



Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	38,664	2,482	30,927	72,073	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,664	2,482	30,927	72,073	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.86%

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

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

I. On what date did you start providing long term care at this location?  
Date started 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/1/13 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 23,276

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Warren Barr Living & Rehab Ctr # 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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
	<b>A. General Services</b>										
1	Dietary	743,529	55,420		798,949		798,949	1,819	800,768		1
2	Food Purchase		695,342		695,342		695,342	(55,786)	639,556		2
3	Housekeeping	366,096	81,377		447,473		447,473	2,862	450,335		3
4	Laundry	25,374	63,723	235,639	324,736		324,736	(6,912)	317,824		4
5	Heat and Other Utilities			426,548	426,548		426,548	(14,674)	411,874		5
6	Maintenance	247,453	55,495	390,786	693,734		693,734	873	694,607		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,382,452</b>	<b>951,357</b>	<b>1,052,973</b>	<b>3,386,782</b>		<b>3,386,782</b>	<b>(71,819)</b>	<b>3,314,963</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			95,702	95,702		95,702		95,702		9
10	Nursing and Medical Records	6,467,138	265,306	80,563	6,813,007		6,813,007	101,415	6,914,422		10
10a	Therapy	280,131			280,131		280,131	(144)	279,987		10a
11	Activities	124,166	10,353		134,519		134,519	114	134,633		11
12	Social Services	576,810	104,805	8,924	690,539		690,539	7,083	697,622		12
13	CNA Training										13
14	Program Transportation			221,200	221,200		221,200		221,200		14
15	Other (specify):*			7,358	7,358		7,358	13,046	20,404		15
16	<b>TOTAL Health Care and Programs</b>	<b>7,448,245</b>	<b>380,464</b>	<b>413,747</b>	<b>8,242,456</b>		<b>8,242,456</b>	<b>121,514</b>	<b>8,363,970</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	346,878			346,878		346,878	150,650	497,528		17
18	Directors Fees										18
19	Professional Services			314,829	314,829		314,829	(12,138)	302,691		19
20	Dues, Fees, Subscriptions & Promotions			243,885	243,885		243,885	(120,658)	123,227		20
21	Clerical & General Office Expenses	256,489	10,804	1,148,110	1,415,403		1,415,403	(332,714)	1,082,689		21
22	Employee Benefits & Payroll Taxes			1,232,489	1,232,489		1,232,489		1,232,489		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,212	5,212		5,212	4,588	9,800		24
25	Other Admin. Staff Transportation			3,128	3,128		3,128		3,128		25
26	Insurance-Prop.Liab.Malpractice			349,941	349,941		349,941	9,136	359,077		26
27	Other (specify):*							95,466	95,466		27
28	<b>TOTAL General Administration</b>	<b>603,367</b>	<b>10,804</b>	<b>3,297,594</b>	<b>3,911,765</b>		<b>3,911,765</b>	<b>(205,672)</b>	<b>3,706,093</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>9,434,064</b>	<b>1,342,625</b>	<b>4,764,314</b>	<b>15,541,003</b>		<b>15,541,003</b>	<b>(155,976)</b>	<b>15,385,027</b>		<b>29</b>

\*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 Living & Rehab Ctr #0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							1,446,440	1,446,440			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			181,342	181,342		181,342	1,493,570	1,674,912			32
33	Real Estate Taxes			912,000	912,000		912,000	7,716	919,716			33
34	Rent-Facility & Grounds			2,134,585	2,134,585		2,134,585	(2,134,324)	261			34
35	Rent-Equipment & Vehicles			24,520	24,520		24,520	(1,029)	23,491			35
36	Other (specify):*							0	0			36
37	<b>TOTAL Ownership</b>			3,252,447	3,252,447		3,252,447	812,374	4,064,821			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	231,828	1,694,244	3,283,055	5,209,127		5,209,127		5,209,127			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			443,916	443,916		443,916		443,916			42
43	Other (specify):*			1,348,237	1,348,237		1,348,237	(1,348,237)				43
44	<b>TOTAL Special Cost Centers</b>	231,828	1,694,244	5,075,208	7,001,280		7,001,280	(1,348,237)	5,653,043			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	9,665,892	3,036,869	13,091,969	25,794,730		25,794,730	(691,840)	25,102,890			45

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



**Warren Barr Living & Rehab Ctr**

ID# 0052415

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Expense	\$ (1,346,619)	43	1
2	Patient Personal Items	(10,486)	10	2
3	Bank Charges	(5,581)	21	3
4	Sequestration Expense	(279,751)	21	4
5	Pharmacy Discounts	(5,070)	10	5
6	Rebates	(2,653)	21	6
7	Therapy Discount	(144)	10a	7
8	Bldg Co - Accounting	(6,932)	19	8
9	Bldg Co - Replacement Tax	(105)	21	9
10	Bldg Co - Amortization	(35,833)	36	10
11	Additional R&M	1,588	06	11
12	Capitalized R&M	(15,506)	06	12
13	Non Allowable Auto Lease	(7,839)	35	13
14	Prior Period Seminar	(403)	24	14
15	Non Allowable Legal	(16,084)	19	15
16	PAC Dues	(20,240)	20	16
17	Non Allowable Professional Fees	(1,618)	43	17
18	Collections	(330)	21	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	<b>Total</b>	(1,753,606)		49

