

Facility Name & ID Number Warren Barr Lincolnshire

0053587 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	144	Skilled (SNF)	144	52,560	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	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			12,653	12,653	8
9	SNF/PED					9
10	ICF	21,394	7,926		29,320	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,394	7,926	12,653	41,973	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.86%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 05/01/2015

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

YES Date 05/01/2015 NO

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

YES NO If YES, enter number of beds certified 144 and days of care provided 9,478

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	596,285	101,828	20,071	718,184		718,184	(28,050)	690,134		1
2	Food Purchase		121,110		121,110		121,110	60	121,170		2
3	Housekeeping	-	8,438	345,148	353,586		353,586	192	353,778		3
4	Laundry	31,997	27,807	32,365	92,169	-	92,169	5	92,174		4
5	Heat and Other Utilities			179,851	179,851		179,851	1,127	180,978		5
6	Maintenance	190,185	56,905	278,350	525,440		525,440	46,418	571,858		6
7	Other (specify):*	-	-	-	-		-	-	-		7
8	TOTAL General Services	818,467	316,088	855,785	1,990,340	-	1,990,340	19,752	2,010,092		8
	B. Health Care and Programs										
9	Medical Director	-	-	61,647	61,647		61,647	588	62,235		9
10	Nursing and Medical Records	3,924,736	241,539	171,799	4,338,074		4,338,074	(452)	4,337,622		10
10a	Therapy	111,405	-	-	111,405		111,405	-	111,405		10a
11	Activities	227,169	16,085	126	243,380		243,380	4,465	247,845		11
12	Social Services	119,005	-	18,729	137,734		137,734	1,603	139,337		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	57,540	57,540		57,540	-	57,540		14
15	Other (specify):* Alloc. Mgmt. Bene	-	-	-	-		-	15,322	15,322		15
16	TOTAL Health Care and Programs	4,382,315	257,624	309,841	4,949,780	-	4,949,780	21,526	4,971,306		16
	C. General Administration										
17	Administrative	100,739	-	687,273	788,012		788,012	(824,859)	(36,847)		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			92,074	92,074		92,074	5,088	97,162		19
20	Dues, Fees, Subscriptions & Promotions			37,694	37,694		37,694	947	38,641		20
21	Clerical & General Office Expenses	149,261	-	94,960	244,221		244,221	188,928	433,149		21
22	Employee Benefits & Payroll Taxes			832,106	832,106		832,106	-	832,106		22
23	Inservice Training & Education			-	-		-	-	-		23
24	Travel and Seminar			510	510		510	1,771	2,281		24
25	Other Admin. Staff Transportation		-	158	158		158	-	158		25
26	Insurance-Prop.Liab.Malpractice			179,975	179,975		179,975	3,264	183,239		26
27	Other (specify):* Alloc. Mgmt. Bene	-	-	-	-		-	6,223	6,223		27
28	TOTAL General Administration	250,000	-	1,924,750	2,174,750	-	2,174,750	(618,638)	1,556,112		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,450,782	573,712	3,090,376	9,114,870	-	9,114,870	(577,360)	8,537,510		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 Lincolnshire

#0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

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			-	-		-	113,733	113,733			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			209,185	209,185		209,185	216	209,401			32
33	Real Estate Taxes			162,001	162,001		162,001	4,338	166,339			33
34	Rent-Facility & Grounds			1,048,644	1,048,644		1,048,644	40,080	1,088,724			34
35	Rent-Equipment & Vehicles			54,957	54,957		54,957	4,065	59,022			35
36	Other (specify):*			-	-		-	-	-			36
37	TOTAL Ownership			1,474,787	1,474,787	-	1,474,787	162,432	1,637,219			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	594,030	1,276,904	1,870,934		1,870,934	-	1,870,934			39
40	Barber and Beauty Shops	-	-	-	-		-	-	-			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			273,047	273,047		273,047	-	273,047			42
43	Other (specify):* Non-Allowable Cos	94,726	-	463,817	558,543		558,543	(558,543)	-			43
44	TOTAL Special Cost Centers	94,726	594,030	2,013,768	2,702,524	-	2,702,524	(558,543)	2,143,981			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,545,508	1,167,742	6,578,931	13,292,181	-	13,292,181	(973,471)	12,318,710			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 Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	(8,520)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	112,992	30		9
10	Interest and Other Investment Income	(4,843)	32		10
11	Discounts, Allowances, Rebates & Refunds	(28,050)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,689)	43		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	(4,433)	43		18
19	Entertainment	(1,496)	43		19
20	Contributions	2,213	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(242,414)	43		24
25	Fund Raising, Advertising and Promotional	3,860	43		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 See Page 5A	(303,585)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (476,965)		\$	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)	(496,506)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (496,506)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (973,471)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Warren Barr Lincolnshire

ID# 0053587

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Personal Items	\$ (9,039)	43	1
2	Labs-Part A	(20,598)	43	2
3	X-Rays-Part A	(14,009)	43	3
4	Consolidated Billing charges	(18,265)	43	4
5	Valet Services	(38,561)	43	5
6	Sequestration Expense	(109,866)	43	6
7	Misc. Income	(23)	21	7
8	Expense LHI to maintenance	3,200	6	8
9	Admissions salary	(94,726)	43	9
10	Non-allowable legal	(1,698)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(303,585)		49

