

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0054353 Facility Name: Warren Barr South Loop Address: 1725 S Wabash Avenue Chicago 60616 County: Cook Telephone Number: (312) 787-9400 Fax #: (312) 787-9590 HFS ID Number: Date of Initial License for Current Owners: 8/14/2014 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steven N. Lavenda Telephone Number: (847) 282-6300 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 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) (Type or Print Name) (Title) Paid Preparer (Signed) * Subject to the attached Accountants Consulting Report (Print Name and Title) (Firm Name & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 (Date) (Date) (Date) Phone # (217) 782-1630
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Facility Name & ID Number

Warren Barr South Loop

#

0054353

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	194	Skilled (SNF)	194	71,004	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,098	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	72,102	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	32,609	1,018	23,522	57,149	8
9	SNF/PED					9
10	ICF	504	16	69	589	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,113	1,034	23,591	57,738	14

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

80.08%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

8/14/2014

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

YES

X

Date

8/14/2014

NO

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

YES

X

NO

If YES, enter number of beds certified

194

and days of care provided

19,040

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2016

Fiscal Year:

12/31/2016

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

Facility Name & ID Number **Warren Barr South Loop** # **0054353** 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	527,084	50,505	200	577,789		577,789		577,789			1
2	Food Purchase		378,999		378,999		378,999	(15,309)	363,690			2
3	Housekeeping	221,906	71,238		293,144		293,144	137	293,281			3
4	Laundry	58,738	97,832	139,852	296,422		296,422		296,422			4
5	Heat and Other Utilities			207,644	207,644		207,644	(11,395)	196,249			5
6	Maintenance	96,115	9,800	216,589	322,504		322,504	156,528	479,032			6
7	Other (specify):*											7
8	TOTAL General Services	903,843	608,374	564,285	2,076,502		2,076,502	129,962	2,206,464			8
	B. Health Care and Programs											
9	Medical Director			96,703	96,703		96,703		96,703			9
10	Nursing and Medical Records	4,400,880	114,147	160,440	4,675,467		4,675,467	117,549	4,793,016			10
10a	Therapy	233,432	6,276	261,750	501,458		501,458	(13,732)	487,726			10a
11	Activities	121,939	8,167	403	130,509		130,509		130,509			11
12	Social Services	414,909	43,960	3,412	462,281		462,281	137,002	599,283			12
13	CNA Training											13
14	Program Transportation			79,068	79,068		79,068	8	79,076			14
15	Other (specify):*							15,785	15,785			15
16	TOTAL Health Care and Programs	5,171,160	172,550	601,776	5,945,486		5,945,486	256,613	6,202,099			16
	C. General Administration											
17	Administrative	191,421		8,850	200,271		200,271	149,122	349,393			17
18	Directors Fees											18
19	Professional Services			257,541	257,541	(882)	256,659	(124,957)	131,702			19
20	Dues, Fees, Subscriptions & Promotions			138,847	138,847		138,847	(89,076)	49,771			20
21	Clerical & General Office Expenses	381,981	8,477	1,203,952	1,594,410		1,594,410	(764,041)	830,369			21
22	Employee Benefits & Payroll Taxes			1,190,611	1,190,611		1,190,611		1,190,611			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,314	5,314		5,314	2,711	8,025			24
25	Other Admin. Staff Transportation			4,015	4,015		4,015		4,015			25
26	Insurance-Prop.Liab.Malpractice			426,207	426,207		426,207	5,651	431,858			26
27	Other (specify):*							64,468	64,468			27
28	TOTAL General Administration	573,402	8,477	3,235,337	3,817,216	(882)	3,816,334	(756,122)	3,060,212			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,648,405	789,401	4,401,398	11,839,204	(882)	11,838,322	(369,548)	11,468,775			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							846,770	846,770			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,472	143,472		143,472	1,163,928	1,307,400			32
33	Real Estate Taxes			314,911	314,911	882	315,793	2,145	317,938			33
34	Rent-Facility & Grounds			2,694,473	2,694,473		2,694,473	(2,693,276)	1,197			34
35	Rent-Equipment & Vehicles			50,695	50,695		50,695	(38,157)	12,538			35
36	Other (specify):*											36
37	TOTAL Ownership			3,203,551	3,203,551	882	3,204,433	(718,590)	2,485,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	258,467	1,510,677	2,775,349	4,544,493		4,544,493		4,544,493			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			339,932	339,932		339,932		339,932			42
43	Other (specify):*			1,305,623	1,305,623		1,305,623	(1,305,623)	(0)			43
44	TOTAL Special Cost Centers	258,467	1,510,677	4,420,904	6,190,048		6,190,048	(1,305,623)	4,884,425			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,906,872	2,300,078	12,025,853	21,232,803		21,232,803	(2,393,760)	18,839,043			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	(14,107)	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	843,903	30		9
10	Interest and Other Investment Income	(7,681)	32		10
11	Discounts, Allowances, Rebates & Refunds	(16,119)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,635)	21		18
19	Entertainment	(10,524)	21		19
20	Contributions	(57,874)	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	(745,729)	21		24
25	Fund Raising, Advertising and Promotional	(34,220)	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	(2,344,899)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,388,953)		\$	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)	(4,808)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,808)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,393,761)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Therapy Discounts	\$ (13,732)	10A	1