Warren Barr Living & Rehab Ctr

Report Period Beginning: ID# 0052415  
 Ending: 01/01/18  
 12/31/18

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

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			1,819									1,819	1
2	Food Purchase	(55,817)		31									(55,786)	2
3	Housekeeping			2,862									2,862	3
4	Laundry			18						(6,930)			(6,912)	4
5	Heat and Other Utilities	(16,376)				1,702							(14,674)	5
6	Maintenance	(13,918)		14,286		2,291	(1,786)						873	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(86,111)</b>		<b>19,016</b>		<b>3,993</b>	<b>(1,786)</b>			<b>(6,930)</b>			<b>(71,819)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(15,556)		117,230					(259)				101,415	10
10a	Therapy	(144)											(144)	10a
11	Activities			114									114	11
12	Social Services			7,083									7,083	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				13,046								13,046	15
16	<b>TOTAL Health Care and Programs</b>	<b>(15,700)</b>		<b>124,427</b>	<b>13,046</b>				<b>(259)</b>				<b>121,514</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			150,650									150,650	17
18	Directors Fees													18
19	Professional Services	(23,015)	6,932	18,315		71		(14,440)					(12,138)	19
20	Fees, Subscriptions & Promotions	(121,701)		1,042		1							(120,658)	20
21	Clerical & General Office Expenses	(963,652)	105	630,273		560							(332,714)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(403)		4,991									4,588	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			8,479		656							9,136	26
27	Other (specify):*			95,466									95,466	27
28	<b>TOTAL General Administration</b>	<b>(1,108,772)</b>	<b>7,037</b>	<b>909,215</b>		<b>1,289</b>		<b>(14,440)</b>					<b>(205,672)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,210,583)</b>	<b>7,037</b>	<b>1,052,657</b>	<b>13,046</b>	<b>5,282</b>	<b>(1,786)</b>	<b>(14,440)</b>	<b>(259)</b>	<b>(6,930)</b>			<b>(155,976)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	1,446,440											1,446,440	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(43,973)	1,529,381	55		8,107							1,493,570	32
33	Real Estate Taxes					7,716							7,716	33
34	Rent-Facility & Grounds		(2,134,585)	70,360		(70,099)							(2,134,324)	34
35	Rent-Equipment & Vehicles	(7,839)			6,810								(1,029)	35
36	Other (specify):*	(35,833)	35,833										0	36
37	<b>TOTAL Ownership</b>	<b>1,358,795</b>	<b>(569,371)</b>	<b>70,415</b>	<b>6,810</b>	<b>(54,276)</b>							<b>812,374</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(1,348,237)											(1,348,237)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,348,237)</b>											<b>(1,348,237)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,200,025)</b>	<b>(562,334)</b>	<b>1,123,073</b>	<b>19,856</b>	<b>(48,995)</b>	<b>(1,786)</b>	<b>(14,440)</b>	<b>(259)</b>	<b>(6,930)</b>			<b>(691,840)</b>	<b>45</b>

**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	34 Rental Income	\$ 2,134,585	FNR WB, LLC		\$	(2,134,585)	1
2	V	21 Replacement Tax Fee		FNR WB, LLC		105	105	2
3	V	19 Professional Fees - Accounting		FNR WB, LLC		6,932	6,932	3
4	V	32 Interest Expense - Mortgage A		FNR WB, LLC		1,529,381	1,529,381	4
5	V	36 Amortization Expense		FNR WB, LLC		35,833	35,833	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	<b>Total</b>		\$ 2,134,585			\$ 1,572,251	\$ * (562,334)	14

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

Facility Name &amp; ID Number

Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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	01		Legacy Healthcare Financial Services		\$ 1,714	\$ 1,714	15
16	V	01		Legacy Healthcare Financial Services		105	105	16
17	V	02		Legacy Healthcare Financial Services		31	31	17
18	V	03		Legacy Healthcare Financial Services		2,862	2,862	18
19	V	04		Legacy Healthcare Financial Services		18	18	19
20	V	06		Legacy Healthcare Financial Services		12,165	12,165	20
21	V	06		Legacy Healthcare Financial Services		2,121	2,121	21
22	V	10		Legacy Healthcare Financial Services		112,494	112,494	22
23	V	10		Legacy Healthcare Financial Services		4,607	4,607	23
24	V	10		Legacy Healthcare Financial Services		129	129	24
25	V	12		Legacy Healthcare Financial Services		7,042	7,042	25
26	V	11		Legacy Healthcare Financial Services		114	114	26
27	V	12		Legacy Healthcare Financial Services		41	41	27
28	V	17		Legacy Healthcare Financial Services		150,650	150,650	28
29	V	19		Legacy Healthcare Financial Services		18,315	18,315	29
30	V	20		Legacy Healthcare Financial Services		1,042	1,042	30
31	V	21		Legacy Healthcare Financial Services		612,555	612,555	31
32	V	21		Legacy Healthcare Financial Services		17,718	17,718	32
33	V	24		Legacy Healthcare Financial Services		4,991	4,991	33
34	V	26		Legacy Healthcare Financial Services		8,479	8,479	34
35	V	27		Legacy Healthcare Financial Services		95,466	95,466	35
36	V	32		Legacy Healthcare Financial Services		55	55	36
37	V	34		Legacy Healthcare Financial Services		70,099	70,099	37
38	V	34		Legacy Healthcare Financial Services		261	261	38
39	Total		\$			\$ 1,123,073	\$ * 1,123,073	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	35 EQUIPMENT RENTAL		Legacy Healthcare Financial Services		365	\$	365	15
16	V	35 AUTO RENTAL		Legacy Healthcare Financial Services		6,445		6,445	16
17	V	15 NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		13,046		13,046	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		\$			\$ 19,856	\$ *	19,856	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		\$ 1,702	\$ 1,702
16	V	6 REPAIRS & MAINTENANCE		CF St. Louis LLC		2,291	2,291
17	V	19 PROFESSIONAL FEES		CF St. Louis LLC		71	71
18	V	20 DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1
19	V	21 OFFICE EXPENSE		CF St. Louis LLC		560	560
20	V	26 INSURANCE		CF St. Louis LLC		656	656
21	V	32 INTEREST EXPENSE		CF St. Louis LLC		8,107	8,107
22	V	33 REAL ESTATE TAXES		CF St. Louis LLC		7,716	7,716
23	V						
24	V						
25	V						
26	V	34 RENT	70,099	CF St. Louis LLC			(70,099)
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		\$ 70,099			\$ 21,104	\$ * (48,995)