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: 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		
1	V	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2	FOOD	Legacy Healthcare Financial Services	100.00%	\$ 43	\$ 43	15	
16	V	3	HOUSEKEEPING SUPPLIES	Legacy Healthcare Financial Services	100.00%	192	192	16	
17	V	4	LINEN REPLACEMENT	Legacy Healthcare Financial Services	100.00%	5	5	17	
18	V	5	UTILITIES	Legacy Healthcare Financial Services	100.00%	11	11	18	
19	V	6	GROUNDS & MAINTENANCE	Legacy Healthcare Financial Services	100.00%	2,573	2,573	19	
20	V	9	MEDICAL DIRECTOR CONSULTANT	Legacy Healthcare Financial Services	100.00%	588	588	20	
21	V	10	MEDICAL SUPPLIES	Legacy Healthcare Financial Services	100.00%	36	36	21	
22	V	11	ACTIVITIES PROGRAM	Legacy Healthcare Financial Services	100.00%	4,448	4,448	22	
23	V	12	SOCIAL SERVICE CONSULTANT	Legacy Healthcare Financial Services	100.00%	70	70	23	
24	V	17	CFO SALARY	Legacy Healthcare Financial Services	100.00%	27,562	27,562	24	
25	V	19	PROFESSIONAL FEES	Legacy Healthcare Financial Services	100.00%	13,736	13,736	25	
26	V	20	FEES, SUBSCRIPTIONS	Legacy Healthcare Financial Services	100.00%	781	781	26	
27	V	21	CLERICAL & GENERAL WAGES	Legacy Healthcare Financial Services	100.00%	156,083	156,083	27	
28	V	21	CLERICAL & GENERAL OTHER COSTS	Legacy Healthcare Financial Services	100.00%	4,313	4,313	28	
29	V	24	SEMINARS	Legacy Healthcare Financial Services	100.00%	1,032	1,032	29	
30	V	26	INSURANCE	Legacy Healthcare Financial Services	100.00%	866	866	30	
31	V	27	EMP. BEN.-GEN. ADMIN.	Legacy Healthcare Financial Services	100.00%	34,510	34,510	31	
32	V	30	DEPRECIATION	Legacy Healthcare Financial Services	100.00%			32	
33	V	32	INTEREST	Legacy Healthcare Financial Services	100.00%	16	16	33	
34	V	33	REAL ESTATE TAXES	Legacy Healthcare Financial Services	100.00%			34	
35	V	34	RENT	Legacy Healthcare Financial Services	100.00%	39,939	39,939	35	
36	V	34	STORAGE	Legacy Healthcare Financial Services	100.00%	84	84	36	
37	V	35	EQUIPMENT RENTAL	Legacy Healthcare Financial Services	100.00%	20	20	37	
38	V	35	AUTO RENTAL	Legacy Healthcare Financial Services	100.00%	2,910	2,910	38	
39	Total		\$			\$ 289,818	\$ *	289,818	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	17 MANAGEMENT FEES	\$ 687,273	Legacy Healthcare Financial Services	100.00%	\$	\$ (687,273)
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		\$ 687,273			\$ 0	\$ * (687,273)

* 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%	\$ 17	\$	17	15
16	V	6 MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	40,131		40,131	16
17	V	6 BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	120		120	17
18	V	10 NURSING SALARIES	99,080	Progressive Healthcare Consulting	100.00%	98,592		(488)	18
19	V	12 ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	17		17	19
20	V	12 CLERGY CONSULANT		Progressive Healthcare Consulting	100.00%	1,529		1,529	20
21	V	12 SOCIAL SERVICES		Progressive Healthcare Consulting	100.00%	4		4	21
22	V	15 EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	15,322		15,322	22
23	V	17 ADMINISTRATIVE SALARY	298,451	Progressive Healthcare Consulting	100.00%	133,303		(165,148)	23
24	V	19 PAYROLL PROCESSING		Progressive Healthcare Consulting	100.00%	311		311	24
25	V	19 PROFESSIONAL LEGAL FEES		Progressive Healthcare Consulting	100.00%	4		4	25
26	V	19 OTHER PROFESSIONAL		Progressive Healthcare Consulting	100.00%	21		21	26
27	V	20 DUES AND SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	164		164	27
28	V	21 OFFICE SALARY		Progressive Healthcare Consulting	100.00%	28,253		28,253	28
29	V	21 OFFICE EXPENSE		Progressive Healthcare Consulting	100.00%	301		301	29
30	V	24 EDUCATION AND SEMINARS		Progressive Healthcare Consulting	100.00%	739		739	30
31	V	26 INSURANCE		Progressive Healthcare Consulting	100.00%	2,109		2,109	31
32	V	27 EMP. BEN.-NURSING	59,630	Progressive Healthcare Consulting	100.00%	31,343		(28,287)	32
33	V	30 DEPRECIATION		Progressive Healthcare Consulting	100.00%	741		741	33
34	V	34 STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	57		57	34
35	V	35 AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,135		1,135	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 457,161			\$ 354,213	\$ *	(102,948)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	CF ST. LOUIS, LLC	100.00%	\$ 1,116	\$	1,116	15
16	V	6 REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,411		1,411	16
17	V	19 ACCOUNTING		CF ST. LOUIS, LLC	100.00%	29		29	17
18	V	19 LEGAL		CF ST. LOUIS, LLC	100.00%				18
19	V	19 PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	46		46	19
20	V	20 DUES AND SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2		2	20
21	V	21 OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1		1	21
22	V	26 INSURANCE		CF ST. LOUIS, LLC	100.00%	289		289	22
23	V	32 INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	5,043		5,043	23
24	V	33 REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	4,133		4,133	24
25	V	33 REAL ESTATE LEGAL		CF ST. LOUIS, LLC	100.00%	205		205	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		\$			\$ 12,275	\$ *	12,275	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs and Maintenance	\$ 24,980	ReMed Services, LLC	1.00%	\$ 23,963	\$ (1,017)
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		\$ 24,980			\$ 23,963	\$ * (1,017)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 30,761	ProPay HR LLC	24.00%	\$ 23,400	\$ (7,361)
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		\$ 30,761			\$ 23,400	\$ * (7,361)

