

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	271	Skilled (SNF)	271	98,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	271	TOTALS	271	98,915	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,108	8,014	42,819	65,941	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,108	8,014	42,819	65,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.66%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/2013 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 271 and days of care provided 35,904

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	506,642	77,207	35,077	618,926		618,926		618,926		1
2	Food Purchase		492,528		492,528		492,528	(11,290)	481,238		2
3	Housekeeping	315,433	75,198	1,135	391,766		391,766	1,254	393,020		3
4	Laundry	54,241	34,225	(10,000)	78,466		78,466		78,466		4
5	Heat and Other Utilities			419,905	419,905		419,905	(13,927)	405,978		5
6	Maintenance	185,902		333,022	518,924		518,924	49,507	568,431		6
7	Other (specify):*										7
8	TOTAL General Services	1,062,218	679,158	779,139	2,520,515		2,520,515	25,544	2,546,059		8
	B. Health Care and Programs										
9	Medical Director			93,900	93,900		93,900		93,900		9
10	Nursing and Medical Records	6,047,694	420,913	25,400	6,494,007		6,494,007	2,042	6,496,049		10
10a	Therapy	399,692		3,508	403,200		403,200		403,200		10a
11	Activities	149,561	20,842	5,332	175,735		175,735	512	176,247		11
12	Social Services	562,723		4,792	567,515		567,515	1,280	568,795		12
13	CNA Training										13
14	Program Transportation			69,004	69,004		69,004		69,004		14
15	Other (specify):*							234	234		15
16	TOTAL Health Care and Programs	7,159,670	441,755	201,936	7,803,361		7,803,361	4,068	7,807,429		16
	C. General Administration										
17	Administrative	305,415		36,282	341,697		341,697	9,818	351,515		17
18	Directors Fees										18
19	Professional Services			461,360	461,360		461,360	(213,831)	247,529		19
20	Dues, Fees, Subscriptions & Promotions			207,106	207,106		207,106	(168,273)	38,833		20
21	Clerical & General Office Expenses	440,000	8,282	1,311,976	1,760,258		1,760,258	(1,075,999)	684,259		21
22	Employee Benefits & Payroll Taxes			2,129,741	2,129,741		2,129,741		2,129,741		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,682	14,682		14,682	(4,848)	9,834		24
25	Other Admin. Staff Transportation			15,703	15,703		15,703		15,703		25
26	Insurance-Prop.Liab.Malpractice			236,732	236,732		236,732	1,194	237,926		26
27	Other (specify):*							50,136	50,136		27
28	TOTAL General Administration	745,415	8,282	4,413,582	5,167,279		5,167,279	(1,401,803)	3,765,476		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,967,303	1,129,195	5,394,657	15,491,155		15,491,155	(1,372,191)	14,118,964		29

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

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

Facility Name & ID Number

Warren Barr Lvg & Rehab Ctr

#0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			307,151	307,151		307,151	644,568	951,719			30
31	Amortization of Pre-Op. & Org.			607,700	607,700		607,700	(607,700)				31
32	Interest			161,690	161,690		161,690	1,901,471	2,063,161			32
33	Real Estate Taxes			657,000	657,000		657,000	4,014	661,014			33
34	Rent-Facility & Grounds			1,917,625	1,917,625		1,917,625	(1,914,930)	2,695			34
35	Rent-Equipment & Vehicles			95,787	95,787		95,787	(27,000)	68,787			35
36	Other (specify):*											36
37	TOTAL Ownership			3,746,953	3,746,953		3,746,953	424	3,747,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,695,610	1,587,178	137,599	4,420,387		4,420,387		4,420,387			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			334,146	334,146		334,146		334,146			42
43	Other (specify):*			1,377,006	1,377,006		1,377,006	(1,377,006)	(0)			43
44	TOTAL Special Cost Centers	2,695,610	1,587,178	1,848,751	6,131,539		6,131,539	(1,377,006)	4,754,533			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,662,913	2,716,373	10,990,361	25,369,647		25,369,647	(2,748,774)	22,620,873			45

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning: 01/01/14

Ending: 12/31/14

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,425)	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	636,837	30		9
10	Interest and Other Investment Income	(2,189)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,709)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(594)	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	(1,408)	21		18
19	Entertainment				19
20	Contributions	(16,619)	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	(819,115)	21		24
25	Fund Raising, Advertising and Promotional	(151,985)	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	(2,589,846)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,972,053)		\$	30

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	2	
		Amount	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)	223,279		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 223,279		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,748,774)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Warren Barr Lvg & Rehab Ctr