2	Patient Personal Items	(8,472)	10	2
3	Marketing	(14,585)	43	3
4	Bank Charges	(7,061)	21	4
5	Sequestration	(218,912)	21	5
6	Non-Allowable Auto Lease	(38,230)	35	6
7	Pharmacy Discounts	(5,830)	10	7
8	Non-Allowable Legal	(16,277)	19	8
9	Non-Allowable Expense	(1,291,038)	43	9
10	Additional R&M	132,461	06	10
11	Building Co - Bank Service Charge	(49,500)	21	11
12	Building Co - Management Fee	(780,000)	21	12
13	Building Co - Processing Fee	(9)	21	13
14	Building Co - Professional Fee	(12,314)	19	14
15	Building Co - Title Fee	(21,400)	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,344,899)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
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 South Loop # 0054353 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	(16,187)		193		685							(15,309)	2
3	Housekeeping			137									137	3
4	Laundry													4
5	Heat and Other Utilities	(14,107)		603			2,110						(11,395)	5
6	Maintenance	132,461		7,999		13,705	2,363						156,528	6
7	Other (specify):*													7
8	TOTAL General Services	102,167		8,932		14,390	4,472						129,962	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(14,302)				131,851							117,549	10
10a	Therapy	(13,732)											(13,732)	10a
11	Activities													11
12	Social Services					137,002							137,002	12
13	CNA Training													13
14	Program Transportation					8							8	14
15	Other (specify):*					15,785							15,785	15
16	TOTAL Health Care and Programs	(28,034)				284,647							256,613	16
	C. General Administration													
17	Administrative			12,434		136,688							149,122	17
18	Directors Fees													18
19	Professional Services	(28,591)	12,314	(111,736)	82	2,019	955						(124,957)	19
20	Fees, Subscriptions & Promotions	(113,494)	21,400	2,451		564	3						(89,076)	20
21	Clerical & General Office Expenses	(1,813,370)	829,509	217,745		2,045	30						(764,041)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,628		1,083							2,711	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,405		3,822	424						5,651	26
27	Other (specify):*			47,103		17,364							64,468	27
28	TOTAL General Administration	(1,955,454)	863,223	171,031	82	163,585	1,412						(756,122)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,881,321)	863,223	179,963	82	462,621	5,884						(369,548)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr South Loop # 0054353 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	843,903		646	2,221								846,770	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,681)	1,166,068	10	804		4,727						1,163,928	32
33	Real Estate Taxes			1,142			1,003						2,145	33
34	Rent-Facility & Grounds		(2,693,393)	60,520		46	(60,450)						(2,693,276)	34
35	Rent-Equipment & Vehicles	(38,230)		73									(38,157)	35
36	Other (specify):*													36
37	TOTAL Ownership	797,992	(1,527,325)	62,392	3,025	46	(54,720)						(718,590)	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):*	(1,305,623)											(1,305,623)	43
44	TOTAL Special Cost Centers	(1,305,623)											(1,305,623)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,388,953)	(664,102)	242,355	3,107	462,668	(48,835)						(2,393,760)	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	\$ 2,693,393	FNR Chicago SL	100.00%	\$	(2,693,393)	1
2	V	21	Bank Service Charge		FNR Chicago SL	100.00%	49,500	49,500	2
3	V	32	Interest		FNR Chicago SL	100.00%	1,166,068	1,166,068	3
4	V	21	Management Fee		FNR Chicago SL	100.00%	780,000	780,000	4
5	V	21	Processing Feee		FNR Chicago SL	100.00%	9	9	5
6	V	19	Professional Fee		FNR Chicago SL	100.00%	12,314	12,314	6
7	V	20	Title Fees		FNR Chicago SL	100.00%	21,400	21,400	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,693,393			\$ 2,029,291	\$ * (664,102)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	Legacy Healthcare Financial Services	100.00%	\$ 193	\$ 193	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	137	137	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	603	603	17
18	V	6	GROUND & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	6,013	6,013	18
19	V	6	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100.00%	1,987	1,987	19
20	V	17	CFO SALARY		Legacy Healthcare Financial Services	100.00%	12,434	12,434	20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	28,264	28,264	21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	2,451	2,451	22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	188,580	188,580	23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	29,165	29,165	24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,628	1,628	25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,405	1,405	26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	47,103	47,103	27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	646	646	28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	10	10	29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	1,142	1,142	30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	60,450	60,450	31
32	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	71	71	32
33	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	73	73	33
34	V								34
35	V	17	MANAGEMENT FEES	8,850	Legacy Healthcare Financial Services	100.00%		(8,850)	35
36	V	19	BOOKKEEPING FEES	140,000	Legacy Healthcare Financial Services	100.00%		(140,000)	36
37	V	17	MANAGEMENT FEES		Legacy Healthcare Financial Services	100.00%	8,850	8,850	37
38	V								38
39	Total			\$ 148,850			\$ 391,205	\$ * 242,355	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%	\$ 82	\$	82
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	2,221		2,221
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	804		804
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$ 3,107	\$ *	3,107