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

Facility Name & ID Number

Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	6 Repairs and Maintenance	\$ 123,392	ML Group Design and Development		\$ 123,392	\$	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		\$ 123,392			\$ 123,392	\$ *	39

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

Facility Name & ID Number

Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YAIR ZUCKERMAN	10.00%	Astoria Place Living & Rehab	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	MENACHEM SHABAT	3.10%	Bella Terra Morton Grove	Morton Grove	Financial Svcs, LLC			2
3	MENACHEM & AHUVA SHABAT DESC	27.95%	Chalet Living & Rehab Center	Chicago				3
4	CHAIM RAJCHENBACH	7.76%	Elmhurst Nursing	Elmhurst	Legacy Real	Skokie	Real Estate	4
5	GPN FAMILY TRUST	23.29%	The Grove of Evanston, LLC	Evanston	Properties, LLC			5
6	DAVID M. FRIEDMAN	4.90%	The Villa at Evergreen	Evergreen Park				6
7	RONALD SHABAT	10.00%	The Grove of Fox Valley	Aurora	Grove Healthcare	Skokie	Real Estate	7
8	THE RAJCHENBACH 2015 FAMILY TR	10.00%	The Grove of LaGrange Park LLC	LaGrange Park	Properties, LLC			8
9	ROSS BOTTNER	3.00%	The Grove at the Lake	Zion				9
10			Lakefront Nursing & Rehab Center, LLC	Chicago	ReMED Services,	Skokie	Medical	10
11			The Grove at Lincoln Park Living & Rehab	Chicago	LLC		Equipment Sales	11
12			Avantara Long-Grove	Long Grove				12
13			The Grove North Living & Rehab Center	Skokie	Progressive	Skokie	Consulting	13
14			The Grove of Northbrook	Northbrook	Healthcare			14
15			Warren Barr North Shore	Highland Park	Consulting			15
16			Avantara Park Ridge	Park Ridge				16
17			Peterson Park Associates Ltd. Partnetship	Chicago	MG Property	Morton Grove	Real Estate	17
18			Warren Barr South Loop	Chicago	Holdings, LLC			18
19			Warren Barr	Chicago				19
20			Aurora Supportive Living	Aurora	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21								21
22					ProPay	Evanston	Payroll Services	22
23								23
24					ML Group Design	Skokie	Asset Mgmt Fees	24
25								25
26					ML Enterprise	Skokie	Asset Mgmt Fees	26
27								27
28					CF St.Louis Inc	Skokie	Management Co.	28
29								29
30								30

Facility Name & ID Number

Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

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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	Ross Bottner	Owner	Administrative	3.00	See Attached	1.18	3.23	Alloc Salary	\$ 5,875	10(7)	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 5,875		13	

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

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V	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	
Line Reference									
1	2	FOOD	AVAIL. BED DAYS	29	\$ 1,460	\$	52,560	\$ 43	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	29	6,519		52,560	192	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	29	171		52,560	5	3
4	5	UTILITIES	AVAIL. BED DAYS	29	372		52,560	11	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	29	87,596		52,560	2,573	5
6	9	MEDICAL DIRECTOR CONSULT	AVAIL. BED DAYS	29	20,000		52,560	588	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	29	1,237		52,560	36	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	29	151,405		52,560	4,448	8
9	12	SOCIAL SERVICE CONSULTANT	AVAIL. BED DAYS	29	2,392		52,560	70	9
10	17	CFO SALARY	AVAIL. BED DAYS	29	938,242	938,242	52,560	27,562	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	29	467,580		52,560	13,736	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	29	26,590		52,560	781	12
13	21	CLERICAL & GENERAL WAGES	AVAIL. BED DAYS	29	5,313,296	5,313,296	52,560	156,083	13
14	21	CLERICAL & GENERAL OTHER	AVAIL. BED DAYS	29	146,833		52,560	4,313	14
15	24	SEMINARS	AVAIL. BED DAYS	29	35,138		52,560	1,032	15
16	26	INSURANCE	AVAIL. BED DAYS	29	29,475		52,560	866	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	29	1,174,773		52,560	34,510	17
18	30	DEPRECIATION	AVAIL. BED DAYS	29			52,560	0	18
19	32	INTEREST	AVAIL. BED DAYS	29	561		52,560	16	19
20	33	REAL ESTATE TAXES	AVAIL. BED DAYS	29			52,560	0	20
21	34	RENT	AVAIL. BED DAYS	29	1,359,562		52,560	39,939	21
22	34	STORAGE	AVAIL. BED DAYS	29	2,843		52,560	84	22
23	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	29	694		52,560	20	23
24	35	AUTO RENTAL	AVAIL. BED DAYS	29	99,070		52,560	2,910	24
25	TOTALS				\$ 9,865,809	\$ 6,251,538		\$ 289,818	25