ID#	0052415
Report Period Beginning:	01/01/14
Ending:	12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration	\$ (337,951)	21	1
2	Patient Personal Items	(3,733)	10	2
3	Meals	(11,712)	21	3
4	Bank Charges	(11,505)	21	4
5	Amortization of Goodwill	(607,700)	31	5
6	Non-Allowable Vehicle Rental	(27,043)	35	6
7	Miscellaneous Income	(58,607)	21	7
8	PAC Dues	(134)	20	8
9	Annual Report	(250)	20	9
10	Marketing Expense	(5,212)	43	10
11	Additional R&M	74,898	06	11
12	Non Allowable Expense	(1,371,794)	43	12
13	Bldg Co. - Loan Fees	(99,020)	19	13
14	Bldg Co. - Legal Fees	(23,086)	19	14
15	Bldg Co. - Other Professional Fees	(6,977)	19	15
16	Bldg Co. - Title Fees	(36,923)	20	16
17	Non Allowable Seminar	(5,582)	24	17
18	Parking Revenue	(24,457)	21	18
19	Professional Fees Refund	(446)	19	19
20	Non Allowable Legal	(32,612)	19	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	(2,589,846)		49

Warren Barr Lvg & Rehab Ctr

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 Ending: 12/31/14

ID# 0052415

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		0	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(11,303)		(3)		16							(11,290)	2
3	Housekeeping			1,254									1,254	3
4	Laundry													4
5	Heat and Other Utilities	(16,425)		2,498									(13,927)	5
6	Maintenance	74,898		2,911		98	(28,400)						49,507	6
7	Other (specify):*													7
8	TOTAL General Services	47,170		6,660		114	(28,400)						25,544	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,733)				5,775							2,042	10
10a	Therapy													10a
11	Activities			512									512	11
12	Social Services					1,280							1,280	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					234							234	15
16	TOTAL Health Care and Programs	(3,733)		512		7,289							4,068	16
	C. General Administration													
17	Administrative					9,818							9,818	17
18	Directors Fees													18
19	Professional Services	(162,141)	129,083	(181,593)	141	679							(213,831)	19
20	Fees, Subscriptions & Promotions	(205,911)	36,923	689		26							(168,273)	20
21	Clerical & General Office Expenses	(1,264,755)		186,189		2,567							(1,075,999)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,582)		713		21							(4,848)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,194									1,194	26
27	Other (specify):*			49,395		741							50,136	27
28	TOTAL General Administration	(1,638,389)	166,006	56,587	141	13,852							(1,401,803)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,594,952)	166,006	63,759	141	21,255	(28,400)						(1,372,191)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/14

Ending:

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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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	636,837		3,178	4,553								644,568	30
31	Amortization of Pre-Op. & Org.	(607,700)											(607,700)	31
32	Interest	(2,189)	1,900,856	18	2,786								1,901,471	32
33	Real Estate Taxes			4,014									4,014	33
34	Rent-Facility & Grounds		(1,914,930)	14,372	(14,372)								(1,914,930)	34
35	Rent-Equipment & Vehicles	(27,043)				43							(27,000)	35
36	Other (specify):*													36
37	TOTAL Ownership	(94)	(14,074)	21,582	(7,033)	43							424	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):*	(1,377,006)											(1,377,006)	43
44	TOTAL Special Cost Centers	(1,377,006)											(1,377,006)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,972,053)	151,932	85,341	(6,892)	21,298	(28,400)						(2,748,774)	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	\$ 1,914,930	FNR WB, LLC	100.00%	\$	(1,914,930)	1
2	V	32 Interest	2	FNR WB, LLC	100.00%	1,900,858	1,900,856	2
3	V	19 Loan Fees		FNR WB, LLC	100.00%	99,020	99,020	3
4	V	19 Legal Fees		FNR WB, LLC	100.00%	23,086	23,086	4
5	V	19 Other Professional Fees		FNR WB, LLC	100.00%	6,977	6,977	5
6	V	20 Title Fees		FNR WB, LLC	100.00%	36,923	36,923	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,914,932			\$ 2,066,864	\$ * 151,932	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%	\$ (3)	\$ (3)
16	V	3 HOUSEKEEPING WAGES		Legacy Healthcare Financial Services	100.00%	1,120	1,120
17	V	3 HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	134	134
18	V	5 UTILITIES		Legacy Healthcare Financial Services	100.00%	2,498	2,498
19	V	6 GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,911	2,911
20	V	11 ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	512	512
21	V	19 PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	8,407	8,407
22	V	20 FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	689	689
23	V	21 CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	174,657	174,657
24	V	21 CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	11,532	11,532
25	V	24 SEMINARS		Legacy Healthcare Financial Services	100.00%	713	713
26	V	26 INSURANCE		Legacy Healthcare Financial Services	100.00%	1,194	1,194
27	V	27 EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	35,691	35,691
28	V	30 DEPRECIATION		Legacy Healthcare Financial Services	100.00%	3,178	3,178
29	V	32 INTEREST		Legacy Healthcare Financial Services	100.00%	18	18
30	V	33 REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	4,014	4,014
31	V	34 RENT		Legacy Healthcare Financial Services	100.00%	14,372	14,372
32	V	17 MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	18,141	18,141
33	V	17 MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	18,141	18,141
34	V	27 HEALTH INS/BENEF.- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	6,852	6,852
35	V	27 HEALTH INS/BENEF.- M. SHABAT		Legacy Healthcare Financial Services	100.00%	6,852	6,852
36	V						
37	V	17 MANAGEMENT FEES	36,282	Legacy Healthcare Financial Services	100.00%		(36,282)
38	V	19 BOOKKEEPING FEES	190,000	Legacy Healthcare Financial Services	100.00%		(190,000)
39	Total		\$ 226,282			\$ 311,623	\$ * 85,341