\* 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 Maintenance	\$ 24,000	ML Group Design and Development		\$ 22,214	\$ (1,786)
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		\$ 24,000			\$ 22,214	\$ * (1,786)

\* 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 Processing	\$ 55,156	ProPay HR LLC		\$ 40,716	\$ (14,440)
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		\$ 55,156			\$ 40,716	\$ * (14,440)

\* 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	10 Medical Supplies	\$ 9,000	ReMED Services		\$ 8,741	\$ (259)
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		\$ 9,000			\$ 8,741	\$ * (259)

\* 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	04 Laundry Services	\$ 297,409	EcoBrite Linen		\$ 290,479	\$ (6,930)
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		\$ 297,409			\$ 290,479	\$ * (6,930)

\* 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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number Warren Barr Living & Rehab Ctr # 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Living & Rehab Ctr

# 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 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	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	\$ 33,257	\$ 33,257	98,915	\$ 1,714	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		98,915	105	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		98,915	31	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		98,915	2,862	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		98,915	18	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	98,915	12,165	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		98,915	2,121	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	98,915	112,494	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		98,915	4,607	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		98,915	129	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	98,915	7,042	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		98,915	114	12
13	12	SOCIAL SERVICE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	800		98,915	41	13
14	17	CFO/ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	98,915	150,650	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		98,915	18,315	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		98,915	1,042	16
17	21	CLERICAL AND GENERAL WAGES	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	98,915	612,555	17
18	21	CLERICAL AND OFFICE EXPENSES	AVAIL. BED DAYS	1,918,919	34	343,715		98,915	17,718	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		98,915	4,991	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		98,915	8,479	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008		98,915	95,466	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		98,915	55	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		98,915	70,099	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		98,915	261	24
25	TOTALS					\$ 21,787,253	\$ 17,394,136		\$ 1,123,073	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 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	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088	98,915	365	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028	98,915	6,445	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092	98,915	13,046	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					\$ 385,208	\$	\$ 19,856	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	1,916,917	34	\$ 32,982	\$ 98,915	\$ 1,702	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396	98,915	2,291	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378	98,915	71	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23	98,915	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860	98,915	560	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721	98,915	656	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106	98,915	8,107	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528	98,915	7,716	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					\$ 408,994	\$	\$ 21,104	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

ML Group Design and Development

Street Address

3424 Oakton Street

City / State / Zip Code

Skokie, IL

Phone Number

( 847) 676-5300

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	6	Maintenace	Direct		\$	\$		22,214	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				\$	\$		22,214	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 ProPay HR LLC  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847) 905-3268  
 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	19	Payroll Services	Direct		\$	\$		\$ 40,716	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				\$	\$		\$ 40,716	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

3424 Oakton Street, Suite 102

City / State / Zip Code

Skokie, IL

Phone Number

( 847) 440-2600

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	10	Medical Supplies	Direct		\$	\$		\$ 8,741	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				\$	\$		\$ 8,741	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

EcoBrite Linen

Street Address

3712 Jarvis Avenue

City / State / Zip Code

Skokie, IL 60076

Phone Number

( 847) 582-4000

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	4	Laundry Services	Direct		\$	\$		\$ 290,479	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				\$	\$		\$ 290,479	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 &amp; ID Number

Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10	Reporting Period Interest Expense											
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
													YES	NO				Original	Balance		
<b>A. Directly Facility Related</b>																					
<b>Long-Term</b>																					
1	The Private Bank		X	Mortgage			\$	\$ 41,197,193			\$ 1,529,381	1									
2												2									
3												3									
4												4									
5												5									
<b>Working Capital</b>																					
6	The Private Bank		X	Note Payable				3,267,000			181,342	6									
7												7									
8												8									
9	TOTAL Facility Related						\$	\$ 44,464,193			\$ 1,710,723	9									
<b>B. Non-Facility Related*</b>																					
10	Interest Income		X								(43,973)	10									
11	Allocated from Legacy Healthca	X									55	11									
12	Allocated from CF St. Louis	X									8,107	12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$ (35,811)	14									
15	TOTALS (line 9+line14)						\$	\$ 44,464,193			\$ 1,674,912	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 Living & Rehab Ctr**# **0052415**