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending: 12/31/17

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 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number 847) 679-9797
 Fax Number 847) 683-2900

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	1,374,590	29	\$ 432	\$ 52,560	\$ 17	1	
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	29	1,049,531	1,049,531	52,560	40,131	2
3	6	BUILDING MAINTENANCE AND	AVAIL. BED DAYS	1,374,590	29	3,133	52,560	120	3	
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	29	2,578,462	2,578,462	52,560	98,592	4
5	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	29	443	52,560	17	5	
6	12	CLERGY CONSULANT	AVAIL. BED DAYS	1,374,590	29	39,998	52,560	1,529	6	
7	12	SOCIAL SERVICES	AVAIL. BED DAYS	1,374,590	29	95	52,560	4	7	
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	29	400,703	52,560	15,322	8	
9	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,374,590	29	3,486,246	3,486,246	52,560	133,303	9
10	19	PAYROLL PROCESSING	AVAIL. BED DAYS	1,374,590	29	8,134	52,560	311	10	
11	19	PROFESSIONAL LEGAL FEES	AVAIL. BED DAYS	1,374,590	29	107	52,560	4	11	
12	19	OTHER PROFESSIONAL	AVAIL. BED DAYS	1,374,590	29	560	52,560	21	12	
13	20	DUES AND SUBSCRIPTIONS	AVAIL. BED DAYS	1,374,590	29	4,293	52,560	164	13	
14	21	OFFICE SALARY	AVAIL. BED DAYS	1,374,590	29	738,904	738,904	52,560	28,253	14
15	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,374,590	29	7,880	52,560	301	15	
16	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,374,590	29	19,314	52,560	739	16	
17	26	INSURANCE	AVAIL. BED DAYS	1,374,590	29	55,168	52,560	2,109	17	
18	27	EMP. BEN.-MGMT	AVAIL. BED DAYS	1,374,590	29	819,705	52,560	31,343	18	
19	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	29	19,384	52,560	741	19	
20	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	29	1,500	52,560	57	20	
21	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	29	29,674	52,560	1,135	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 9,263,666	\$ 7,853,143	\$ 354,213	25	

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	5	UTILITIES	AVAIL. BED DAYS	29	\$ 37,998	\$	52,560	\$ 1,116	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	29	48,042		52,560	1,411	2
3	19	ACCOUNTING	AVAIL. BED DAYS	29	1,001		52,560	29	3
4	19	LEGAL	AVAIL. BED DAYS	29			52,560		4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	29	1,564		52,560	46	5
6	20	DUES AND SUBSCRIPTIONS	AVAIL. BED DAYS	29	76		52,560	2	6
7	21	OFFICE EXPENSE	AVAIL. BED DAYS	29	32		52,560	1	7
8	26	INSURANCE	AVAIL. BED DAYS	29	9,839		52,560	289	8
9	32	INTEREST EXPENSE	AVAIL. BED DAYS	29	171,679		52,560	5,043	9
10	33	REAL ESTATE TAXES	AVAIL. BED DAYS	29	140,710		52,560	4,133	10
11	33	REAL ESTATE LEGAL	AVAIL. BED DAYS	29	6,986		52,560	205	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				\$ 417,927	\$		\$ 12,275	25

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending: 12/31/17

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 ReMed Services, LLC
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 679-9797
 Fax Number (847) 683-2900

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Repairs & Maintenance	Direct Allocation		\$	\$		\$ 23,963	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				\$	\$		\$ 23,963	25

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ProPay HR LLC

Street Address 2201 W. Main Street

City / State / Zip Code Evanston, IL 60202

Phone Number ()

Fax Number ()

1	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	Payroll Services	Direct		\$	\$		\$ 23,400	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				\$	\$		\$ 23,400	25

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization ML Group Design and Development
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 679-9797
 Fax Number (847) 683-2900

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.

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 and Maintenance	Direct Allocation		\$	\$		\$ 123,392	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				\$	\$		\$ 123,392	25

Facility Name & ID Number

Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

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		7	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						
Working Capital																		
6	The Private Bank		X	CapEx		8/9/2017	2,500,000	2,846,989	1/1/2019	Libor + 4.75%	209,185	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,500,000	\$ 2,846,989			\$ 209,185	9						
B. Non-Facility Related*																		
10												10						
11												11						
12											(4,843)	12						
13											5,059	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 216	14						
15	TOTALS (line 9+line14)						\$ 2,500,000	\$ 2,846,989			\$ 209,401	15						

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

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

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

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 2016 report.			\$	7,515	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.)	2016		\$	169,516	2
3. Under or (over) accrual (line 2 minus line 1).			\$	166,134	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		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.)					
		Alloc Fr. Mgmt Co.		205	5
		Alloc Fr. Mgmt Co.		4,133	
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.			\$	166,339	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	168,518	8		
	2013	168,518	9		
	2014	172,509	10		
	2015	166,492	11		
	2016	169,516	12		
Beginning Accrual Adjusted					
Allocated from CF St. Louis LLC:		4133			