* 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%	141	\$	141	15
16	V	30 DEPRECIATION		Legacy Real Properties	100.00%	4,553		4,553	16
17	V	32 INTEREST EXPENSE		Legacy Real Properties	100.00%	2,786		2,786	17
18	V								18
19	V								19
20	V								20
21	V	34 RENT	14,372	Legacy Real Properties	100.00%			(14,372)	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		\$ 14,372			\$ 7,480	\$ *	(6,892)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2	FOOD	Progressive Healthcare Consulting	100.00%	\$ 16	\$ 16	15	
16	V	6	BUILDING MAINTENANCE AND R&M	Progressive Healthcare Consulting	100.00%	98	98	16	
17	V	10	MEDICAL AND NURSING SUPPLIES	Progressive Healthcare Consulting	100.00%	7	7	17	
18	V	10	NURSING SALARIES	Progressive Healthcare Consulting	100.00%	5,768	5,768	18	
19	V	12	CLERGY SALARY	Progressive Healthcare Consulting	100.00%	241	241	19	
20	V	12	ADMISSIONS SALARY	Progressive Healthcare Consulting	100.00%	5,651	5,651	20	
21	V	15	EMP. BEN.-NURSING	Progressive Healthcare Consulting	100.00%	234	234	21	
22	V	17	ADMIN SALARY- NON OWNER	Progressive Healthcare Consulting	100.00%	9,818	9,818	22	
23	V	19	PROFESSIONAL FEES	Progressive Healthcare Consulting	100.00%	679	679	23	
24	V	20	FEES, SUBSCRIPTIONS	Progressive Healthcare Consulting	100.00%	26	26	24	
25	V	21	CLERICAL & GENERAL	Progressive Healthcare Consulting	100.00%	2,567	2,567	25	
26	V	24	SEMINARS	Progressive Healthcare Consulting	100.00%	21	21	26	
27	V	27	NURSING BENEFITS	Progressive Healthcare Consulting	100.00%	741	741	27	
28	V	35	AUTO RENTAL	Progressive Healthcare Consulting	100.00%	43	43	28	
29	V							29	
30	V							30	
31	V							31	
32	V	12	CLERGY	Progressive Healthcare Consulting	100.00%		(4,612)	32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 4,612			\$ 25,910	\$ *	21,298	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	06 Repairs & Maintenance	\$ 28,400	ML GROUP DESIGN AND DEVELOPMENT		\$	\$ (28,400)
16	V						
17	V						
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		\$ 28,400			\$	\$ * (28,400)

* 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	06 Repairs & Maintenance	\$ 11,091	REMED SERVICES	100.00%	\$ 11,091	\$	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		\$ 11,091			\$ 11,091	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	NETZACH INVESTMENTS, LLC	10.000%	ASTORIA PLACE	CHICAGO	FNR WB, LLC		BUILDING COMPANY	1
2	EREZ BAVER	2.500%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING COMPANY	2
3	CHAIM RAJCHENBACH	28.520%	CHALET LIVING & REHAB	CHICAGO	LEGACY HEALTHCARE FINAN	LINCOLNWOOD	HOME OFFICE/BOOKKEEP	3
4	MENACHEM SHABAT	28.520%	ELMBROOK	ELMHURST	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTING	4
5	RONALD SHABAT	10.384%	THE GROVE OF EVANSTON,LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSE EQUIPMENT	5
6	YAIR ZUCKERMAN	2.086%	THE VILLA AT EVERGREEN	EVERGREEN PARK	ML GROUP DESIGN & DEVELO	SKOKIE	ASSET MANAGEMENT	6
7	SUSAN FRIEDMAN	5.000%	THE GROVE OF FOX VALLEY	AURORA	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8	RAJCHENBACH FAMILY TRUST	6.685%	THE GROVE OF LAGRANGE PARK LLC	LAGRANGE PARK				8
9	YOSEPH & NAOMI RAJCHENBACH	0.437%	THE GROVE AT THE LAKE	ZION				9
10	AVROHOM & CHANA BUSEL	0.437%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				10
11	SHLOMO ZALMAIN BUSEL & CHAVA BUSEL	0.437%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER	CHICAGO				11
12	PINCHAS & NAHAMA SCHWARTZ	0.437%	AVANTARA LONG GROVE	LONG GROVE				12
13	ROSS BOTTNER	2.606%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE				13
14	JACK RAJCHENBACH	1.951%	THE GROVE OF NORTHBROOK	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR	CHICAGO				19
20			AURORA SUPPORTIVE LIVING	AURORA				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 Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 Lvg & Rehab Ctr # 0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Chaim Rajchenbach	Owner	Adminstrative	28.52%	See Attached	4.54	9.08%	Mgmt Fees	\$ 18,141	17-03	1
2	Menachem Shabat	Owner	Adminstrative	28.52%	See Attached	4.54	9.08%	Mgmt Fees	18,141	17-03	2
3	Yair Zuckerman	Owner	Administrative	2.09%	See Attached	4.16	10.40%	Alloc. Salary	20,799	17-01	3
4	Ross Bottner	Owner	CFO	2.61%	See Attached	3.63	9.08%	Alloc. Salary	18,141	21-07	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	\$ 75,222		13