Report Period Beginning:

**01/01/18**

Ending:

**12/31/18****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2017 report.				\$	<b>386,471</b>	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.)				\$	<b>985,330</b>	2
3. Under or (over) accrual (line 2 minus line 1).				\$	<b>598,859</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<b>320,857</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<b>919,716</b>	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2013	<u>615,603</u>	8	<b>FOR BHF USE ONLY</b>		
	2014	<u>628,004</u>	9	13	FROM R. E. TAX STATEMENT FOR 2017	\$ 13
	2015	<u>832,183</u>	10	14	PLUS APPEAL COST FROM LINE 5	\$ 14
	2016	<u>909,580</u>	11	15	LESS REFUND FROM LINE 6	\$ 15
	2017	<u>977,614</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16
<b>2018 Accrual = \$977,614 x .3282 = \$320,857</b>						
<b>Allocated from CF St. Louis, LLC: \$7,716</b>						
<b>Beginning Accrual Adjusted</b>						

**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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Warren Barr Living & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052415

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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>27,145.49</u>	\$ <u>27,145.49</u>
2.	<u>17-04-423-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>950,468.58</u>	\$ <u>950,468.58</u>
3.	<u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>492,481.94</u>	\$ <u>7,715.80</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u><u>1,470,096.01</u></u>	\$ <u><u>985,329.87</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2017 REAL ESTATE TAX COST DOCUMENTATION**

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Warren Barr Living & Rehab Ctr COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0052415  
 CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_  
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18 Ending:

12/31/18

**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 CF St. Louis</u>			<u>10,184</u>	2
3	<b>TOTALS</b>			\$ <b>4,010,184</b>	3

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	\$ 30,630,000	\$	39	\$ 785,385	\$ 785,385	\$ 3,615,283	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2013		891,734		20	46,717	46,717	272,083	9
10	Various		2014		589,334		20	34,754	34,754	173,771	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 Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			403,593		19,005	19,005	56,578	68
69								69
70		\$	32,514,661	\$	885,860	\$ 885,860	\$ 4,117,714	70

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

Facility Name &amp; ID Number Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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		\$ 32,514,661	\$		\$ 885,860	\$ 885,860	\$ 4,117,714	1
2	Installed Fire Alarm System	2015	5,880		20	294	294	1,176	2
3	6Th And 7Th Floor Doors	2015	3,450		20	173	173	690	3
4	Installed Fan Coil Unit For Resident Room	2015	2,999		20	150	150	600	4
5	Repaired Wiring For Phones	2015	2,654		20	133	133	531	5
6	Rewired Phones And Computers To Resident Rooms	2015	5,636		20	282	282	1,127	6
7	Replaced Sprinkler Valve	2015	2,705		20	135	135	541	7
8	Installed Fan Coil Unit	2015	3,915		20	196	196	783	8
9	Repaired Cooling Tower	2015	5,478		20	274	274	1,096	9
10	Repaired Air Handler On 2Nd Floor	2015	3,814		20	191	191	763	10
11	2Nd Floor Blinds	2015	3,920		20	196	196	784	11
12	Repaired 2Nd Fl Air Handler	2015	4,140		20	207	207	828	12
13	Rewired Cable From 2Nd Fl Med Rec Rm To Office	2015	3,180		20	159	159	636	13
14	Repaired 9Th Floor Pipes	2015	5,263		20	263	263	1,053	14
15	Repaired Insulation On 1St, 8Th And 9Th Floor	2015	6,633		20	332	332	1,327	15
16	Repaired 2 Passenger Elevator	2015	18,000		20	900	900	3,600	16
17	Removed And Installed New Windows In Facility	2015	13,750		20	688	688	2,750	17
18	Installed Fire Dampers On 9Th Floor	2015	6,680		20	334	334	1,336	18
19	8Th Floor - Drywall/Patchwork/Paint	2015	6,500		20	325	325	1,300	19
20	Installed Air Compressor And Air Dyer In Boiler Room	2015	14,154		20	708	708	2,831	20
21	Fire Alarm System On 1St Floor	2015	5,475		20	274	274	1,095	21
22	Installed New Air Handlers/Water Lines For Pipe Insulation	2015	2,787		20	139	139	557	22
23	Installed Door For Garage	2015	4,936		20	247	247	987	23
24	Repaired Dampers On 3Rd And 4Th Floor	2015	4,972		20	249	249	994	24
25	Repaired Elevators	2015	3,930		20	197	197	786	25
26	1St Floor Fire Alarm System	2015	6,025		20	301	301	1,205	26
27	Fire Alarm In Elevator	2015	6,419		20	321	321	1,284	27
28	8Th Floor - Tiling/Trim Moldings/Lights/Ceiling Paint	2015	9,543		20	477	477	1,909	28
29	5Th Floor Bathroom Tiling	2015	9,692		20	485	485	1,938	29
30	1St Floor Exterior - Installed Fabric And Level Existing Ground	2015	3,345		20	167	167	669	30
31	Installed Zone Dampers For 3 Offices By Lobby	2015	4,749		20	237	237	950	31
32	Signs For East/West Side Of Facility/1St And 9Th Floor	2015	7,918		20	396	396	1,584	32
33	Installed Glass And Brackets For Side And Back Walls	2015	3,400		20	170	170	680	33
34	TOTAL (lines 1 thru 33)		\$ 32,706,605	\$		\$ 895,457	\$ 895,457	\$ 4,156,103	34