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincolnshire COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053587

CONTACT PERSON REGARDING THIS REPORT Moti Ninio

TELEPHONE (847) 676-5315 FAX #: (773) 248-9703

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-15-200-062</u>	<u>Long Term Care Facility</u>	\$ <u>169,516.22</u>	\$ <u>169,516.22</u>
2. _____	_____	\$ _____	\$ _____
3. <u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>463,439.48</u>	\$ <u>4,133.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>632,955.70</u></u>	\$ <u><u>173,649.22</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 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,477 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lincolnshire Assisted Living

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Row 1: Allocated from CF St. Louis, \$ 19,094, 1. Row 2: 2. Row 3: TOTALS, \$ 19,094, 3.

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$ -	\$ -		\$ -		\$ -	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9											9
10		Allocation C.F St. Louis, LLC			31,217					1,784	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 31,217	\$		\$	\$	\$ 1,784	70

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 31,217	\$		\$	\$	\$ 1,784	1
2	Kitchen - Millwork/Countertop/Cabinet	2015	25783		20	752	752	2,793	2
3	Resident Rm/Dining/Hallways - Wall Sconces/Light Fixtures	2015	20930		20	610	610	2,093	3
4	Resident Rooms - Power Outlets/Cables/Plates	2015	4200		20	123	123	403	4
5	Resident Rooms - Carpet/Flooring	2015	4300		20	125	125	412	5
6	Tile In Riviera Wing	2015	6400		20	187	187	613	6
7	Resident Room Carpet	2015	31057.59		20	906	906	2,976	7
8	Wood/Fire Rated Door & Hinges For Corridor	2015	10953.37		20	319	319	1,050	8
9	Glass Door	2015	7730		20	225	225	741	9
10	Resident Room Flooring	2015	14056.91		20	410	410	1,347	10
11	Cape Cod Unit Tile	2015	7714.56		20	225	225	739	11
12	Double Egress Fire Doors	2015	2992		20	87	87	287	12
13	Corridors Carpet/Flooring	2015	9096.06		20	265	265	834	13
14	Cape Cod Unit Drapery/Curtains	2015	12109		20	353	353	1,060	14
15	Cape Cod Unit Wallcovering	2015	3102.36		20	90	90	271	15
16	Cape Cod Unit Glass Mount Bracket	2015	4052.23		20	118	118	355	16
17	Cape Cod Unit Double Doors	2015	7730		20	225	225	676	17
18	Corridor Signage	2015	3855.18		20	112	112	418	18
19	Cape Cod Unit - New Frames/Doors	2015	3646.56		20	106	106	304	19
20	New Compressor For Chiller	2015	8896.5		20	259	259	816	20
21	Install Door Controls	2015	20150		20	588	588	1,931	21
22	Drapery - Coventry/Palm Beach Wings	2015	6000		20	175	175	500	22
23	Dining Area/Guest Room - Valance/Rods/Divider Panels	2015	33300		20	971	971	3,608	23
24	Bathroom/Resident Rooms - Dividers/Doors	2015	17820		20	520	520	1,931	24
25	Resident Rooms/Corridors - Painting	2015	16900		20	493	493	1,690	25
26	Cape Cod Unit Wallcovering	2015	5603		20	163	163	514	26
27	East Wing - Primer/Tile	2015	30947		20	903	903	3,353	27
28	Dining Room, Hallway, Gym & Library - Painted Ceiling/Walls	2016	9850		20	493	493	985	28
29	Hallways - Tiles & Carpet	2016	6392.36		20	320	320	639	29
30	Cape Cod -Installed Roller Shades	2016	5580		20	279	279	558	30
31	Wireless Access Point	2016	58169.04		20	2,908	2,908	5,817	31
32	Security Cameras	2016	25993		20	1,300	1,300	2,599	32
33	Hallways - Vinyl Tiles, Carpet	2016	4100.36		20	205	205	410	33
34	TOTAL (lines 1 thru 33)		\$ 460,627	\$		\$ 14,818	\$ 14,818	\$ 44,505	34