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization Legacy Healthcare Financial Services
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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

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	2	FOOD	AVAIL. BED DAYS	1,090,513	21	\$ (38)	\$ 98,915	\$ (3)	1
2	3	HOUSEKEEPING WAGES	AVAIL. BED DAYS	1,090,513	21	12,349	98,915	1,120	2
3	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,090,513	21	1,477	98,915	134	3
4	5	UTILITIES	AVAIL. BED DAYS	1,090,513	21	27,544	98,915	2,498	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,090,513	21	32,093	98,915	2,911	5
6	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,090,513	21	5,642	98,915	512	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,090,513	21	92,690	98,915	8,407	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,090,513	21	7,596	98,915	689	8
9	21	CLERICAL & GENERAL WAC	AVAIL. BED DAYS	1,090,513	21	1,925,545	98,915	174,657	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,090,513	21	127,135	98,915	11,532	10
11	24	SEMINARS	AVAIL. BED DAYS	1,090,513	21	7,856	98,915	713	11
12	26	INSURANCE	AVAIL. BED DAYS	1,090,513	21	13,167	98,915	1,194	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,090,513	21	393,489	98,915	35,691	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,090,513	21	35,040	98,915	3,178	14
15	32	INTEREST	AVAIL. BED DAYS	1,090,513	21	199	98,915	18	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,090,513	21	44,250	98,915	4,014	16
17	34	RENT	AVAIL. BED DAYS	1,090,513	21	158,445	98,915	14,372	17
18	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	21	200,000	1	18,141	18
19	17	MANAGEMENT FEES- M. SH	AVG HOURS WKD	50	21	200,000	1	18,141	19
20	27	HEALTH INS/BENEF.- C. RAJ	AVG HOURS WKD	50	21	75,547	1	6,852	20
21	27	HEALTH INS/BENEF.- M. SHA	AVG HOURS WKD	50	21	75,547	1	6,852	21
22									22
23									23
24									24
25	TOTALS					\$ 3,435,573	\$ 1,937,894	\$ 311,623	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization Legacy Real Properties
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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

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	1,090,513	21	1,550	54,385	141	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,090,513	21	50,196	54,385	4,553	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,090,513	21	30,719	54,385	2,786	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					\$ 82,465	\$	\$ 7,480	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization Progressive Healthcare Consulting
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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

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	2	FOOD	AVAIL. BED DAYS	18	\$ 149	\$	98,915	\$ 16	1
2	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	18	943		98,915	98	2
3	10	MEDICAL AND NURSING SU	AVAIL. BED DAYS	18	68		98,915	7	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	18	55,460	55,460	98,915	5,768	4
5	12	CLERGY SALARY	AVAIL. BED DAYS	18	2,320	2,320	98,915	241	5
6	12	ADMISSIONS SALARY	AVAIL. BED DAYS	18	54,336	54,336	98,915	5,651	6
7	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	18	2,247		98,915	234	7
8	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	18	94,409	94,409	98,915	9,818	8
9	19	PROFESSIONAL FEES	AVAIL. BED DAYS	18	6,532		98,915	679	9
10	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	18	250		98,915	26	10
11	21	CLERICAL & GENERAL	AVAIL. BED DAYS	18	24,680		98,915	2,567	11
12	24	SEMINARS	AVAIL. BED DAYS	18	199		98,915	21	12
13	27	NURSING BENEFITS	AVAIL. BED DAYS	18	7,129		98,915	741	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	18	413		98,915	43	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 249,135	\$ 206,525		\$ 25,910	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization ML Group Design and Development
 Street Address 7040 N. Ridgeway Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (773) 415-3071
 Fax Number ()