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

Facility Name &amp; ID Number Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 32,706,605	\$		\$ 895,457	\$ 895,457	\$ 4,156,103	1
2	Welded Window For 9Th Floor	2015	3,086		20	154	154	617	2
3	9Th Floor - Repaired Carpet/Floor/Bathroom Walls/Tiles	2015	2,780		20	139	139	556	3
4	Sprinkler System In Garage/Generator/Storage Room	2015	17,406		20	870	870	3,481	4
5	9Th Floor Window Washing	2015	4,200		20	210	210	840	5
6	4 Resid Rm - Tiling/Outlet Cover And Paint	2015	11,118		20	556	556	2,224	6
7	Paint Ceiling/Post On 1St Fl Exterior/9Th Fl Window	2015	4,715		20	236	236	943	7
8	Fire Alarm System	2015	15,865		20	793	793	3,173	8
9	Seal Existing Stone Floor	2015	3,350		20	168	168	670	9
10	Repaired Tempering Valves	2015	3,405		20	170	170	681	10
11	8Th Floor Mirrors/Tiling	2015	7,543		20	377	377	1,509	11
12	Installed Floor Tile On Entrance Floor	2015	6,000		20	300	300	1,200	12
13	Signs For 9Th Floor	2015	3,241		20	162	162	648	13
14	Repaired Heaters	2015	33,426		20	1,671	1,671	6,685	14
15	1St Floor Shades	2015	6,186		20	309	309	1,237	15
16	Fire Alarm System	2015	8,395		20	420	420	1,679	16
17	Musics System In Lobby	2015	3,000		20	150	150	600	17
18	Chandelier And Hand Rails	2015	5,906		20	295	295	1,181	18
19	Ring Chandelier	2015	13,744		20	687	687	2,749	19
20	Light Fixture For 5Th Floor Corridor	2015	5,258		20	263	263	1,052	20
21	Bathroom Tiling	2015	7,058		20	353	353	1,412	21
22	9Th Floor Doors	2015	2,875		20	144	144	575	22
23	Polished Marble For 1St Floor Welcome Center	2015	2,532		20	127	127	506	23
24	Repaired Elevator Handrails	2015	18,900		20	945	945	3,780	24
25	Bathroom Shower Curtains	2015	2,728		20	136	136	546	25
26	9Th Floor - Removal Of Floor Tile	2015	52,224		20	2,611	2,611	10,445	26
27	9Th Fl Pt Room - Concrete Support Brackets	2015	2,890		20	145	145	578	27
28	9Th Floor Exit Sign	2015	7,649		20	382	382	1,530	28
29	9Th Floor Pt Room - Fire Alarm	2015	5,993		20	300	300	1,199	29
30	9Th Floor Pt Room - New Roof	2015	13,200		20	660	660	2,640	30
31	9Th Floor Pt Room - New Metal Panels	2015	4,330		20	217	217	866	31
32	5Th Floor Corridors, Resid Rm & Bath, Lounge & Dining Rm	2015			20				32
33	Electric, Plumbing, Tiling, Flooring	2015	373,250		20	18,750	18,750	75,000	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 33,358,855	\$		\$ 928,157	\$ 928,157	\$ 4,286,903	34