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

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

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		\$ 460,627	\$		\$ 14,818	\$ 14,818	\$ 44,505	1
2	Repaired Boiler	2016	2,732		20	137	137	273	2
3	Painted Resident Rooms/Bathrooms/Kitchen/Lounge/Office	2016	9,160		20	458	458	916	3
4	Installed Nurse Stations, Counters, Cabinets	2016	23,460		20	1,173	1,173	2,346	4
5	Tuscany Wing - Drywall & Nurses Station Repair	2016	2,633		20	132	132	263	5
6	Painted Dining Room And Hallways	2016	25,200		20	1,260	1,260	2,520	6
7	Architectural Fees - Wing Conversion	2016	12,000		20	600	600	1,200	7
8	Exterior Signage	2016	14,135		20	707	707	1,414	8
9	Tuscany/Barcelona Wing - Carpeting	2016	19,655		20	983	983	1,965	9
10	Unit Melbourne - Carpeting	2016	3,995		20	200	200	400	10
11	Painted 8 Regular And 4 Double Rooms	2016	11,957		20	598	598	1,196	11
12	Chiller Hook Up	2016	2,590		20	130	130	259	12
13	Repair Leaks In 4-Rtu Hydronic Coils	2016	6,646		20	332	332	665	13
14	Landscaping Including Shrubs & Ground Cover	2016	8,749		20	437	437	875	14
15	Installation Of Wiring For Kiosk, Nurse Station, And Speaker Loc	2016	4,496		20	524	524	1,349	15
16	Replaced Garbage Disposal	2016	3,250		20	379	379	758	16
17	Repaired Generator	2016	2,934		20	342	342	734	17
18	Repaired Pump	2016	4,902		20	327	327	654	18
19	Installed Light Fixtures For Melbourne, Tuscany & Sydney Wings	2016	3,853		20	502	502	1,362	19
20	Demolition Of 9 Fixtures & Can Lights For Nurse Stations	2016	3,610		20	182	182	416	20
21	Insulated Chilled Water Pipes/Mechanical Room Pipes	2016	10,875		20	544	544	1,088	21
22	Repaired Pump	2016	4,902		20	245	245	490	22
23	Removed And Replaced Garbage Disposal	2016	2,650		20	133	133	265	23
24	Repaired Fire Alarm System	2016	3,124		20	156	156	312	24
25	Repaired Valves On Boiler	2016	3,033		20	152	152	303	25
26	Cape Cod Unit - Demo/Carpentry/Drywall/Electical/Tiling.Paintin	2016	334,638		20	16,732	16,732	33,464	26
27	West Wing - Installed Nurse Station/Work Hub	2016	28,688		20	1,434	1,434	2,869	27
28	Installed New Chiller	2016	168,000		20	8,400	8,400	16,800	28
29	Repair cracks in curb, storm drain & wooden fence	2017	4,250		20	106	106	106	29
30	Cut down 47 trees, hauled away and ground stumps	2017	9,800		20	245	245	245	30
31									31
32	Replace high low pressure switch, fix compressor	2017	2,540		20	64	64	64	32
33	East boiler replaced and leaking water lines fixed	2017	7,907		20	198	198	198	33
34	TOTAL (lines 1 thru 33)		\$ 1,206,990	\$		\$ 52,628	\$ 52,628	\$ 120,272	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,206,990	\$		\$ 52,628	\$ 52,628	\$ 120,272	1
2	Knock down frames or doors, preped hinges, install								2
3	hinges and double engress frames and doors	2017	7,761		20	194	194	194	3
4									4
5	Maintenance on 4 large slope roofs, cleaned gutters, fixed								5
6	damaged fascia and shingles	2017	6,300		20	158	158	158	6
7									7
8									8
9									9
10	Allocated from CF St. Louis LLC	2016	193,815		20			19,381	10
11	Allocated from CF St. Louis LLC	2017	4,498		20			225	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)		\$ 1,419,364	\$		\$ 52,980	\$ 52,980	\$ 140,230	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	\$ 635,758	\$	\$ 50,410	\$ 50,410	10	\$ 126,210	71
72	Current Year Purchases	193,326		9,602	9,602	10	9,602	72
73	Fully Depreciated Assets							73
74	Allocated from Legacy HC & Progessive & CF St. Louis	22,144		741	741	10	4,972	74
75	TOTALS	\$ 851,228	\$	\$ 60,753	\$ 60,753		\$ 140,784	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	N/A			\$	\$ -	\$ -	\$		\$	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)	\$ 2,289,686	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,733	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 113,733	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 281,014	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living Addition - 2016	\$ 53,025	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 53,025	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 237,529	92
93			93
94			94
95		\$ 237,529	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.

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning: 1/1/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Cambridge Realty

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

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:	<u>144</u>		\$ <u>1,048,644</u>			3
4	Additions						4
5	<u>Offsite Storage</u>			<u>141</u>			5
6	<u>Alloc Legacy/Progressive HC</u>			<u>39,939</u>			6
7	TOTAL	144		\$ 1,088,724			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.	<u>12/31/2018</u>	\$ <u>1,842,097</u>
13.	<u>12/31/2019</u>	\$ <u>1,854,747</u>
14.	<u>12/31/2020</u>	\$ <u>1,867,652</u>

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: \$ 54,700 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	<u>Auto Lease</u>		\$ _____	\$ <u>277</u>	17
18					18
19	<u>Allocation from Progressive</u>			<u>1,135</u>	19
20	<u>Allocation from Legacy Financial Services</u>			<u>2,910</u>	20
21	TOTAL		\$ _____	\$ 4,322	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: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/17

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Durable Medical Equipment Rental	40,395
Oxygen Equipment Rental	705
Dietary Equipment Rental	2,100
Maintenance Equipment Rental	2,905
Office Equipment Rental	8,575
Allocation Legacy Healthcare Financial Services	20
Total - Line 16	<u>54,700</u>