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

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	6	Repairs & Maintenance			\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization ReMed Services, LLC
 Street Address 7040 N. Ridgeway Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (855) 501-5500
 Fax Number ()

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

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	6	Repairs & Maintenance	Direct		\$	\$		\$ 11,091	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				\$	\$		\$ 11,091	25

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Name of Lender	2		3	4	5	6		8	9	10						
		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			\$	\$ 25,826,636			\$ 1,782,007	1					
2	LendCo		X	Mortgage				12,164,619				2					
3	Capex		X	Note Payable				1,561,524			118,851	3					
4												4					
5												5					
Working Capital																	
6	The Private Bank		X	Line of Credit				2,880,319			161,690	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$ 42,433,098			\$ 2,062,548	9					
B. Non-Facility Related*																	
10	Interest Income		X								(2,189)	10					
11	Allocated from Legacy HC	X									18	11					
12	Allocated from Legacy Real Pro	X									2,786	12					
13	See Supplemental Schedule										(2)	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 613	14					
15	TOTALS (line 9+line14)						\$	\$ 42,433,098			\$ 2,063,161	15					

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

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$	8					
9												9					
10												10					
11												11					
12												12					
13												13					
14	TOTAL Working Capital											14					
	B. Non-Facility Related*																
15	Interest Income - Bldg Co.		X				\$	\$			\$	(2)	15				
16												16					
17												17					
18												18					
19												19					
20	TOTAL Non-Facility Related											(2)	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	579,384		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	619,617		2
3. Under or (over) accrual (line 2 minus line 1).		\$	40,233		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	620,781		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	661,014		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	_____	8	FOR BHF USE ONLY	
	2010	_____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____ 13
	2011	_____	10	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14
	2012	607,382	11	15	LESS REFUND FROM LINE 6 \$ _____ 15
	2013	615,603	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
Beginning Accrual Adjusted					
Allocated from Legacy Healthcare Financial Services = \$4,014					

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lvg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052415

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-04-423-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>17,807.74</u>	\$ <u>17,807.74</u>
2. <u>17-04-423-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>597,794.94</u>	\$ <u>597,794.94</u>
3. <u>10-35-104-076-0000</u>	<u>Home Office Allocation</u>	\$ <u>38,392.03</u>	\$ <u>3,482.35</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>653,994.71</u></u>	\$ <u><u>619,085.03</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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? YES NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,152 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 9

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>4,000,000</u>	1
2	<u>Allocated from Legacy Real Properties</u>			<u>7,421</u>	2
3	TOTALS			\$ 4,007,421	3

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	271		2013	1976	\$ 24,553,000	\$	39	\$ 629,564	\$ 629,564	\$ 629,564	
5											
6											
7											
8											
	Improvement Type**										
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											
32											
33											
34											
35											
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 Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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	<u>Related Building Company (Pages 12F & 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H & 12I)</u>		125,851	3,865		5,235	1,370	24,162	68
69	<u>Financial Statement Depreciation</u>			307,151			(307,151)		69
70	TOTAL (lines 4 thru 69)		\$ 24,678,851	\$ 311,016		\$ 634,799	\$ 323,783	\$ 653,726	70