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

Facility Name &amp; ID Number Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 33,358,855	\$		\$ 928,157	\$ 928,157	\$ 4,286,903	1
2	Installed Alarm System/Wanderguard System	2016	3,451		20	173	173	518	2
3	Installed Cables For Speakers/Phones	2016	36,172		20	1,809	1,809	5,426	3
4	Installed Outlets On 9Th Floor	2016	4,500		20	225	225	675	4
5	Lobby Area Office Dampers	2016	5,306		20	265	265	796	5
6	Pa Amplifier And Speakers	2016	5,897		20	295	295	885	6
7	Installed Pedestrian Door And Frame	2016	2,790		20	140	140	419	7
8	Corridor Sprinkler System	2016	7,187		20	359	359	1,078	8
9	Repaired Elevator	2016	15,059		20	753	753	2,259	9
10	Repaired Door Motor/Cables	2016	8,021		20	401	401	1,203	10
11	Kitchen - Replaced Walk In Cooler, New Coil Unit, Temperature C	2016	6,944		20	347	347	1,042	11
12	Main Entrance - Installed Wander Guard System	2016	5,176		20	259	259	776	12
13	5Th Floor Drapery	2016	8,826		20	441	441	1,324	13
14	9Th Floor Shades	2016	2,975		20	149	149	446	14
15	Kitchen Millwork	2016	19,888		20	994	994	2,983	15
16	Repaired South Elevator Doors	2016	3,575		20	179	179	536	16
17	Roof Repair Over Glass Entrance	2016	8,700		20	435	435	1,305	17
18	Furnished And Installed Door Sensor For Elevators	2016	5,100		20	255	255	765	18
19	Installed New Springs/Air Switch For Doors	2016	2,592		20	130	130	389	19
20	Repaired 9Th Floor Nurse Call System	2016	4,350		20	218	218	653	20
21	Repaired Roof	2016	3,572		20	179	179	536	21
22	Repaired Motor/Valves/Pipes On Air Handlers	2016	3,730		20	187	187	560	22
23	7Th And 8Th Floor Bathrooms Sprinkler Repair	2016	9,667		20	483	483	1,450	23
24	5Th-8Th Floor Shower Rooms - Tiling/Paint/Flooring	2016	40,163		20	2,008	2,008	6,024	24
25	East/West Spa Room - Demo/Framing/Floor/Tiling/Millwork/Electr	2016	268,825		20	15,000	15,000	45,000	25
26	Kitchen - Stationary/Millwork	2016	22,819		20	1,141	1,141	3,423	26
27	Security System For 1St Floor And 9Th Floor Therapy Room	2016	18,914		20	946	946	2,837	27
28	8Th Flr Resid Rms/Lobby/Dining-Demo/Lighting/Framing/Flooring	2016	39,370		20	1,969	1,969	5,906	28
29	5Th Floor Electric/Plumbing/Paint/Flooring/Sprinkler	2016	74,401		20	3,758	3,758	11,273	29
30	2Nd Flr Offices - Demo/Masonry/Carpentry/Millwork/Electrical/Pa	2016	228,132		20	11,407	11,407	34,220	30
31	9Th Flr Pt Room - Flooring/Roof Deck/Doors/Demo/Electrical/Pain	2016			20				31
32	Concrete/Sprinkler/Architectural And Engineering Fees	2016	1,184,223		20	59,211	59,211	177,633	32
33	1St Flr Lobby/Exterior-A/C System/Electrical/Plumbing/Demo/Tile	2016			20				33
34	TOTAL (lines 1 thru 33)		\$ 35,409,181	\$		\$ 1,032,270	\$ 1,032,270	\$ 4,599,241	34

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

Facility Name &amp; ID Number Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 35,409,181	\$		\$ 1,032,270	\$ 1,032,270	\$ 4,599,241	1
2	<u>Doors/Sprinkler/Carpentry/Architectural And Engineering Fees/Pe</u>	2016	1,479,480		20	73,974	73,974	221,922	2
3	<u>Ice Block Glass Tile (21,902)</u>	2016	20,273		20	1,014	1,014	1,014	3
4	<u>Electrical Work For Corridor Door Operator</u>	2017	4,350		20	218	218	435	4
5	<u>Installed Glass Mirror Rooms 401 And 405</u>	2017	3,070		20	154	154	307	5
6	<u>Installed Two Keypads-3Rd Flr West Stairwell/Egress Locks 2Nd F</u>	2017	8,876		20	444	444	888	6
7	<u>Installed New Drain In Kitchen/Cut Floor Tile/Pipes</u>	2017	3,650		20	183	183	365	7
8	<u>Repaired Pipes In Rooms 814 And 815</u>	2017	3,870		20	194	194	387	8
9	<u>Medical Curtains</u>	2017	5,775		20	289	289	578	9
10	<u>Fire Sprinkler System Repair</u>	2017	3,473		20	174	174	347	10
11	<u>Repaired Leaking Pipes</u>	2017	3,245		20	162	162	325	11
12	<u>Hvac Repair - Thermostat, Sensor, Wires, Relays, Filters, Belts</u>	2017	3,682		20	184	184	368	12
13	<u>Hvac-Air Handler Control System</u>	2017	10,892		20	545	545	1,089	13
14	<u>Parking Entrance Door Repair</u>	2017	3,968		20	198	198	397	14
15	<u>Hvac - Air Handler Control System</u>	2017	11,308		20	565	565	1,131	15
16	<u>Cubicle Curtain Tracks For 5Th And 6Th Floor</u>	2017	6,224		20	311	311	622	16
17	<u>Removal &amp; Repair Of #1 Heating Pump</u>	2017	4,250		20	213	213	425	17
18	<u>Replace Broken Pipe In Dishwasher Area</u>	2017	3,500		20	175	175	350	18
19	<u>Elevator Flooring &amp; 9Th Fl Outlets</u>	2017	4,340		20	217	217	434	19
20	<u>Repair Handrails On 5Th,6Th, 7Th Floors &amp; 9Th Fl Hvac</u>	2017	30,261		20	1,513	1,513	3,026	20
21	<u>90 Cubicle Curtains</u>	2017	18,749		20	937	937	1,875	21
22	<u>Repair &amp; Adjusted Elevator Roller Guide</u>	2017	3,738		20	187	187	374	22
23	<u>Damper Replacement (8,418)</u>	2018	7,792		20	390	390	390	23
24	<u>Replace Compressor &amp; Leaking Pipe (6,605)</u>	2018	6,114		20	306	306	306	24
25	<u>Repair Air Handler Coil (4,176)</u>	2018	3,866		20	193	193	193	25
26	<u>Install Booster Pump For Domestic Water System (3,924)</u>	2018	3,632		20	182	182	182	26
27	<u>Repair Heat Circulating Pump (13,059)</u>	2018	12,087		20	604	604	604	27
28	<u>Repair Doors On 2, 5, 6-8 Floors (4,250)</u>	2018	3,934		20	197	197	197	28
29	<u>Install New Building Drain Pipe (5,700)</u>	2018	5,276		20	264	264	264	29
30	<u>21 Keypad Deadbolt With Auto Lock (2,705)</u>	2018	2,504		20	125	125	125	30
31	<u>Repair 2Nd Fl Air Handlers In Boiler Rm (5,100)</u>	2018	4,721		20	236	236	236	31
32	<u>Bathroom Wall &amp; Fl Tiles, Wallpaper, Lobby Electrical (10,700)</u>	2018	9,904		20	495	495	495	32
33	<u>Illuminated Lobby Sign (2,699)</u>	2018	2,498		20	125	125	125	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 37,108,481	\$		\$ 1,117,235	\$ 1,117,235	\$ 4,839,015	34