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>It is the policy of this facility to only hire certified nurses aides. 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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	7,538	\$ 542,724	\$	7,538	\$ 542,724	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,209	87,075		1,209	87,075	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		8,988	647,105		8,988	647,105	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				566,441		566,441	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					27,589		27,589	12
13	Other (specify): _____									13
14	TOTAL			\$	17,735	\$ 1,276,904	\$ 594,030	17,735	\$ 1,870,934	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$ 2,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>560,873</u>)	3,210,909	3,210,909	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,270	56,270	6
7	Other Prepaid Expenses	19,966	19,966	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	203,626	203,626	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,492,771	\$ 3,492,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		19,094	13
14	Buildings, at Historical Cost		31,217	14
15	Leasehold Improvements, at Historical Cost	821,741	1,388,147	15
16	Equipment, at Historical Cost	1,135,986	851,228	16
17	Accumulated Depreciation (book methods)	(275,572)	(281,014)	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 (spe CIP)	237,529	237,529	22
23	Other(specify): <u>See Sch 17A</u>	2,265,246	2,265,246	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,184,930	\$ 4,511,447	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,677,701	\$ 8,004,218	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,208,049	\$ 1,208,049	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	273,898	273,898	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,577	9,577	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	4,898,949	4,898,949	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,390,473	\$ 6,390,473	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,846,989	2,846,989	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,846,989	\$ 2,846,989	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,237,462	\$ 9,237,462	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,559,761)	\$ (1,233,244)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,677,701	\$ 8,004,218	48

*(See instructions.)

Facility Name: Warren Barr Lincolnshire
 IDPH License ID Number: 0053587
 Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	After	
	Operating	Consolidation
Refund	14,966	14,966
Insurance Refund Exchange	1,572	1,572
Escrow-R&R	176,000	176,000
Payroll Clearing	4,821	4,821
Security Deposit	5,763	5,763
Due to/from-Warren Barr Lincolnshire	504	504
Total - Line 9	203,626	203,626

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
Refund Transfer	94,569	94,569
Due to/from Warren Barr Lincolnshire & ALF	1,507,081	1,507,081
Due to/from Warren Barr Lincolnshire & Avanta	121,458	121,458
Due to/from Warren Barr Lincolnshire & Bella	196,632	196,632
Due to/from prior owner	156,232	156,232
Due to/from Medicare	187,958	187,958
Bad Debt Part A MMAI	1,316	1,316
Total - Line 23	2,265,246	2,265,246

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Exchange	868	868
Payroll Exchange	3,988	3,988
Employee Loans, Adv, Wage Assign	800	800
Rent Security Deposit	9,500	9,500
Due to/from Warren Barr Lincolnshire Management	1,766,702	1,766,702
Due to/from Warren Barr Gold Coast & Warren	705	705
Due to/from Warren Barr South Loop & Warren	80,000	80,000
Due to/from Carlton & Warren Barr Lincolnshire	3,213	3,213
Due to/from others	744,976	744,976
Accrued Expense	99,218	99,218
Accrued Management Fees Entities	1,924,856	1,924,856
Due to/from IDPA	3,803	3,803
Due to BCBS-UPP	66,824	66,824
Loan from BCBS	106,653	106,653
Total - Line 36	4,812,106	4,812,106

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,034,867)	1
2	Restatements (describe):		2
3	Prior period adjustment	(349,002)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,383,869)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,892)	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)	\$ (175,892)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,559,761)	24 *

* This must agree with page 17, line 47.

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,315,002	1
2	Discounts and Allowances for all Levels	(7,959,777)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,355,225	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,060,227	6
7	Oxygen	155	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,060,382	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	553,664	17
18	Sale of Supplies to Non-Patients	32,244	18
19	Laboratory	70,356	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	2,407	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 658,726	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,843	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,843	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	37,113	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 37,113	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,116,289	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,990,340	31
32	Health Care	4,949,780	32
33	General Administration	2,174,750	33
B. Capital Expense			
34	Ownership	1,474,787	34
C. Ancillary Expense			
35	Special Cost Centers	2,429,477	35
36	Provider Participation Fee	273,047	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,292,181	40
41	Income before Income Taxes (line 30 minus line 40)**	(175,892)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (175,892)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,972,671	44
45	Private Pay - Net Inpatient Revenue	1,855,146	45
46	Medicare - Net Inpatient Revenue	839,154	46
47	Other-(specify) Insurance	(101,667)	47
48	Other-(specify) Part B	(210,079)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,355,225	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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.

^ - This entity is a cash basis taxpayer

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/17

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Rentals	8,995
Discouns Earned	26,876
Rebates	1,174
Misc. Income	23
Laboratory-Prior Period	45
Total - Line 28	37,113