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	Progressive Healthcare Consulting	100.00%	\$ 685	\$ 685	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	13,234	13,234	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	471	471	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	183	183	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	131,668	131,668	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	165	165	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	2,390	2,390	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	134,447	134,447	22
23	V	14	PATIENT TRANSPORTATION		Progressive Healthcare Consulting	100.00%	8	8	23
24	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	19,712	19,712	24
25	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	138,313	138,313	25
26	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	2,019	2,019	26
27	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	564	564	27
28	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	2,045	2,045	28
29	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	1,083	1,083	29
30	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	40,835	40,835	30
31	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	3,822	3,822	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	46	46	32
33	V								33
34	V	10	NURSING		Progressive Healthcare Consulting	100.00%			34
35	V	17	ADMINSTRATIVE	1,625	Progressive Healthcare Consulting	100.00%		(1,625)	35
36	V	15	PAYROLL TAXES - NURSING	3,927	Progressive Healthcare Consulting	100.00%		(3,927)	36
37	V	27	PAYROLL TAXES - NON-NURSING	23,471	Progressive Healthcare Consulting	100.00%		(23,471)	37
38	V								38
39	Total			\$ 29,023			\$ 491,691	\$ * 462,668	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%	\$ 2,110	\$ 2,110	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,363	2,363	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	955	955	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	3	3	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	30	30	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	424	424	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	4,727	4,727	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	1,003	1,003	22
23	V								23
24	V	34	RENT	60,450	CF ST. LOUIS, LLC	100.00%		(60,450)	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			\$ 60,450			\$ 11,615	\$ * (48,835)	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 (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

Facility Name & ID Number

Warren Barr South Loop

0054353

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YAIR ZUCKERMAN	52.50%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	FNR CHICAGO SL		BUILDING CO	1
2	DINA ZUCKERMAN	4.90%	BETHANY TERRACE	MORTON GROVE	LEGACY HC & FINANCIAL	LINCOLNWOOD	HOME OFFICE/BOOKKEEPER	2
3	HARRY SCHAYER	15.80%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	3
4	JACK ZUCKERMAN	4.90%	ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	4
5	MORDECHAY NINIO	2.40%	EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	5
6	NOAM ZUCKERMAN	4.90%	GROVE OF FOX VALLEY	AURORA	REMEDIATION SERVICES	LINCOLNWOOD	NURSING EQUIPMENT	6
7	NAVA ZUCKERMAN	4.90%	LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	7
8	SHAI BERDUGO	4.90%	GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	8
9	YEHOASHUA SEIF	4.80%	LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVING	LINCOLNSHIRE	ASSISTED LIVING	9
10			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	10
11			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			CHALET SKILLED NURSING FACILITY LLC	CHICAGO				18
19			WARREN BARR LIVING AND REHAB	CHICAGO				19
20			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT				20
21			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				21
22			CLARK SKILLED NURSING FACILITY	CHICAGO				22
23			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				23
24			AZRIA MONTCLAIR	OMAHA, NE				24
25			AZRIA OLATHE	OLATHE, KS				25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Warren Barr South Loop # 0054353 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yair Zuckerman	Owner	Administrative	52.50%	See Attached	2.21	4.42%	Mgmt Fees	\$ 8,850	17-3	1
2	Yehoshua Seif	Owner	Administrative	4.80%	None	40	100.00%	Salary	69,736	17-1	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	\$ 78,586		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 South Loop # 0054353 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 South Loop # 0054353 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	\$	72,102	\$ 193	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,629,488	29	3,107		72,102	137	2
3	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	13,622		72,102	603	3
4	6	GROUND & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	135,883		72,102	6,013	4
5	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,629,488	29	44,897	44,897	72,102	1,987	5
6	17	CFO SALARY	AVAIL. BED DAYS	1,629,488	29	281,003	281,003	72,102	12,434	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	638,760		72,102	28,264	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	55,387		72,102	2,451	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,629,488	29	4,261,866	4,261,866	72,102	188,580	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,629,488	29	659,124		72,102	29,165	10
11	24	SEMINARS	AVAIL. BED DAYS	1,629,488	29	36,800		72,102	1,628	11
12	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	31,752		72,102	1,405	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,629,488	29	1,064,526		72,102	47,103	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	14,600		72,102	646	14
15	32	INTEREST	AVAIL. BED DAYS	1,629,488	29	234		72,102	10	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	25,813		72,102	1,142	16
17	34	RENT	AVAIL. BED DAYS	1,629,488	29	1,366,146		72,102	60,450	17
18	34	STORAGE	AVAIL. BED DAYS	1,629,488	29	1,600		72,102	71	18
19	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,629,488	29	1,654		72,102	73	19
20										20
21	17	MANAGEMENT FEES- Y. ZUC	AVG HOURS WKD	50	29	200,000		3.13	8,850	21
22										22
23										23
24										24
25	TOTALS					\$ 8,841,129	\$ 4,587,766		\$ 391,205	25

Facility Name & ID Number Warren Barr South Loop # 0054353 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	\$ 1,852	\$	72,102	\$ 82	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	50,196		72,102	2,221	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	18,179		72,102	804	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	\$		\$ 3,107	25