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

Facility Name &amp; ID Number Warren Barr Living &amp; Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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		\$ 37,108,481	\$		\$ 1,117,235	\$	\$ 4,839,015	1
2	2Nd Fl Mechanical Rm Chilled Water Pumps (6,000)	2018	5,554		20	278	278	278	2
3	Paint Resident Rms & Waiting Area Ceiling Repair (8,550)	2018	7,914		20	396	396	396	3
4	Repaired Drywalls In Resident Rms On Fl 5-8 (4,250)	2018	3,934		20	197	197	197	4
5	Install New Coil In Conference Rm A (3,560)	2018	3,295		20	165	165	165	5
6	Door Holder Installation (7,529)	2018	6,969		20	348	348	348	6
7	Repair Door On East Side Of Building (3,785)	2018	3,503		20	175	175	175	7
8	Refurbish Marley Cooling Tower (38,225)	2018	35,381		20	1,769	1,769	1,769	8
9	Lobby Chandelier & Carpet, Lobby Bathroom Tile (13,119)	2018	12,143		20	607	607	607	9
10	Paint Ceiling & Install Lighting Fixtures In Lobby (10,897)	2018	10,086		20	504	504	504	10
11	Lobby Carpet (2,521)	2018	2,333		20	117	117	117	11
12	9Th Fl Air Handler Controls Repair (12,780)	2018	11,829		20	591	591	591	12
13	Repair Water Supply Lines (8,955)	2018	8,289		20	414	414	414	13
14	Repair 9Th Fl Pt Walls (2,650)	2018	2,453		20	123	123	123	14
15	Hallway & Lobby Make-Up Air Controls Repair (18,000)	2018	16,661		20	833	833	833	15
16	Design Fee For Tiles (12,750)	2018	11,801		20	590	590	590	16
17	Piping Repairs On Dual Temp System (5,681)	2018	5,258		20	263	263	263	17
18	Repair Ducts On 3Rd & 4Th Fl Soc Serv Office (4,705)	2018	4,355		20	218	218	218	18
19	Repair Hot Water Valves On Upper Floors (5,120)	2018	4,739		20	237	237	237	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 37,264,978	\$		\$ 1,125,060	\$ 7,825	\$ 4,846,840	34

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

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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.

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	54,835		35	1,567	1,567	4,700	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	340,450		20	17,022	17,022	51,067	9
10	Allocated from CF St. Louis, LLC	2017	7,902		20	395	395	790	10
11									11
12									12
13	Allocated from Legacy HC	2018	406		20	20	20	20	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)		\$ 403,593	\$		\$ 19,005	\$ 19,005	\$ 56,578	34

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

Facility Name & ID Number Warren Barr Living & Rehab Ctr

# 0052415

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 403,593	\$		\$ 19,005	\$ 19,005	\$ 56,578	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
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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)		\$ 403,593	\$		\$ 19,005	\$ 19,005	\$ 56,578	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	\$ 3,172,033	\$	\$ 315,832	\$ 315,832	10	\$ 1,524,799	71
72	Current Year Purchases	106,449		7,909	7,909	10	7,909	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,278,482	\$	\$ 323,741	\$ 323,741		\$ 1,532,708	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Bus	2015	\$ 23,822	\$	\$ 4,764	\$ 4,764	5	\$ 19,057	76
77		Therapy Bus	2016	3,500		700	700	5	2,100	77
78										78
79										79
80	TOTALS			\$ 27,322	\$	\$ 5,464	\$ 5,464		\$ 21,157	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)	\$ 44,424,468	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)	\$ 1,446,440	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,446,440	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,392,880	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		\$	92
93			93
94			94
95		\$	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								5
6	<u>Allocated from Legacy Healthcare</u>				<u>261</u>			6
7	<b>TOTAL</b>				\$ <b>261</b>			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. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2021                      \$ \_\_\_\_\_