Facility Name & ID Number **Warren Barr Lincolnshire**

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,759	2,055	\$ 110,361	\$ 53.70	1
2	Assistant Director of Nursing	2,149	2,322	102,233	44.03	2
3	Registered Nurses	32,878	35,920	1,214,602	33.81	3
4	Licensed Practical Nurses	21,755	23,996	669,979	27.92	4
5	CNAs & Orderlies	97,926	104,932	1,630,286	15.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,194	5,698	111,405	19.55	8
9	Activity Director	2,603	2,795	59,413	21.26	9
10	Activity Assistants	11,668	12,695	167,756	13.21	10
11	Social Service Workers	5,430	5,816	119,005	20.46	11
12	Dietician					12
13	Food Service Supervisor	3,818	4,091	103,679	25.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,799	39,482	492,606	12.48	15
16	Dishwashers					16
17	Maintenance Workers	7,809	8,460	190,185	22.48	17
18	Housekeepers					18
19	Laundry	2,822	3,015	31,997	10.61	19
20	Administrator	1,804	2,080	79,817	38.37	20
21	Assistant Administrator	691	742	20,922	28.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,087	10,228	149,261	14.59	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	2,097	2,197	39,755	18.10	31
32	Other Health C: See Sch 20A	4,035	4,299	157,521	36.64	32
33	Other(specify) See Sch 20A	3,974	4,929	94,725	19.22	33
34	TOTAL (lines 1 - 33)	254,298	275,752	\$ 5,545,508 *	\$ 20.11	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 20,071	1(3)	35
36	Medical Director	Monthly	61,647	9(3)	36
37	Medical Records Consultant	Monthly	4,800	10(3)	37
38	Nurse Consultant	Monthly	1,440	10(3)	38
39	Pharmacist Consultant	Monthly	17,818	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	126	11(3)	44
45	Social Service Consultant	Monthly	20,332	12(3),(7)	45
46	Other(specify) <u>Transitional</u>	Monthly	2,000	10(3)	46
47	<u>MDS Consultant</u>	Monthly	33,494	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 161,728		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,248	\$ 59,882	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,905	43,817	10(3)	52
53	TOTAL (lines 50 - 52)	3,153	\$ 103,699		53

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/17

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS/Care Plan Coordinator LPN	1,510	1,618	56,724	\$ 35.06
MDS/Care Plan Coordinator RN	2,525	2,681	100,797	\$ 37.60
Total - Line 32 Other Health Care (specify):	4,035	4,299	157,521	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Coord(Asst/Clerk)	1,388	2,080	25,137	\$ 12.09
Admissions Director	1,308	1,457	42,009	\$ 28.83
Guest Services Aide	143	149	2,487	\$ 16.69
Guest Services Director	1,135	1,243	25,092	\$ 20.19
Total - Line 33 Other (specify):	3,974	4,929	94,725	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Elizabeth Carrasco	Administrator	0.00%	\$ 79,817	Workers' Compensation Insurance	\$ 111,163	IDPH License Fee	\$ 1,990		
Meir Sharp	Assistant Admin	0.00%	20,922	Unemployment Compensation Insurance	95,116	Advertising: Employee Recruitment			
				FICA Taxes	413,668	Health Care Worker Background Check			
				Employee Health Insurance	142,901	(Indicate # of checks performed <u>828</u>)	8,276		
				Employee Meals		Patient Background Checks	189		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	4,539		
				401K Expense	27,629	License and Permits	20,999		
				Employee Physical Exams	15,896	Allocated from Legacy HC	781		
				Other Employee Benefits	25,733	Allocated from Progressive HC	164		
						Allocated from CF St. Louis LLC	2		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,739	TOTAL (agree to Schedule V, line 22, col.8)		\$ 38,641			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees(eliminated in column 7)			\$ 687,273	N/A			Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 687,273				Seminar Expense	510	
C. Professional Services							Allocated from Legacy HC		1,032
Vendor/Payee	Type		Amount				Allocated from Progressive Consulting		739
Marcum LLP	Accounting		\$ 471				Entertainment Expense		()
Compliance Resources Inc.	Compliance Legal		2,666				(agree to Sch. V, line 24, col. 8)		
Documentation Solutions Inc.	Compliance Legal		3,240				TOTAL		\$ 2,281
Strauss Data consulting	Data processing		18						
BlueOrange Compliance	Compliance		1,153						
McCabe Kirshner & Ballester PC	Legal		766						
PSD Solutions	Computer Consulting		656						
Lexisnexis Risk Solutions	Data processing		43						
Legacy Accrual	Accrual		601						
Management & Network Services	Claims processing		750						
Phonamations	Telephone Systems		150						
See schedule 21C			81,560						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 92,074	TOTAL					

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/17

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
MTS Consulting	Tax Consulting	942
Deborah D. Cole Goodwill	Consulting	1,000
Personnel Planners	Unemployment Consulting	1,269
Integra Scripts, LLC	Perscription Consulting	3,614
Adam Zollinger Interiors	Interior Design	402
Achieve Accreditation LLC	Joint Commission Consultant	6,183
Legacy Reimbursement		20,491
Much Shelist	Legal	228
Meyer Magence	Legal	3,312
Stone Pogrund & Korey LLC	Legal	2,818
Corporation Service Company	Legal	107
Stone, McGuire & Siegel	Legal	9,390
Shire Law Group, PC	Legal	800
Kitch Drutchas Wagner Valitutt	Legal	245
Paycor Fees	Payroll Services	30,761
		<u>81,560</u>
	Total (agree to Schedule V, line 19, column 3)	<u><u>92,074</u></u>
Allocated from Management Company Legal Fees		4
Allocated from Management Company Professional Services		14,114
Allocated from Management Company Accounting		29
Less: Paycor		(7,361)
Less: Non-Allowable Legal Fees		(1,698)
	Total (agree to Schedule V, line 19, column 8)	<u><u>97,162</u></u>

Facility Name & ID Number Warren Barr Lincolnshire

0053587

Report Period Beginning:

1/1/17

Ending:

12/31/17

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? 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. \$ 61,736 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. \$ 273,047
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. \$ OT Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees