	28
29	5Th Floor Bathroom Tiling	2015	9,692		20	485	485	969	29
30	1St Floor Exterior - Installed Fabric And Level Existing Ground	2015	3,345		20	167	167	334	30
31	Installed Zone Dampers For 3 Offices By Lobby	2015	4,749		20	237	237	475	31
32	Signs For East/West Side Of Facility/1St And 9Th Floor	2015	7,918		20	396	396	792	32
33	Installed Glass And Brackets For Side And Back Walls	2015	3,400		20	170	170	340	33
34	TOTAL (lines 1 thru 33)		\$ 32,646,417	\$ 1,490,410		\$ 885,496	\$ (604,914)	\$ 2,378,159	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

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 12E, Carried Forward		\$ 32,646,417	\$		\$ 885,496	\$ (604,914)	\$ 2,378,159	1
2	Welded Window For 9Th Floor	2015	3,086		20	154	154	309	2
3	9Th Floor - Repaired Carpet/Floor/Bathroom Walls/Tiles	2015	2,780		20	139	139	278	3
4	Sprinkler System In Garage/Generator/Storage Room	2015	17,406		20	870	870	1,741	4
5	9Th Floor Window Washing	2015	4,200		20	210	210	420	5
6	4 Resid Rm - Tiling/Outlet Cover And Paint	2015	11,118		20	556	556	1,112	6
7	Paint Ceiling/Post On 1St Fl Exterior/9Th Fl Window	2015	4,715		20	236	236	472	7
8	Fire Alarm System	2015	15,865		20	793	793	1,586	8
9	Seal Existing Stone Floor	2015	3,350		20	168	168	335	9
10	Repaired Tempering Valves	2015	3,405		20	170	170	341	10
11	8Th Floor Mirrors/Tiling	2015	7,543		20	377	377	754	11
12	Installed Floor Tile On Entrance Floor	2015	6,000		20	300	300	600	12
13	Signs For 9Th Floor	2015	3,241		20	162	162	324	13
14	Repaired Heaters	2015	33,426		20	1,671	1,671	3,343	14
15	1St Floor Shades	2015	6,186		20	309	309	619	15
16	Fire Alarm System	2015	8,395		20	420	420	840	16
17	Musics System In Lobby	2015	3,000		20	150	150	300	17
18	Chandelier And Hand Rails	2015	5,906		20	295	295	591	18
19	Ring Chandelier	2015	13,744		20	687	687	1,374	19
20	Light Fixture For 5Th Floor Corridor	2015	5,258		20	263	263	526	20
21	Bathroom Tiling	2015	7,058		20	353	353	706	21
22	9Th Floor Doors	2015	2,875		20	144	144	288	22
23	Polished Marble For 1St Floor Welcome Center	2015	2,532		20	127	127	253	23
24	Repaired Elevator Handrails	2015	18,900		20	945	945	1,890	24
25	Bathroom Shower Curtains	2015	2,728		20	136	136	273	25
26	9Th Floor - Removal Of Floor Tile	2015	52,224		20	2,611	2,611	5,222	26
27	9Th Fl Pt Room - Concrete Support Brackets	2015	2,890		20	145	145	289	27
28	9Th Floor Exit Sign	2015	7,649		20	382	382	765	28
29	9Th Floor Pt Room - Fire Alarm	2015	5,993		20	300	300	599	29
30	9Th Floor Pt Room - New Roof	2015	13,200		20	660	660	1,320	30
31	9Th Floor Pt Room - New Metal Panels	2015	4,330		20	217	217	433	31
32	5Th Floor Corridors, Resid Rm & Bath, Lounge & Dining Rm	2015			20				32
33	Electric, Plumbing, Tiling, Flooring	2015	375,000		20	18,750	18,750	37,500	33
34	TOTAL (lines 1 thru 33)		\$ 33,300,417	\$		\$ 918,196	\$ 32,700	\$ 2,443,559	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

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 12F, Carried Forward		\$ 33,300,417	\$		\$ 918,196	\$ 918,196	\$ 2,443,559	1
2	Installed Alarm System/Wanderguard System	2016	3,451		20	173	173	173	2
3	Installed Cables For Speakers/Phones	2016	36,172		20	1,809	1,809	1,809	3
4	Installed Outlets On 9Th Floor	2016	4,500		20	225	225	225	4
5	Lobby Area Office Dampers	2016	5,306		20	265	265	265	5
6	Pa Amplifier And Speakers	2016	5,897		20	295	295	295	6
7	Installed Pedestrian Door And Frame	2016	2,790		20	140	140	140	7
8	Corridor Sprinkler System	2016	7,187		20	359	359	359	8
9	Repaired Elevator	2016	15,059		20	753	753	753	9
10	Repaired Door Motor/Cables	2016	8,021		20	401	401	401	10
11	Kitchen - Replaced Walk In Cooler, New Coil Unit, Temperature Control	2016	6,944		20	347	347	347	11
12	Main Entrance - Installed Wander Guard System	2016	5,176		20	259	259	259	12
13	5Th Floor Drapery	2016	8,826		20	441	441	441	13
14	9Th Floor Shades	2016	2,975		20	149	149	149	14
15	Kitchen Millwork	2016	19,888		20	994	994	994	15
16	1St & 9Th Floor - Installed Doors, Frames And Hardware	2016	16,435		20	822	822	822	16
17	Repaired South Elevator Doors	2016	3,575		20	179	179	179	17
18	Roof Repair Over Glass Entrance	2016	8,700		20	435	435	435	18
19	Furnished And Installed Door Sensor For Elevators	2016	5,100		20	255	255	255	19
20	Installed New Springs/Air Switch For Doors	2016	2,592		20	130	130	130	20
21	Repaired 9Th Floor Nurse Call System	2016	4,350		20	218	218	218	21
22	Repaired Roof	2016	3,572		20	179	179	179	22
23	Repaired Motor/Valves/Pipes On Air Handlers	2016	3,730		20	187	187	187	23
24	7Th And 8Th Floor Bathrooms Sprinkler Repair	2016	9,667		20	483	483	483	24
25	1St And 9Th Floor - Flooring	2016	284,283		20	14,214	14,214	14,214	25
26	5Th-8Th Floor Shower Rooms - Tiling/Paint/Flooring	2016	40,163		20	2,008	2,008	2,008	26
27	East/West Spa Room - Demo/Framing/Floor/Tiling/Millwork/Electrical	2016	300,000		20	15,000	15,000	15,000	27
28	Kitchen - Stationary/Millwork	2016	22,819		20	1,141	1,141	1,141	28
29	Security System For 1St Floor And 9Th Floor Therapy Room	2016	18,914		20	946	946	946	29
30	8Th Flr Resid Rms/Lobby/Dining-Demo/Lighting/Framing/Flooring	2016	39,370		20	1,969	1,969	1,969	30
31	5Th Floor Electric/Plumbing/Paint/Flooring/Sprinkler	2016	75,151		20	3,758	3,758	3,758	31
32	2Nd Flr Offices - Demo/Masonry/Carpentry/Millwork/Electrical/Paint	2016	228,132		20	11,407	11,407	11,407	32
33	9Th Flr Pt Room - Flooring/Roof Deck/Doors/Demo/Electrical/Paint	2016			20				33
34	TOTAL (lines 1 thru 33)		\$ 34,499,163	\$		\$ 978,133	\$ 978,133	\$ 2,503,497	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$34,499,163	\$		\$978,133	\$	\$2,503,497	1
2	Concrete/Sprinkler/Architectural And Engineering Fees	2016	1,184,223		20	59,211	59,211	59,211	2
3	1St Flr Lobby/Exterior-A/C System/Electrical/Plumbing/Demo/Til	2016			20				3
4	Doors/Sprinkler/Carpentry/Architectural And Engineering Fees/P	2016	1,479,480		20	73,974	73,974	73,974	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$37,162,866	\$		\$1,111,318	\$133,185	\$2,636,682	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	38,583	1,432	30	1,286	(146)	9,646	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy HC & Financial Services	2012	1,736	38	20	87	49	434	9
10	Allocated from Legacy HC & Financial Services	2013	5,552	121	20	278	157	1,110	10
11	Allocated from Legacy HC & Financial Services	2014	542	12	20	27	15	81	11
12	Allocated from Legacy HC & Financial Services	2015	747	16	20	37	21	75	12
13									13
14	Allocated from Legacy Real Properties	2009	21,911	354	20	1,096	742	7,395	14
15	Allocated from Legacy Real Properties	2010	6,663	108	20	267	159	1,734	15
16	Allocated from Legacy Real Properties	2011	9,470	153	20	473	320	2,841	16
17									17
18	Allocated from CF St. Louis LLC	2016	55,206		20	2,760	2,760	2,760	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)		\$ 140,410	\$ 2,234		\$ 6,311	\$ 4,077	\$ 26,076	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	\$2,839,809	\$1,537	\$283,981	\$282,444	10	\$880,381	71
72	Current Year Purchases	250,883	173	23,717	23,544	10	23,717	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$3,090,692	\$1,710	\$307,698	\$305,988		\$904,098	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		Bus	2015	\$23,822	\$	\$4,764	\$4,764	5	\$9,529	76
77		Therapy Bus	2016	3,500		700	700	5	700	77
78										78
79										79
80	TOTALS			\$27,322	\$	\$5,464	\$5,464		\$10,229	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)	\$39,769,410	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,492,120	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,198,658	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(293,462)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,292,486	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$875,110	92
93			93
94			94
95		\$875,110	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YESNO
- 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:				\$			3
4	Additions							4
5	Storage/Parking Space				3,602			5
6	Allocated from Legacy HC and Progressive HC				161			6
7	TOTAL				\$3,763			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:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$13,747Description: 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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 1,434,457		\$	\$		\$ 1,434,457	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	292,303					292,303	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	1,539,160		69,229			1,608,389	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				1,978,787		1,978,787	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			30		533,591	422,733		956,354	13
14	TOTAL			\$ 3,265,950		\$ 602,820	\$ 2,401,520		\$ 6,270,290	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,500	\$ 410,072	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,563,002	5,563,002	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(390,911)	(390,911)	6
7	Other Prepaid Expenses	39,126	399,815	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	361,164	361,164	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,574,881	\$ 6,344,142	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,562	4,325,933	13
14	Buildings, at Historical Cost	8,261	20,690,348	14
15	Leasehold Improvements, at Historical Cost	6,568,703	6,568,703	15
16	Equipment, at Historical Cost	2,488,570	7,177,112	16
17	Accumulated Depreciation (book methods)	(933,133)	(5,995,638)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	4,533,019	11,295,343	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,688,982	\$ 44,061,801	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,263,863	\$ 50,405,943	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,548,183	\$ 1,548,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,514,860	7,907,767	29
30	Accrued Salaries Payable	983,233	983,233	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	33,113	33,113	31
32	Accrued Real Estate Taxes(Sch.IX-B)		348,588	32
33	Accrued Interest Payable	109,453	1,350,863	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	280,408	280,408	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,469,250	\$ 12,452,155	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		36,519,614	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	6,974,958	7,358,779	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,974,958	\$ 43,878,393	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,444,208	\$ 56,330,548	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,819,655	\$ (5,924,605)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,263,863	\$ 50,405,943	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,106,881	1
2	Restatements (describe):		2
3	PY Depreciation	175,725	3
4	PY Office Expense	39,632	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,322,238	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(502,583)	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)	\$ (502,583)	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)	\$ 5,819,655	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 25,019,435	1
2	Discounts and Allowances for all Levels	(17,905,407)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,114,028	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	18,278,703	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 18,278,703	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	1,961,697	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	204,673	19
20	Radiology and X-Ray	56,710	20
21	Other Medical Services	65,200	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,288,280	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,133	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,133	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	76,493	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 76,493	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 27,766,637	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,896,017	31
32	Health Care	8,374,349	32
33	General Administration	5,286,243	33
	B. Capital Expense		
34	Ownership	3,616,699	34
	C. Ancillary Expense		
35	Special Cost Centers	7,734,477	35
36	Provider Participation Fee	361,435	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,269,220	40
41	Income before Income Taxes (line 30 minus line 40)**	(502,583)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (502,583)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,818,851	44
45	Private Pay - Net Inpatient Revenue	330,200	45
46	Medicare - Net Inpatient Revenue	3,847,599	46
47	Other-(specify) Insurance	1,117,378	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,114,028	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	1,939	2,108	\$ 146,669	\$ 69.58	1
2	Assistant Director of Nursing	1,867	2,029	96,387	47.50	2
3	Registered Nurses	74,796	81,300	2,860,381	35.18	3
4	Licensed Practical Nurses	35,019	38,064	1,125,241	29.56	4
5	CNAs & Orderlies	147,866	160,724	2,082,086	12.95	5
6	CNA Trainees					6
7	Licensed Therapist	79,978	86,932	3,265,950	37.57	7
8	Rehab/Therapy Aides	12,038	13,085	198,767	15.19	8
9	Activity Director	3,602	3,915	88,342	22.57	9
10	Activity Assistants	7,614	8,276	89,397	10.80	10
11	Social Service Workers	17,846	19,398	406,555	20.96	11
12	Dietician	902	980	23,568	24.05	12
13	Food Service Supervisor	3,684	4,005	105,044	26.23	13
14	Head Cook	9,856	10,713	178,474	16.66	14
15	Cook Helpers/Assistants	34,989	38,032	445,512	11.71	15
16	Dishwashers					16
17	Maintenance Workers	6,894	7,493	138,821	18.53	17
18	Housekeepers	28,351	30,816	333,059	10.81	18
19	Laundry	3,441	3,740	39,460	10.55	19
20	Administrator	3,088	3,356	159,974	47.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	497	540	17,171	31.80	23
24	Clerical	36,420	39,587	650,622	16.44	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	1,149	1,248	23,284	18.66	31
32	Other Health Care(specify)					32
33	Other(specify)	6,177	6,715	87,547	13.04	33
34	TOTAL (lines 1 - 33)	518,013	563,056	\$ 12,562,311 *	\$ 22.31	34

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	\$ 1,440	01-03	35
36	Medical Director	Monthly	105,816	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	271,460	10-03	38
39	Pharmacist Consultant	Monthly	21,007	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				44
45	Social Service Consultant	Monthly	1,721	12-03	45
46	Other(specify) Clergy	Monthly	987	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 406,831		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	16	400	10-03	52
53	TOTAL (lines 50 - 52)	16	\$ 400		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Crystal Shelby	Administrator	0.00%	\$ 2,115	Workers' Compensation Insurance		\$ 328,185	IDPH License Fee	\$ 3,980	
Scott Sklar	Administrator	0.00%	157,859	Unemployment Compensation Insurance		236,484	Advertising: Employee Recruitment		
				FICA Taxes		942,771	Health Care Worker Background Check	19,140	
				Employee Health Insurance		586,397	(Indicate # of checks performed 1914)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	51,165	
				Union Pension		45,608	License and Permit	23,782	
				401K Expense		52,139	Allocated from Legacy HC	3,371	
				Employee Physical Exams		37,624	Allocated from Progressive HC	775	
				Other Employee Benefits		79,479	Allocated from CF St. Louis LLC	5	
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 159,975	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 102,218		
Description				Amount					
Management Fees - Yair Zuckerman				\$ 12,174					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 12,174					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Marcum LLP	Accounting		\$ 26,257			\$	Out-of-State Travel	\$	
Documentation Solutions	Compliance Audit		16,889						
LW Consulting	Technology Consultant		5,625						
Achieve Accreditation	Joint Commission Consult		10,407				In-State Travel		
DC Data Corporation	Project Management		643						
Global Water Technology	Water Treatment		3,158						
IIT/Source Tech	Data Processing		335						
IL Rytes Corporation	Compliance		9,123				Seminar Expense	16,188	
Lexis Nexis	Data Processing		2,106				Allocated from Legacy HC	2,240	
Legacy Healthcare	Bookkeeping		60,000				Allocated from Progressive HC	1,489	
See Attached	Legal		98,207						
See Supplemental Schedule			102,462				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 335,212			TOTAL (agree to Sch. V, line 24, col. 8)		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Warren Barr Lvg & Rehab Ctr		STATE OF ILLINOIS	#	0052415	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>IL Council on LTC \$35,252</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>64,843</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>361,435</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>Yes</u>							
(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? 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.			<u>No</u>							
(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?			\$ <u>No</u> Indicate the amount. \$ <u>N/A</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% Ln 14</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							