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 24,678,851	\$ 311,016		\$ 634,799	\$ 323,783	\$ 653,726	1
2	Fence	2013	2,600		20	130	130	260	2
3	Chrome Faucet And Pop Up Handle	2013	3,233		20	162	162	323	3
4	Custom Wall Sconce	2013	10,150		20	508	508	1,015	4
5	7Th Floor Bathroom Flooring	2013	6,400		20	320	320	640	5
6	7Th Floor Sprinkler System	2013	30,108		20	1,505	1,505	3,011	6
7	6Th Floor Nurse Call System	2013	26,000		20	1,300	1,300	2,600	7
8	Electrical Wiring On 7Th Floor	2013	5,000		20	250	250	500	8
9	3Rd,4Th,7Th Floor - Demolition, Repaired Walls, New Drop Ceilir	2013	30,000		20	1,500	1,500	3,000	9
10	7Th Floor - Electric Work, Woodwork	2013	25,000		20	1,250	1,250	2,500	10
11	7Th Floor - Replaced Doors And Locks, Tiling	2013	30,000		20	1,500	1,500	3,000	11
12	Cafeteria, Resid Rooms, Bathrooms, Corridors - Wallpapers	2013	2,650		20	133	133	265	12
13	Handrails	2013	3,279		20	164	164	328	13
14	Chrome Faucet	2013	3,725		20	186	186	373	14
15	7Th Floor Lighting	2013	4,450		20	223	223	445	15
16	7Th Floor Wallcoverings	2013	5,991		20	300	300	599	16
17	Boiler Repair	2013	6,153		20	308	308	615	17
18	7Th Floor Doors	2013	6,347		20	317	317	635	18
19	Cubicle Curtains	2013	15,851		20	793	793	1,585	19
20	7Th Floor Wallcoverings	2013	7,958		20	398	398	796	20
21	Corridor - Carpeting Tile	2013	9,226		20	461	461	923	21
22	Bathroom Tilings	2013	13,465		20	673	673	1,347	22
23	7Th Floor Shower Room Tiling	2013	13,493		20	675	675	1,349	23
24	7Th Floor Fire Dampers	2013	25,320		20	1,266	1,266	2,532	24
25	6Th Floor - Priming And Painting, Plubing, Drop Ceiling, Walls	2013	30,000		20	1,500	1,500	3,000	25
26	Wood Doors	2013	10,211		20	511	511	1,021	26
27	7Th Floor - Countertops, Ceramic Tiling	2013	50,000		20	2,500	2,500	5,000	27
28	6Th Floor Nurse Call System	2013	11,800		20	590	590	1,180	28
29	6Th Floor Wallcoverings	2013	8,346		20	417	417	835	29
30	Handrails	2013	4,109		20	205	205	411	30
31	Shower Room Tiling	2013	5,044		20	252	252	504	31
32	Corridors And Common Areas - Carpeting	2013	9,310		20	466	466	931	32
33	Common Area Carpeting	2013	10,290		20	515	515	1,029	33
34	TOTAL (lines 1 thru 33)		\$ 25,104,360	\$ 311,016		\$ 656,075	\$ 345,059	\$ 696,277	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		\$ 25,104,360	\$ 311,016		\$ 656,075	\$ 345,059	\$ 696,277	1
2	6Th Floor - Demolition, Rough Carpentry	2013	40,000		20	2,000	2,000	4,000	2
3	7Th Floor Patient Rooms, Corridors, Offices - Painting	2013	51,315		20	2,566	2,566	5,132	3
4	7Th Floor Shower Room, Dining Room - Flooring, Countertop, Hv	2013	69,110		20	3,456	3,456	6,911	4
5	Alley Lighting	2013	2,585		20	129	129	259	5
6	7Th Floor Handrail	2013	3,165		20	158	158	317	6
7	6Th Floor Resident Room Ceiling Lights	2013	3,599		20	180	180	360	7
8	6Th And 7Th Floor Tiling And Wall Base	2013	3,940		20	197	197	394	8
9	6Th Floor Light Fixtures	2013	4,360		20	218	218	436	9
10	Repaired Doors	2013	5,400		20	270	270	540	10
11	6Th Floor Handrail	2013	5,709		20	285	285	571	11
12	Shower Room Tiling	2013	12,300		20	615	615	1,230	12
13	6Th Floor Sprinklers	2013	17,000		20	850	850	1,700	13
14	Shower Room Tiling	2013	17,835		20	892	892	1,784	14
15	7Th Floor - Construction	2013	30,000		20	1,500	1,500	3,000	15
16	Shower Room Tiling	2013	33,153		20	1,658	1,658	3,315	16
17	7Th Floor Electrical Work	2013	45,000		20	2,250	2,250	4,500	17
18	6Th Floor Wallcoverings	2013	6,012		20	301	301	301	18
19	Wall Sconce	2013	6,983		20	349	349	349	19
20	6Th Floor - Wallpaper, Ceiling, Walls, Tiling	2013	55,000		20	2,750	2,750	2,750	20
21	Security Cameras	2013	39,153		20	1,958	1,958	1,958	21
22	Shower Room Grab Bars	2013	2,607		20	130	130	130	22
23	Installed New Wood Doors	2013	31,801		20	1,590	1,590	1,590	23
24	Lower Level Shades	2013	10,238		20	512	512	512	24
25	Lower Level Shades	2013	12,561		20	628	628	628	25
26	Landscaping- Installed Upper Terrace For Lower Patio	2014	19,902		20	995	995	995	26
27	6Th Floor Nurse Call System	2014	25,053		20	1,253	1,253	1,253	27
28	6Th Floor - Prime And Paint, Flooring, Doors, Plumbing	2014	70,000		20	3,500	3,500	3,500	28
29	Elevator Repairs	2014	3,463		20	173	173	173	29
30	Boiler Repair	2014	6,804		20	340	340	340	30
31	6Th Floor And Garage Sprinkler Repair	2014	23,902		20	1,195	1,195	1,195	31
32	6Th Floor - Electric Work, Nurse Station, Flooring	2014	175,750		20	8,788	8,788	8,788	32
33	Repaired Condenser	2014	4,975		20	249	249	249	33
34	TOTAL (lines 1 thru 33)		\$ 25,943,034	\$ 311,016		\$ 698,008	\$ 386,992	\$ 755,434	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 25,943,034	\$ 311,016		\$ 698,008	\$ 386,992	\$ 755,434	1
2	Paging Sytem	2014	3,622		20	181	181	181	2
3	Repaired Dry Valve And Pipes	2014	10,826		20	541	541	541	3
4	Sprinkler Repair	2014	8,228		20	411	411	411	4
5	Door Repairs - Egress Locks	2014	3,888		20	194	194	194	5
6	5Th-9Th Floor Fire Dampers	2014	17,308		20	865	865	865	6
7	Signage	2014	6,715		20	336	336	336	7
8	2Nd Floor Hydronic Pipe Repair	2014	4,549		20	227	227	227	8
9	Repaired Pump For Chiller	2014	18,989		20	949	949	949	9
10	Door And Frame	2014	35,368		20	1,768	1,768	1,768	10
11	Heating/Cooling Unit Repair	2014	4,069		20	203	203	203	11
12	Fire Pump Anunciator	2014	4,311		20	216	216	216	12
13	Fire Dampers In Bathroom	2014	8,652		20	433	433	433	13
14	Repaired Colvent Plate Exchangers And Seals	2014	12,616		20	631	631	631	14
15	Anunciator System	2014	16,120		20	806	806	806	15
16	5Th Floor Tiling	2014	69,501		20	3,475	3,475	3,475	16
17	Heating/Cooling Unit Repair	2014	12,091		20	605	605	605	17
18	Replaced Hot Water Heater	2014	16,463		20	823	823	823	18
19	Glass Mount Bracket	2014	4,226		20	211	211	211	19
20	Doors	2014	8,382		20	419	419	419	20
21	5Th Floor Shower Room And Spa Tiling	2014	3,248		20	162	162	162	21
22	Handrails For Common Corridors	2014	7,198		20	360	360	360	22
23	5Th Floor Resident Rooms Light Fixtures	2014	6,968		20	348	348	348	23
24	5Th Floor Corridors Floor Covering	2014	9,254		20	463	463	463	24
25	6Th Floor Resident Rooms Wallpaper	2014	6,546		20	327	327	327	25
26	6Th Floor Corridors Wallpaper	2014	6,015		20	301	301	301	26
27	3Rd And 4Th Floor Corridors And Resident Rooms Painting	2014	3,500		20	175	175	175	27
28	Wood Doors For Corridors And Resident Rooms	2014	21,042		20	1,052	1,052	1,052	28
29	6Th Floor Common Area And Nurse Station - Fire Dampers	2014	22,570		20	1,128	1,128	1,128	29
30	Generator For 5Th Floor	2014	12,971		20	649	649	649	30
31	5Th Floor Corridors, Resid Rm & Bath, Lounge & Dining Rm	2014			20				31
32	Electric, Plumbing, Tiling, Flooring	2014	50,000		20	2,500	2,500	2,500	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 26,358,269	\$ 311,016		\$ 718,770	\$ 407,754	\$ 776,196	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	\$ 26,358,269	\$ 311,016		\$ 718,770	\$ 407,754	\$ 776,196		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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 26,358,269	\$ 311,016		\$ 718,770	\$ 407,754	\$ 776,196		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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	57,494	1,917	30	1,916	(1)	10,541	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Legacy Healthcare Financial Services	2012	2,586	179	20	129	(50)	388	9
10	Allocated from Legacy Healthcare Financial Services	2013	8,273	574	20	414	(160)	827	10
11	Allocated from Legacy Healthcare Financial Services	2014	808	56	20	40	(16)	40	11
12									12
13	Allocated from Legacy Real Properties	2009	32,650	816	20	1,633	817	7,755	13
14	Allocated from Legacy Real Properties	2010	9,928	323	20	397	74	1,789	14
15	Allocated from Legacy Real Properties	2011	14,112		20	706	706	2,822	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 125,851	\$ 3,865		\$ 5,235	\$ 1,370	\$ 24,162	34

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 12H, Carried Forward		\$ 125,851	\$ 3,865		\$ 5,235	\$ 1,370	\$ 24,162	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 125,851	\$ 3,865		\$ 5,235	\$ 1,370	\$ 24,162	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	\$ 1,970,796	\$ 2,845	\$ 197,080	\$ 194,235	10	\$ 280,678	71
72	Current Year Purchases	358,690	1,021	35,869	34,848	10	35,869	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,329,486	\$ 3,866	\$ 232,949	\$ 229,083		\$ 316,547	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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 32,695,177	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 314,882	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 951,719	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 636,837	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,092,743	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	5th Fl Renovation & Architect	\$ 1,143,549	92
93			93
94			94
95		\$ 1,143,549	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				2,695			5
6								6
7	TOTAL				\$ 2,695			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 57,956 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	Facility	Cadillac XTS	\$ 899.00	\$ 10,788	17
18	Allocated from Progressive Healthcare			43	18
19					19
20					20
21	TOTAL		\$ 899.00	\$ 10,831	21

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr # 0052415 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 1,161,153		\$	\$		\$ 1,161,153	1	
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	281,269					281,269	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39 - 01	hrs	1,253,188					1,253,188	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 prescripts					1,361,861	1,361,861	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>See Supplemental</u>						137,599	225,317	362,916	13	
14	TOTAL			\$ 2,695,610		\$ 137,599	\$ 1,587,178		\$ 4,420,387	14	

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr# 0052415Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 490,948	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	7,512,478	7,512,478	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,713	62,713	6
7	Other Prepaid Expenses	163,060	378,092	7
8	Accounts Receivable (owners or related parties)	1,549	1,718,708	8
9	Other(specify):	619,490	619,490	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,360,290	\$ 10,783,429	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,000,000	13
14	Buildings, at Historical Cost		24,553,000	14
15	Leasehold Improvements, at Historical Cost	1,349,519	1,349,519	15
16	Equipment, at Historical Cost	1,249,565	2,369,565	16
17	Accumulated Depreciation (book methods)	(60,174)	(389,594)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	6,419,275	9,472,984	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,958,185	\$ 41,355,474	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,318,475	\$ 52,138,903	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,517,128	\$ 3,517,129	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,880,319	4,441,843	29
30	Accrued Salaries Payable	642,753	642,753	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,829	27,829	31
32	Accrued Real Estate Taxes(Sch.IX-B)		620,781	32
33	Accrued Interest Payable		309,620	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	155,220	1,285,663	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,223,249	\$ 10,845,618	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		37,991,255	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,195,312	2,195,312	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,195,312	\$ 40,186,567	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,418,561	\$ 51,032,185	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,899,914	\$ 1,106,718	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,318,475	\$ 52,138,903	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,715,087	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,715,087	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,184,827	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)	\$ 2,184,827	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)	\$ 7,899,914	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,890,865	1
2	Discounts and Allowances for all Levels	(13,829,675)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,061,190	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,551,662	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 17,551,662	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,405,199	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	311,932	19
20	Radiology and X-Ray	65,270	20
21	Other Medical Services	62,813	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,845,214	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,189	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,189	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	94,219	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 94,219	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 27,554,474	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,520,515	31
32	Health Care	7,803,361	32
33	General Administration	5,167,279	33
B. Capital Expense			
34	Ownership	3,746,953	34
C. Ancillary Expense			
35	Special Cost Centers	5,797,393	35
36	Provider Participation Fee	334,146	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 25,369,647	40
41	Income before Income Taxes (line 30 minus line 40)**	2,184,827	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,184,827	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,612,328	44
45	Private Pay - Net Inpatient Revenue	1,855,005	45
46	Medicare - Net Inpatient Revenue	2,670,569	46
47	Other-(specify) <u>Insurance</u>	923,288	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,061,190	49

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

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

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

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

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	2,672	2,729	\$ 169,472	\$ 62.10	1
2	Assistant Director of Nursing	4,292	4,412	218,398	49.50	2
3	Registered Nurses	63,339	65,106	2,198,027	33.76	3
4	Licensed Practical Nurses	50,545	52,087	1,450,989	27.86	4
5	CNAs & Orderlies	133,262	137,383	1,848,159	13.45	5
6	CNA Trainees					6
7	Licensed Therapist	67,968	70,070	2,695,610	38.47	7
8	Rehab/Therapy Aides	15,818	16,307	399,692	24.51	8
9	Activity Director	1,916	1,964	41,976	21.37	9
10	Activity Assistants	9,656	9,885	107,585	10.88	10
11	Social Service Workers	14,586	14,884	406,039	27.28	11
12	Dietician					12
13	Food Service Supervisor	3,889	3,929	103,519	26.35	13
14	Head Cook	7,613	7,738	99,453	12.85	14
15	Cook Helpers/Assistants	26,105	26,638	303,670	11.40	15
16	Dishwashers					16
17	Maintenance Workers	7,168	7,328	185,902	25.37	17
18	Housekeepers	30,181	30,693	315,433	10.28	18
19	Laundry	5,113	5,240	54,241	10.35	19
20	Administrator	6,380	6,511	305,415	46.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,535	27,077	440,000	16.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,325	2,381	45,405	19.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	15,622	15,981	273,928	17.14	33
34	TOTAL (lines 1 - 33)	494,985	508,343	\$ 11,662,913 *	\$ 22.94	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	723	\$ 35,077	01-03	35
36	Medical Director	Monthly	63,900	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	21,000	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	54	3,508	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,332	11-03	44
45	Social Service Consultant	Monthly	180	12-03	45
46	Other(specify)				46
47	<u>Psychiatric Consultant</u>	Monthly	30,000	09-03	47
48	<u>Clergy</u>	Monthly	4,612	12-03	48
49	TOTAL (lines 35 - 48)	777	\$ 168,009		49

C. CONTRACT NURSES

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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Warren Barr Lvg & Rehab Ctr

0052415

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$407
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 78,747 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 334,146
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.