Facility Name & ID Number Warren Barr South Loop # 0054353 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	\$	71,905	\$ 685	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	21	214,912	214,912	71,905	13,234	2
3	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	1,167,679	21	7,646		71,905	471	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	21	2,971		71,905	183	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	21	2,138,189	2,138,189	71,905	131,668	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	21	2,679		71,905	165	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	21	38,812	38,812	71,905	2,390	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	21	2,183,313	2,183,313	71,905	134,447	8
9	14	PATIENT TRANSPORTATION	AVAIL. BED DAYS	1,167,679	21	128		71,905	8	9
10	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	21	320,111		71,905	19,712	10
11	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	21	2,246,090	2,246,090	71,905	138,313	11
12	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	21	32,793		71,905	2,019	12
13	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	21	9,154		71,905	564	13
14	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	21	33,203		71,905	2,045	14
15	24	SEMINARS	AVAIL. BED DAYS	1,167,679	21	17,580		71,905	1,083	15
16	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,167,679	21	663,131		71,905	40,835	16
17	26	INSURANCE	AVAIL. BED DAYS	1,167,679	21	62,063		71,905	3,822	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,167,679	21	750		71,905	46	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,984,649	\$ 6,821,317		\$ 491,691	25

Facility Name & ID Number Warren Barr South Loop # 0054353 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	\$	72,102	\$ 2,110	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	53,400		72,102	2,363	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	21,572		72,102	955	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	76		72,102	3	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,629,488	29	678		72,102	30	5
6	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	9,585		72,102	424	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	106,824		72,102	4,727	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	22,674		72,102	1,003	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	\$		\$ 11,615	25

Facility Name & ID Number Warren Barr South Loop # 0054353 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 South Loop # 0054353 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 South Loop # 0054353 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 South Loop # 0054353 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 South Loop # 0054353 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			\$	28,525,000			\$	1,021,408	1
2	Note Payable		X	Member/Shareholder Loan				2,946,464				49,500	2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X	Line of Credit				3,464,106				143,472	6
7	The Private Bank		X	CapEX				2,102,640				95,160	7
8	See Supplemental Schedule				-							5,541	8
9	TOTAL Facility Related						\$	37,038,210			\$	1,315,080	9
	B. Non-Facility Related*												
10	Interest Income		X									(7,681)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(7,681)	14
15	TOTALS (line 9+line14)						\$	37,038,210			\$	1,307,399	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					\$					\$	10
9	Alloc from Legacy Real Property	X											804
10	Allocated from CF St. Louis	X											4,727
11													11
12													12
13													13
14	TOTAL Working Capital												5,541
	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.)

B. Real Estate Taxes

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr South Loop COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054353

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-22-300-045-0000</u>	<u>Long Term Care Facility</u>	\$ <u>5,798.43</u>	\$ <u>5,798.43</u>
2. <u>17-22-300-047-0000</u>	<u>Long Term Care Facility</u>	\$ <u>6,008.08</u>	\$ <u>6,008.08</u>
3. <u>17-22-300-049-0000</u>	<u>Long Term Care Facility</u>	\$ <u>6,212.78</u>	\$ <u>6,212.78</u>
4. <u>17-22-300-074-0000</u>	<u>Long Term Care Facility</u>	\$ <u>13,993.37</u>	\$ <u>13,993.37</u>
5. <u>17-22-301-014-0000</u>	<u>Long Term Care Facility</u>	\$ <u>17,922.94</u>	\$ <u>17,922.94</u>
6. <u>17-22-301-015-0000</u>	<u>Long Term Care Facility</u>	\$ <u>43,407.68</u>	\$ <u>43,407.68</u>
7. <u>17-22-301-016-0000</u>	<u>Long Term Care Facility</u>	\$ <u>173,062.75</u>	\$ <u>173,062.75</u>
8. <u>17-22-301-017-0000</u>	<u>Long Term Care Facility</u>	\$ <u>88,088.16</u>	\$ <u>88,088.16</u>
9. <u>17-22-301-050-0000</u>	<u>Long Term Care Facility</u>	\$ <u>27,341.37</u>	\$ <u>27,341.37</u>
10. <u>10-35-104-076-0000</u>	<u>Home Office Allocation</u>	\$ <u>40,927.41</u>	\$ <u>1,810.97</u>
	TOTALS	\$ <u><u>422,762.97</u></u>	\$ <u><u>383,646.53</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr South Loop COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0054353
CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	<u>\$ 440,762.19</u>	<u>\$ 5,921.51</u>
2.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
3.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
4.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
5.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
6.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
		TOTALS	\$ 440,762.19	\$ 5,921.51

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 3

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		1982	\$ 1,748,076	1
2	Allocated from Legacy Real Properties			3,620	2
3	TOTALS			\$ 1,751,696	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	197		2014	1983	\$ 14,080,962	\$	35	\$ 402,313	\$ 402,313	\$ 966,517	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr South Loop

0054353

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		102,068	1,624		4,588	2,964	18,955	68
69								69
70		\$ 14,183,030	\$ 1,624		\$ 406,901	\$ 405,277	\$ 985,472	70