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: \$ 9,849 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>Facility</u>	<u>GM Cadillac CT6</u>	\$ <u>599.70</u>	\$ <u>7,196</u>	17
18	<u>Allocated from Legacy Healthcare</u>			<u>6,445</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>599.70</b>	\$ <b>13,641</b>	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 Living & Rehab Ctr # 0052415 Report Period Beginning: 01/01/18 Ending: 12/31/18  
 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	\$ 101,160		\$ 1,236,069						\$ 1,337,229				1	
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	16,510		296,971										313,481	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 01	hrs	114,158		1,385,071										1,499,229	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							1,240,759						1,240,759	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify):							364,944		453,485						818,429	13
14	TOTAL			\$ 231,828		\$ 3,283,055		\$ 1,694,244					\$ 5,209,127				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 Living & Rehab Ctr

# 0052415

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 83,406	\$ 116,336	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,874,225	3,874,225	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,481	45,481	6
7	Other Prepaid Expenses	76,888	113,563	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	768,058	768,058	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,849,058	\$ 4,918,663	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,562	4,325,933	13
14	Buildings, at Historical Cost	90,848	20,772,935	14
15	Leasehold Improvements, at Historical Cost	7,366,598	7,366,598	15
16	Equipment, at Historical Cost	2,840,901	7,529,443	16
17	Accumulated Depreciation (book methods)	(3,223,977)	(9,774,658)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	7,388,270	7,549,423	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 14,486,202	\$ 37,769,674	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 19,335,260	\$ 42,688,337	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,264,661	\$ 2,264,660	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,267,000	3,267,000	29
30	Accrued Salaries Payable	711,562	711,562	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,067	33,067	31
32	Accrued Real Estate Taxes(Sch.IX-B)		320,857	32
33	Accrued Interest Payable	200,035	1,695,704	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	779,670	779,982	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,255,995	\$ 9,072,832	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		41,197,193	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	7,583,877	816,602	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 7,583,877	\$ 42,013,795	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 14,839,872	\$ 51,086,627	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,495,388	\$ (8,398,290)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 19,335,260	\$ 42,688,337	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>6,923,509</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity Adjustment</b>	<b>(3,679,005)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,244,504</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,250,900</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(16)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,250,884</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,495,388</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 26,107,110	1
2	Discounts and Allowances for all Levels	(15,835,062)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,272,048	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,188,375	6
7	Oxygen	854	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 15,189,229	8
<b>C. Other Operating Revenue</b>			
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	1,216,817	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	149,707	19
20	Radiology and X-Ray	65	20
21	Other Medical Services	110,345	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,476,934	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	43,973	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 43,973	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	63,446	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 63,446	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 27,045,630	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,386,782	31
32	Health Care	8,242,456	32
33	General Administration	3,911,765	33
<b>B. Capital Expense</b>			
34	Ownership	3,252,447	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	6,557,364	35
36	Provider Participation Fee	443,916	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 25,794,730	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,250,900	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,250,900	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,792,231	44
45	Private Pay - Net Inpatient Revenue	871,675	45
46	Medicare - Net Inpatient Revenue	2,470,932	46
47	Other-(specify) <u>Insurance</u>	137,210	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 10,272,048	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 Living & Rehab Ctr

# 0052415

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,152	3,376	\$ 195,898	\$ 58.03	1
2	Assistant Director of Nursing	1,144	1,273	64,623	50.76	2
3	Registered Nurses	52,956	57,198	1,935,795	33.84	3
4	Licensed Practical Nurses	58,201	62,917	1,892,705	30.08	4
5	CNAs & Orderlies	129,034	141,121	2,267,032	16.06	5
6	CNA Trainees					6
7	Licensed Therapist	3,846	6,204	231,828	37.37	7
8	Rehab/Therapy Aides	10,937	11,978	275,934	23.04	8
9	Activity Director	1,952	2,080	46,440	22.33	9
10	Activity Assistants	6,428	6,667	77,726	11.66	10
11	Social Service Workers	19,231	20,670	458,977	22.20	11
12	Dietician	2,658	2,840	77,510	27.29	12
13	Food Service Supervisor	3,016	3,262	91,017	27.90	13
14	Head Cook	9,142	9,819	169,780	17.29	14
15	Cook Helpers/Assistants	30,868	33,044	405,222	12.26	15
16	Dishwashers					16
17	Maintenance Workers	11,652	12,208	247,453	20.27	17
18	Housekeepers	27,251	29,610	366,096	12.36	18
19	Laundry	1,739	2,013	25,374	12.61	19
20	Administrator	1,936	2,080	173,843	83.58	20
21	Assistant Administrator	1,744	1,856	63,796	34.37	21
22	Other Administrative	1,936	2,487	109,239	43.93	22
23	Office Manager	2,057	2,193	31,960	14.57	23
24	Clerical	12,302	13,095	224,529	17.15	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	3,786	4,016	73,722	18.36	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	11,442	11,835	159,393	13.47	33
34	TOTAL (lines 1 - 33)	408,410	443,842	\$ 9,665,892 *	\$ 21.78	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		\$		35
36	Medical Director	Monthly	95,702	09-03	36
37	Medical Records Consultant	Monthly	400	10-03	37
38	Nurse Consultant	Monthly	48,834	10-03	38
39	Pharmacist Consultant	Monthly	31,329	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	8,924	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 185,189		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



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

Report Period Beginning:

01/01/18Ending: 12/31/18**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. HCCI \$34,780 ; IHCA \$8,943
- (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. \$ 72,259 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. \$ 443,916  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (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