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,183,030	\$ 1,624		\$ 406,901	\$ 405,277	\$ 985,472	1
2	2Nd Fl Tile - Mannington Java, Adhesive Fullspread Mannington	2014	30,099		20	1,505	1,505	3,512	2
3	2N Fl Tile-Florida 420 Mat Buff Streamline, Bull Nose, Armstrong	2014	22,248		20	1,112	1,112	2,596	3
4	Exterior Rendering	2014	4,600		20	657	657	1,479	4
5	Drapery Panels	2014	6,885		20	1,377	1,377	3,098	5
6	Sign-Room Numbers, Stairs, Salon, Spac, Tub Room, Med Room,	2014	3,440		20	344	344	774	6
7	Installing New Water Heater	2014	14,588		20	1,216	1,216	2,634	7
8	32 Bypass Doors That Costs \$140.00 Each	2014	5,223		20	261	261	609	8
9	Lobby Drywall & Paint	2014	13,925		20	696	696	1,625	9
10	4Th Fl Guestrms & Corridor Drywall & Paint	2014	19,867		20	993	993	2,318	10
11	Electrical Work For 4Th Floor	2014	5,673		20	284	284	638	11
12	Patch & Paint 14 Rooms	2014	30,653		20	1,533	1,533	3,448	12
13	Vanity Lights	2014	2,801		20	560	560	1,307	13
14	Chandelier	2014	12,634		20	2,527	2,527	5,896	14
15	4Th Floor - Demo/Electrical/Flooring/Plumbing/Carpentry	2015	43,675		20	2,184	2,184	4,368	15
16	Chiller Replacement	2015	158,276		20	7,914	7,914	15,828	16
17	5Th Floor Basement/Hallway/Laundry - Repaired Pipes	2015	5,200		20	260	260	520	17
18	4Th Floor Spa - Demo/Tiling	2015	8,365		20	418	418	837	18
19	5Th Floor Corridor - Demo/Tiling	2015	35,524		20	1,776	1,776	3,552	19
20	Paint On 5Th Floor Resident Rms	2015	33,955		20	1,698	1,698	3,396	20
21	5Th Floor Corridor Sprinklers	2015	4,982		20	249	249	498	21
22	5Th Floor Shower Room Repair Tiling/Valves/Corner Guards	2015	4,190		20	210	210	419	22
23	4Th Floor Shower/Spa Room - Valves/Drains	2015	17,783		20	889	889	1,778	23
24	5Th Floor Corridor - Demo/Tiling	2015	31,591		20	1,580	1,580	3,159	24
25	Administrative Fees	2015	5,352		20	268	268	535	25
26	Design Fee Lobby	2015	6,800		20	340	340	680	26
27	5Th Floor Bathroom - Shower Base/Faucet/Head	2015	2,500		20	125	125	250	27
28	5Th Floor Wall Partition/Valves/Paint/Tiles	2015	5,870		20	294	294	587	28
29	5Th Floor Tiling	2015	6,434		20	322	322	643	29
30	Cubicle Cutrain Tracks For 5Th Floor	2015	3,217		20	161	161	322	30
31	Cubicle Cutrain Tracks For 5Th Floor	2015	3,975		20	199	199	398	31
32	4Th And 5Th Floor Shades	2015	4,500		20	225	225	450	32
33	Permit Fees	2015	4,469		20	223	223	447	33
34	TOTAL (lines 1 thru 33)		\$ 14,742,324	\$ 1,624		\$ 439,299	\$ 437,675	\$ 1,054,071	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

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		\$ 14,742,324	\$ 1,624		\$ 439,299	\$ 437,675	\$ 1,054,071	1
2	4Th Floor Shades	2015	24,650		20	1,233	1,233	2,465	2
3	Install A/C System For Server Room	2015	4,430		20	222	222	443	3
4	5Th Floor Corridor - Tiling/Demo	2015	31,591		20	1,580	1,580	3,159	4
5	4Th Floor West Shower Room Demolition	2015	8,365		20	418	418	837	5
6	5Th Floor Corridor Wallcovering	2015	5,600		20	280	280	560	6
7	3Rd Floor Corridor Tiling	2015	5,518		20	276	276	552	7
8	5Th Floor Corridor/Lounge - Drywall/Ceiling/Wallcovering	2015	8,985		20	449	449	899	8
9	Repaired 5Th Floor Valves/Lighting/Railing	2015	9,145		20	457	457	915	9
10	5Th Floor Bathroom - Valves/Drains	2015	6,800		20	340	340	680	10
11	4Th Floor Heat Pump	2015	4,988		20	249	249	499	11
12	Landscaping Front Of Wall/Sidewalk/Walkway	2015	17,838		20	892	892	1,784	12
13	Therapy Rm/Office/Gym - Demo/Electrical	2015	23,956		20	1,198	1,198	2,396	13
14	5Th Floor Tiling	2015	7,574		20	379	379	757	14
15	5Th Floor Nurse Stations - Demo/Installed New Wiring	2015	18,575		20	929	929	1,858	15
16	5Th Floor 2Nd Spa Demolition	2015	8,650		20	433	433	865	16
17	Sprinkler System	2015	5,400		20	270	270	540	17
18	5Th Floor Corridor Cornerguards/Drywall	2015	5,480		20	274	274	548	18
19	Sprinkler System	2015	3,665		20	183	183	367	19
20	4Th Floor Drapery	2015	5,623		20	281	281	562	20
21	Security System	2015	21,964		20	1,098	1,098	2,196	21
22	Inspection	2015	5,220		20	261	261	522	22
23	5Th Floor Corridor/Lounge - Tiling And Baseboards	2015	5,600		20	280	280	560	23
24	Sprinkler System	2015	4,980		20	249	249	498	24
25	Installed Exhaust Fan For Pump Room	2015	6,429		20	321	321	643	25
26	Installed Sewage System	2015	10,995		20	550	550	1,100	26
27	5Th Floor Bathroom Valves/Drains	2015	6,800		20	340	340	680	27
28	Installed Exhaust Fan And Concrete Work	2015	8,644		20	432	432	864	28
29	5Th Floor Pipe Insulation For Chiller	2015	14,193		20	710	710	1,419	29
30	Repairing Wiring For Phone System	2015	11,810		20	590	590	1,181	30
31	Permit Fee	2015	8,938		20	447	447	894	31
32	5Th Floor Signs	2015	3,621		20	181	181	362	32
33	4Th And 5Th Floor - Electrical And Lights	2015	15,553		20	778	778	1,555	33
34	TOTAL (lines 1 thru 33)		\$ 15,073,904	\$ 1,624		\$ 455,878	\$ 454,254	\$ 1,087,229	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

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		\$ 15,073,904	\$ 1,624		\$ 455,878	\$ 454,254	\$ 1,087,229	1
2	Bathroom Faucet	2015	2,649		20	132	132	265	2
3	Heating And A/C Repairs	2015	11,738		20	587	587	1,174	3
4	Install Kiosks & Electrical Outlets On 1St, 2Nd, 3Rd Fl	2015	3,550		20	178	178	355	4
5	4Th Floor Electrical Light Fixtures	2015	7,860		20	393	393	786	5
6	Handrails For Corridors	2015	3,381		20	169	169	338	6
7	5Th Floor Light Fixtures	2015	3,125		20	156	156	313	7
8	5Th Floor Shower Room Grab Bars	2015	2,889		20	144	144	289	8
9	3Rd Floor Drapery	2015	8,138		20	407	407	814	9
10	5Th Floor Drapery	2015	8,138		20	407	407	814	10
11	5Th Floor Light Fixtures	2015	2,801		20	140	140	280	11
12	5Th Fl Hallway/Bathrooms/Reside Rm Lights	2015	10,684		20	534	534	1,068	12
13	5Th Floor Shades	2015	11,140		20	557	557	1,114	13
14	3Rd Floor Wallcoverings	2015	20,293		20	1,015	1,015	2,029	14
15	5Th Floor Sliding Doors	2015	6,600		20	330	330	660	15
16	5Th Floor Flooring/Tiling	2015	46,426		20	2,321	2,321	4,643	16
17	3Rd Floor Light Fixtures	2015	3,840		20	192	192	384	17
18	5Th Floor Elevator/Lobby Light Fixtures	2015	2,925		20	293	293	585	18
19	Phone System	2015	112,291		20	11,229	11,229	27,582	19
20	Rise Ductwork	2015	2,540		20	127	127	254	20
21	Heating Pump Repair	2015	3,334		20	167	167	333	21
22	Repair Leaking Pipe	2015	3,910		20	195	195	391	22
23	2-5Th Floor Renovation - Supplies	2015	43,067		20	2,153	2,153	4,307	23
24	Repaired And Installed New Motor For Pump	2016	3,204		20	160	160	160	24
25	Removed And Relocated 4 Cables Of Servers - Admin Office/Lobb	2016	5,105		20	255	255	255	25
26	Installed Termination Bar/24 Gauge Steel Counter/Gutter	2016	6,000		20	300	300	300	26
27	Installed A/C System For Elevator Equipment Room	2016	8,588		20	429	429	429	27
28	Repaired Elevator	2016	17,870		20	894	894	894	28
29	Repaired Fire Alarm On 4Th & 5Th Floor Patient Rooms	2016	5,559		20	278	278	278	29
30	Rewired Fire Alarm System	2016	5,673		20				30
31	Installed Fire Alarm System	2016	15,054		20	753	753	753	31
32	Installed Heat Pump System In Break Room	2016	5,889		20	294	294	294	32
33	1St And 2Nd Floor Offices - Shades	2016	7,400		20	370	370	370	33
34	TOTAL (lines 1 thru 33)		\$ 15,475,565	\$ 1,624		\$ 481,439	\$ 479,815	\$ 1,139,740	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

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		\$ 15,475,565	\$ 1,624		\$ 481,439	\$ 479,815	\$ 1,139,740	1
2	Repaired West Elevator Cooling System	2016	2,578		20	129	129	129	2
3	Repaired Roof/Patch Holes/Insulation Boards	2016	34,422		20	1,721	1,721	1,721	3
4	3Rd Floor Cubicle Curtains	2016	19,223		20	961	961	961	4
5	1St And 3Rd Floor Patient Room Shades	2016	21,320		20	1,066	1,066	1,066	5
6	Permit Fee For Parking Spaces And Curb Lane	2016	2,530		20	127	127	127	6
7	Chiller Replacement	2016	26,385		20	1,319	1,319	1,319	7
8	Removed Fountain/Installed Steel Courtyard Edging	2016	3,785		20	189	189	189	8
9	Re-Angled Kitchen Hood Filters	2016	2,500		20	125	125	125	9
10	Security System	2016	11,299		20	565	565	565	10
11	Repaired Sprinkler Pipes/Valves	2016	4,896		20	245	245	245	11
12	Repaired Air Conditioner On 4Th Floor	2016	2,798		20	140	140	140	12
13	1St Floor Cubicle Curtains	2016	8,560		20	428	428	428	13
14	1St Floor Signage	2016	2,852		20	143	143	143	14
15	Repaired Parking Lot With Gravel	2016	8,250		20	413	413	413	15
16	1St Floor Patient Room Shades	2016	13,360		20	668	668	668	16
17	Repaired Fire Alarm System In South Wing	2016	17,318		20	866	866	866	17
18	Repaired Elevator By Lobby	2016	3,000		20	150	150	150	18
19	1St Floor - Carpentry And Millwork	2016	11,040		20	552	552	552	19
20	Exterior Signage	2016	4,511		20	226	226	226	20
21	Installed Elevator Ceiling Panels	2016	2,750		20	138	138	138	21
22	Repaired 17 Exhaust Curbs	2016	4,250		20	213	213	213	22
23	Installed Wiring For Phone System	2016	4,000		20	200	200	200	23
24	Repaired Elevator	2016	5,536		20	277	277	277	24
25	1St Floor Light Fixtures	2016	2,600		20	130	130	130	25
26	2Nd Floor Light Fixtures	2016	22,650		20	1,133	1,133	1,133	26
27	Therapy/Office/Gym - Demo/Masonry/Framing/Flooring/Electrical	2016			20				27
28	Related Architect/Design/Idph Fees	2016	3,336,767		20	166,838	166,838	166,838	28
29	3Rd Floor - Electrical/Window/Paint/Handrails/Shades	2016	40,961		20	2,048	2,048	2,048	29
30	Repaired Elevator By Main Lobby	2016	13,000		20	650	650	650	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,108,706	\$ 1,624		\$ 663,096	\$ 661,472	\$ 1,321,397	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Warren Barr South Loop

0054353

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	28,047	1,041	30	935	(106)	7,012	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Healthcare & Financial Services	2012	1,262	28	20	63	35	315	9
10	Allocated from Legacy Healthcare & Financial Services	2013	4,036	88	20	202	114	807	10
11	Allocated from Legacy Healthcare & Financial Services	2014	394	9	20	20	11	59	11
12	Allocated from Legacy Healthcare & Financial Services	2015	543	12	20	27	15	54	12
13									13
14	Allocated from Legacy Real Properties	2009	15,928	257	20	796	539	5,376	14
15	Allocated from Legacy Real Properties	2010	4,843	78	20	194	116	1,260	15
16	Allocated from Legacy Real Properties	2011	6,884	111	20	344	233	2,065	16
17									17
18	Allocated from CF St. Louis LLC	2016	40,131		20	2,007	2,007	2,007	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)		\$ 102,068	\$ 1,624		\$ 4,588	\$ 2,964	\$ 18,955	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 102,068	\$ 1,624		\$ 4,588	\$ 2,964	\$ 18,955	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 102,068	\$ 1,624		\$ 4,588	\$ 2,964	\$ 18,955	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	\$1,404,697	\$1,117	\$150,990	\$149,873	10	\$384,525	71
72	Current Year Purchases	326,850	126	32,685	32,559	10	32,685	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,731,547	\$1,243	\$183,674	\$182,431		\$417,209	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$22,591,949	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,867	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$846,770	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$843,903	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,738,607	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	\$84,384	92
93			93
94			94
95		\$84,384	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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				1,080			5
6	Allocated from Legacy HC and Progressive HC				117			6
7	TOTAL				\$ 1,197			7

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

9. Option to Buy:
- YES
- NO
- Terms:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 12,538
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual 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 - 03	hrs	\$		\$ 1,042,314	\$		\$ 1,042,314	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			343,439			343,439	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,111,715			1,111,715	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				515,304		515,304	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			258,467		277,881	995,373		1,531,721	13
14	TOTAL			\$ 258,467		\$ 2,775,349	\$ 1,510,677		\$ 4,544,493	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	\$ 1,000	\$ 77,960	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,402,136	7,402,136	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	498,085	498,085	6
7	Other Prepaid Expenses	24,134	273,134	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	24,902	24,902	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,950,257	\$ 8,276,217	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,748,076	13
14	Buildings, at Historical Cost		9,873,577	14
15	Leasehold Improvements, at Historical Cost	708,920	708,920	15
16	Equipment, at Historical Cost	195,838	866,800	16
17	Accumulated Depreciation (book methods)	1,000	(504,932)	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>	913,442	10,320,391	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,819,200	\$ 23,012,832	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,769,457	\$ 31,289,049	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,938,511	\$ 1,938,512	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,464,106	5,566,746	29
30	Accrued Salaries Payable	276,138	276,138	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	11,524	11,524	31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,982	32
33	Accrued Interest Payable		84,671	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,690,279	\$ 7,905,573	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,946,464	39
40	Mortgage Payable		28,525,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	3,180,198	3,368,698	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,180,198	\$ 34,840,162	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,870,477	\$ 42,745,735	46
47	TOTAL EQUITY(page 18, line 24)	\$ 898,980	\$ (11,456,686)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,769,457	\$ 31,289,049	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,999,626	1
2	Restatements (describe):		2
3	Equity Adjustment	(4,527,041)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,527,415)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,426,395	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)	\$ 2,426,395	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)	\$ 898,980	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 20,829,588	1
2	Discounts and Allowances for all Levels	(11,145,271)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,684,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	11,813,087	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 11,813,087	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	996,443	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	184,083	19
20	Radiology and X-Ray	39,951	20
21	Other Medical Services	897,955	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,118,432	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,681	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,681	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	35,681	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,681	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,659,198	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,076,502	31
32	Health Care	5,945,486	32
33	General Administration	3,817,216	33
	B. Capital Expense		
34	Ownership	3,203,551	34
	C. Ancillary Expense		
35	Special Cost Centers	5,850,116	35
36	Provider Participation Fee	339,932	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,232,803	40
41	Income before Income Taxes (line 30 minus line 40)**	2,426,395	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,426,395	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,684,317	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,684,317	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	2,391	2,599	\$ 151,848	\$ 58.43	1
2	Assistant Director of Nursing	1,762	1,915	78,842	41.17	2
3	Registered Nurses	39,157	42,562	1,385,547	32.55	3
4	Licensed Practical Nurses	43,862	47,676	1,373,019	28.80	4
5	CNAs & Orderlies	107,192	116,513	1,379,414	11.84	5
6	CNA Trainees					6
7	Licensed Therapist	9,076	9,865	258,467	26.20	7
8	Rehab/Therapy Aides	11,279	12,260	233,432	19.04	8
9	Activity Director	1,976	2,148	32,569	15.16	9
10	Activity Assistants	7,613	8,275	89,370	10.80	10
11	Social Service Workers	18,582	20,198	414,909	20.54	11
12	Dietician					12
13	Food Service Supervisor	3,521	3,827	111,461	29.12	13
14	Head Cook	5,918	6,432	86,432	13.44	14
15	Cook Helpers/Assistants	25,114	27,298	329,191	12.06	15
16	Dishwashers					16
17	Maintenance Workers	6,214	6,754	96,115	14.23	17
18	Housekeepers	19,066	20,724	221,906	10.71	18
19	Laundry	4,985	5,419	58,738	10.84	19
20	Administrator	2,491	2,707	166,988	61.69	20
21	Assistant Administrator	526	572	24,433	42.72	21
22	Other Administrative					22
23	Office Manager	1,061	1,153	33,042	28.66	23
24	Clerical	24,316	26,431	348,939	13.20	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	848	922	16,296	17.67	31
32	Other Health Care(specify)					32
33	Other(specify)	867	942	15,915	16.89	33
34	TOTAL (lines 1 - 33)	337,817	367,192	\$ 6,906,873 *	\$ 18.81	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	\$ 200	01-03	35
36	Medical Director	Monthly	96,703	09-03	36
37	Medical Records Consultant	Monthly	2,000	10-03	37
38	Nurse Consultant	Monthly	145,957	10-03	38
39	Pharmacist Consultant	Monthly	1,281	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	261,750	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	403	11-03	44
45	Social Service Consultant	Monthly	2,126	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	1,286	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 511,706		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	221	\$ 11,042	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6	160	10-03	52
53	TOTAL (lines 50 - 52)	227	\$ 11,202		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Warren Barr South Loop

0054353

Report Period Beginning:

01/01/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Yehoshua Seif

Administrator

4.80%

\$ 69,736

Crystal Shelby

Administrator

0.00%

97,252

Moshe Weinberger

Assistant Admin

0.00%

24,433

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 191,421

B. Administrative - Other

Description

Amount

Management Fees - Yair Zuckerman

\$ 8,850

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 8,850

C. Professional Services

Vendor/Payee

Type

Amount

Marcum LLP

Accounting

\$ 12,794

Legacy Healthcare

Bookkeeping

140,000

See Attached

Legal

45,095

Documentation Solutions

Compliance Audit

8,157

2401 Incorporated

Architectural Fees

5,887

Achieve Accreditation

Joint Commission Consult

7,151

IL Rytes Corporation

Compliance

5,881

Lexis Nexis

Data Processing

113

Lighthouse Services

Compliance

732

Personnel Planners

Unemployment Tax Consult

2,568

PSD Solutions

Data Processing

7,932

See Supplemental Schedule

21,232

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 257,542

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 212,705

Unemployment Compensation Insurance

160,168

FICA Taxes

528,375

Employee Health Insurance

212,550

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Union Pension

5,915

401K Expense

5,504

Employee Physical Exams

18,254

Other Employee Benefits

47,140

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,190,611

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

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

28,130

(Indicate # of checks performed 2813)

Patient Background Checks

Dues and Subscriptions

2,954

License and Permits

15,667

Allocated from Legacy HC

2,451

Allocated from Progressive HC

564

Allocated from CF St. Louis LLC

3

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 49,769

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

5,314

Allocated from Legacy HC

1,628

Allocated from Progressive HC

1,083

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 8,025

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees