FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0053587

Facility Name: Warren Barr Lincolnshire

Address: 150 Jamestown Lane (Number) Lincolnshire (City) 60069 (Zip Code)

County: Lake

Telephone Number: (847) 883-9000 **Fax #** (847) 883-9029

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2015

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	35,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	35,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,042	8,042	8
9	SNF/PED					9
10	ICF	3,650	10,818		14,468	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,650	10,818	8,042	22,510	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.80%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/1/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 6,616

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	374,754	55,565	47,814	478,133		478,133		478,133			1
2	Food Purchase		155,590		155,590		155,590	(6,380)	149,210			2
3	Housekeeping	105,297	11,838	152,110	269,245		269,245	32	269,277			3
4	Laundry	40,582	15,487		56,069		56,069		56,069			4
5	Heat and Other Utilities			113,689	113,689		113,689	(8,311)	105,378			5
6	Maintenance	154,563		172,807	327,370		327,370	40,947	368,317			6
7	Other (specify):*											7
8	**TOTAL General Services**	675,196	238,480	486,420	1,400,096		1,400,096	26,288	1,426,384			8
	B. Health Care and Programs											
9	Medical Director			26,152	26,152		26,152		26,152			9
10	Nursing and Medical Records	2,319,813	136,597	22,964	2,479,374		2,479,374	2,431	2,481,805			10
10a	Therapy	54,778			54,778		54,778		54,778			10a
11	Activities	118,468	7,859	1,836	128,163		128,163	64	128,227			11
12	Social Services	183,771		418	184,189		184,189	12,361	196,550			12
13	CNA Training											13
14	Program Transportation			2,692	2,692		2,692		2,692			14
15	Other (specify):*							1,849	1,849			15
16	**TOTAL Health Care and Programs**	2,676,830	144,456	54,062	2,875,348		2,875,348	16,704	2,892,052			16
	C. General Administration											
17	Administrative	82,694		485	83,179		83,179	10,863	94,042			17
18	Directors Fees											18
19	Professional Services			255,839	255,839	(30)	255,809	(113,516)	142,293			19
20	Dues, Fees, Subscriptions & Promotions			87,984	87,984		87,984	(71,032)	16,952			20
21	Clerical & General Office Expenses	212,654	2,365	315,828	530,847		530,847	(204,474)	326,373			21
22	Employee Benefits & Payroll Taxes			572,113	572,113		572,113		572,113			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,101	7,101		7,101	(37)	7,064			24
25	Other Admin. Staff Transportation			6,164	6,164		6,164		6,164			25
26	Insurance-Prop.Liab.Malpractice			74,803	74,803		74,803	1,119	75,922			26
27	Other (specify):*							10,070	10,070			27
28	**TOTAL General Administration**	295,348	2,365	1,320,317	1,618,030	(30)	1,618,000	(367,006)	1,250,994			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,647,374	385,301	1,860,799	5,893,474	(30)	5,893,444	(324,014)	5,569,430			29

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

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

Facility Name & ID Number Warren Barr Lincolnshire #0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,802	39,802		39,802	9,066	48,868			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			969	969		969	347	1,316			32
33	Real Estate Taxes			108,000	108,000	30	108,030	610	108,640			33
34	Rent-Facility & Grounds			568,711	568,711		568,711	(0)	568,711			34
35	Rent-Equipment & Vehicles			16,553	16,553		16,553	(763)	15,790			35
36	Other (specify):*											36
37	**TOTAL Ownership**			734,035	734,035	30	734,065	9,259	743,324			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		363,584	697,169	1,060,753		1,060,753		1,060,753			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,106	143,106		143,106		143,106			42
43	Other (specify):*			455,481	455,481		455,481	(455,481)	0			43
44	**TOTAL Special Cost Centers**		363,584	1,295,756	1,659,340		1,659,340	(455,481)	1,203,859			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,647,374	748,885	3,890,590	8,286,849		8,286,849	(770,235)	7,516,614			45

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,652)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,949	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(6,084)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(748)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(550)	21		18
19	Entertainment				19
20	Contributions	(12,953)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,459)	21		24
25	Fund Raising, Advertising and Promotional	(58,385)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(495,877)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (735,759)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34,477)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (34,477)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (770,235)		37

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

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

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

Warren Barr Lincolnshire

ID# 0053587

Report Period Beginning: 05/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (63,176)	21	1
2	Miscellaneous Income	(1,803)	21	2
3	Patient Personal Items	(3,498)	10	3
4	Asset Management Fees	(16,000)	06	4
5	Meals	(6,544)	21	5
6	Bank Charges	(3,477)	21	6
7	Non-Allowable Vehicle Rental	(1,388)	35	7
8	Non-Allowable Seminars	(345)	24	8
9	Non-Allowable Legal	(82)	19	9
10	Additional R&M	61,506	06	10
11	Assisted Living Expense	(5,589)	06	11
12	Non-Allowable Expense	(455,481)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(495,877)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(6,832)				452							(6,380)	2
3	Housekeeping			32									32	3
4	Laundry													4
5	Heat and Other Utilities	(8,652)		341									(8,311)	5
6	Maintenance	39,917		779		251							40,947	6
7	Other (specify):*													7
8	**TOTAL General Services**	24,433		1,152		703							26,288	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,498)				5,929							2,431	10
10a	Therapy													10a
11	Activities			64									64	11
12	Social Services					12,361							12,361	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					1,849							1,849	15
16	**TOTAL Health Care and Programs**	(3,498)		64		20,139							16,704	16
	C. General Administration													
17	Administrative			485		10,378							10,863	17
18	Directors Fees													18
19	Professional Services	(82)		(113,585)		151							(113,516)	19
20	Fees, Subscriptions & Promotions	(71,338)		283		23							(71,032)	20
21	Clerical & General Office Expenses	(236,009)		35,138		(3,603)							(204,474)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(345)		285		23							(37)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			216		903							1,119	26
27	Other (specify):*			8,798		1,272							10,070	27
28	**TOTAL General Administration**	(307,773)		(68,380)		9,147							(367,006)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(286,838)		(67,164)		29,988							(324,014)	29

Warren Barr Lincolnshire

ID# 0053587

Report Period Beginning: 05/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Warren Barr Lincolnshire** **#** **0053587** **Report Period Beginning:** **05/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	7,949		483	634								9,066	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			4	343								347	32
33	Real Estate Taxes			610									610	33
34	Rent-Facility & Grounds			2,270	(2,270)								(0)	34
35	Rent-Equipment & Vehicles	(1,388)		440		185							(763)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	6,560		3,807	(1,293)	185							9,259	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(455,481)											(455,481)	43
44	**TOTAL Special Cost Centers**	(455,481)											(455,481)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(735,759)		(63,357)	(1,293)	30,173							(770,235)	45

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING SUPPLIES	$	Legacy Healthcare Financial Services	100.00%	$ 32	$ 32	15
16	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	341	341	16
17	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	779	779	17
18	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	64	64	18
19	V	17	MANAGEMENT FEES - Y. ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	485	485	19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	6,415	6,415	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	283	283	21
22	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	31,898	31,898	22
23	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	3,240	3,240	23
24	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	285	285	24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	216	216	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	8,798	8,798	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	483	483	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	4	4	28
29	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	610	610	29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	2,270	2,270	30
31	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	440	440	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	19	BOOKKEEPING FEES	120,000	Legacy Healthcare Financial Services	100.00%		(120,000)	36
37	V								37
38	V								38
39	Total			$ 120,000			$ 56,643	$ * (63,357)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION		Legacy Real Properties	100.00%	634	$ 634	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	343	343	16
17	V								17
18	V								18
19	V	34	RENT	2,270	Legacy Real Properties	100.00%		(2,270)	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			$ 2,270			$ 977	$ * (1,293)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 452	$ 452	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	1	1	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	250	250	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	1	1	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	17,288	17,288	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	3	3	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	437	437	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	20,111	20,111	22
23	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	3,212	3,212	23
24	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	21,231	21,231	24
25	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	151	151	25
26	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	23	23	26
27	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	300	300	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	23	23	28
29	V	27	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	4,025	4,025	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	903	903	30
31	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	185	185	31
32	V	17	ADMINISTRATOR	10,853	Progressive Healthcare Consulting	100.00%		(10,853)	32
33	V	10	NURSING	11,360	Progressive Healthcare Consulting	100.00%		(11,360)	33
34	V	12	SOCIAL SERVICE	8,190	Progressive Healthcare Consulting	100.00%		(8,190)	34
35	V	21	CLERICAL	3,903	Progressive Healthcare Consulting	100.00%		(3,903)	35
36	V	15	PAYROLL TAXES - NURSING	1,363	Progressive Healthcare Consulting	100.00%		(1,363)	36
37	V	27	PAYROLL TAXES	2,753	Progressive Healthcare Consulting	100.00%		(2,753)	37
38	V								38
39	Total			$ 38,422			$ 68,595	$ * 30,173	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YAIR ZUCKERMAN	0.90%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	1
2	DINA ZUKERMAN	0.10%	BETHANY TERRACE	MORTON GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3	10 PACK TENANT, LLC	99.00%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			GROVE OF FOX VALLEY	AURORA	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				9
10			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				10
11			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR LIVING AND REHAB	CHICAGO				19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yair Zuckerman	Owner	Administrative	0.90%	See Attached	0.59	1.48%	Alloc Sal/Fee	$ 2,960	17-3/17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 2,960		13

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,253,624	23	$ 2,296	$	17,280	$ 32	1
2	5	UTILITIES	AVAIL. BED DAYS	1,253,624	23	24,766		17,280	341	2
3	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,253,624	23	56,504		17,280	779	3
4	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,253,624	23	4,642		17,280	64	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,253,624	23	465,391		17,280	6,415	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,253,624	23	20,516		17,280	283	6
7	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,253,624	23	2,314,153	2,314,153	17,280	31,898	7
8	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,253,624	23	235,020		17,280	3,240	8
9	24	SEMINARS	AVAIL. BED DAYS	1,253,624	23	20,662		17,280	285	9
10	26	INSURANCE	AVAIL. BED DAYS	1,253,624	23	15,655		17,280	216	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,253,624	23	638,286		17,280	8,798	11
12	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	35,040		17,280	483	12
13	32	INTEREST	AVAIL. BED DAYS	1,253,624	23	267		17,280	4	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,253,624	23	44,250		17,280	610	14
15	34	RENT	AVAIL. BED DAYS	1,253,624	23	164,669		17,280	2,270	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,253,624	23	31,945		17,280	440	16
17										17
18	17	MGMT FEES- Y. ZUCKERMAN	AVG HOURS WKD	50	20	32,807		0.74	485	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,106,869	$ 2,314,153		$ 56,643	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	46,013		17,280	634	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,253,624	23	24,899		17,280	343	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					$ 70,912	$		$ 977	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,167,679	20	$ 30,560	$	17,280	$ 452	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	65	65	17,280	1	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	20	16,865		17,280	250	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	47		17,280	1	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	1,168,252	1,168,252	17,280	17,288	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	187		17,280	3	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	29,559	29,559	17,280	437	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	1,358,960	1,358,960	17,280	20,111	8
9	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	217,026		17,280	3,212	9
10	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	1,434,659	1,434,659	17,280	21,231	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	10,207		17,280	151	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	1,577		17,280	23	12
13	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	20,243		17,280	300	13
14	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	1,535		17,280	23	14
15	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	272,007		17,280	4,025	15
16	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	61,041		17,280	903	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	1,167,679	20	12,512		17,280	185	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,635,301	$ 3,991,495		$ 68,595	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Alloc from Legacy HC	X									4	6
7	Alloc from Legacy Real Prop	X									343	7
8												8
9	TOTAL Facility Related						$	$			$ 347	9
	B. Non-Facility Related*											
10	Interest		X								969	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 969	14
15	TOTALS (line 9+line14)						$	$			$ 1,316	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	64,509	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.)	$	173,119	2
3. Under or (over) accrual (line 2 minus line 1).	$	108,610	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	30	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 90 **For** 2010-12 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	108,640	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	144,496	8
	2011	154,567	9
	2012	168,518	10
	2013	168,518	11
	2014	172,509	12

Allocated from Legacy Real Properties: $610

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincolnshire COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053587

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-200-062	Long Term Care Facility	$ 172,509.08	$ 172,509.08
2.	10-35-104-076-0000	Home Office Allocation	$ 39,271.59	$ 541.32
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 211,780.67	$ 173,050.40

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincolnshire COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053587

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

Lincolnshire Assisted Living

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Legacy Real Properties			$ 1,128	1
2					2
3	TOTALS			$ 1,128	3

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		19,294	551		803	252	4,476	68
69	Financial Statement Depreciation			39,802			(39,802)		69
70	TOTAL (lines 4 thru 69)		$ 19,294	$ 40,353		$ 803	$ (39,550)	$ 4,476	70

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 12A, Carried Forward		$ 19,294	$ 40,353		$ 803	$ (39,550)	$ 4,476	1
2	Resid Rm/Dining Rm/Hallway - Wall Sconces, Light Fixtures	2015	20,930		20	1,047	1,047	1,047	2
3	Resident Rooms - Power Outlets/Cables/Plates	2015	4,200		20	210	210	210	3
4	Resident Rooms - Carpet/Flooring	2015	4,300		20	215	215	215	4
5	Tiling For Rivieria Wing	2015	6,400		20	320	320	320	5
6	Resident Room Carpeting	2015	31,058		20	1,553	1,553	1,553	6
7	Wood/Fire Rated Doors And Hinges For Corridors	2015	10,953		20	548	548	548	7
8	Glass Doors	2015	7,730		20	387	387	387	8
9	Resident Room Flooring	2015	14,057		20	703	703	703	9
10	Cape Cod Unit Tiling	2015	7,715		20	386	386	386	10
11	Double Egress Fire Doors	2015	2,992		20	150	150	150	11
12	Corridors Carpeting/Flooring	2015	9,096		20	455	455	455	12
13	Cape Cod Unit Wallcovering	2015	5,603		20	280	280	280	13
14	Cape Cod Unit Drapery/Curtains	2015	12,109		20	605	605	605	14
15	Cape Cod Unit Wallcovering	2015	3,102		20	155	155	155	15
16	Cape Cod Unit Glass Mount Bracket	2015	4,052		20	203	203	203	16
17	Cape Cod Unit Double Doors	2015	7,730		20	387	387	387	17
18	Corridor Signage	2015	3,855		20	193	193	193	18
19	Cape Cod Unit - New Frame, Doors	2015	3,647		20	182	182	182	19
20	Repaired Chillers	2015	8,897		20	445	445	445	20
21	Bathroom/Resident Rm - Dividers/Doors	2015	17,820		20	891	891	891	21
22	Dining Area/Guest Room - Valance, Rods, Divider Panels	2015	33,300		20	1,665	1,665	1,665	22
23	Install Door Controls	2015	20,150		20	1,008	1,008	1,008	23
24	Coventry/Palm Beach Wing - Drapery	2015	6,000		20	300	300	300	24
25	Kitchen - Millwork/Countertop/Cabinet	2015	25,783		20	1,289	1,289	1,289	25
26	East Wing - Primer/Tiling	2015	30,947		20	1,547	1,547	1,547	26
27	Resident Rooms/Corridors - Painting	2015	16,900		20	845	845	845	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 12B, Carried Forward		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 12D, Carried Forward		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	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
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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)		$ 338,619	$ 40,353		$ 16,769	$ (23,584)	$ 20,442	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	8,737	297	20	291	(6)	1,893	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy HC Financial Services	2012	393	26	20	20	(6)	79	9
10	Allocated from Legacy HC Financial Services	2013	1,257	82	20	63	(19)	189	10
11	Allocated from Legacy HC Financial Services	2014	123	8	20	6	(2)	12	11
12	Allocated from Legacy HC Financial Services	2015	169	11	20	8	(3)	8	12
13									13
14	Allocated from Legacy Real Properties	2009	4,962	73	20	248	175	1,427	14
15	Allocated from Legacy Real Properties	2010	1,509	22	20	60	38	332	15
16	Allocated from Legacy Real Properties	2011	2,144	32	20	107	75	536	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)		$ 19,294	$ 551		$ 803	$ 252	$ 4,476	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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		$ 19,294	$ 551		$ 803	$ 252	$ 4,476	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,294	$ 551		$ 803	$ 252	$ 4,476	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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	$ 4,869	$ 547	$ 486	$ (61)	10	$ 1,918	71
72	Current Year Purchases	316,111	18	31,611	31,593	10	31,611	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 320,980	$ 565	$ 32,097	$ 31,532		$ 33,529	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 660,727	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,918	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,867	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,949	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 53,972	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	Cape Cod Unit	$ 192,702	92
93			93
94			94
95		$ 192,702	95

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		140		$ 567,766			3
4	Additions							4
5	Storage				945			5
6								6
7	TOTAL		140		$ 568,711 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 9,611 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	GM Truck	$ 999.00	$ 5,994	17
18	Allocated from Progressive HC			185	18
19					19
20					20
21	TOTAL		$ 999.00	$ 6,179	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs		$		$ 272,897	$		$ 272,897	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				83,743			83,743	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				307,627			307,627	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts					323,171		323,171	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): See Supplemental						32,902	40,413		73,315	13
14	TOTAL				$		$ 697,169	$ 363,584		$ 1,060,753	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.

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Lincolnshire **#** 0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,177,633		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,077		6
7	Other Prepaid Expenses	20,776		7
8	Accounts Receivable (owners or related parties)	77,945		8
9	Other(specify):	333,781		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,641,712	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	231,347		15
16	Equipment, at Historical Cost	456,152		16
17	Accumulated Depreciation (book methods)	(39,802)		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):	229,925		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 877,622	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,519,334	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,681,490	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,595		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,115		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	462,866		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,237,066	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,237,066	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (717,732)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,519,334	$	48

***(See instructions.)**

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(717,732)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (717,732)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (717,732)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,210,180	1
2	Discounts and Allowances for all Levels	(3,536,782)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,673,398	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,473,345	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,473,345	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	319,432	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,331	19
20	Radiology and X-Ray	5,680	20
21	Other Medical Services	10,044	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 414,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,887	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,887	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,569,117	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,400,096	31
32	Health Care	2,875,348	32
33	General Administration	1,618,030	33
	B. Capital Expense		
34	Ownership	734,035	34
	C. Ancillary Expense		
35	Special Cost Centers	1,516,234	35
36	Provider Participation Fee	143,106	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,286,849	40
41	**Income before Income Taxes (line 30 minus line 40)****	(717,732)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (717,732)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 560,865	44
45	Private Pay - Net Inpatient Revenue	2,674,740	45
46	Medicare - Net Inpatient Revenue	470,217	46
47	Other-(specify) Insurance/Managed Care	(32,424)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,673,398	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 Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,056	1,080	$ 61,039	$ 56.52	1
2	Assistant Director of Nursing	530	546	24,555	45.01	2
3	Registered Nurses	21,437	22,108	662,104	29.95	3
4	Licensed Practical Nurses	20,209	20,894	610,123	29.20	4
5	CNAs & Orderlies	56,891	58,822	928,313	15.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,722	1,778	54,778	30.81	8
9	Activity Director	1,274	1,274	26,941	21.15	9
10	Activity Assistants	7,101	7,316	91,527	12.51	10
11	Social Service Workers	12,776	13,151	183,771	13.97	11
12	Dietician					12
13	Food Service Supervisor	1,519	1,575	38,395	24.38	13
14	Head Cook	3,979	4,091	76,574	18.72	14
15	Cook Helpers/Assistants	19,723	20,270	259,785	12.82	15
16	Dishwashers					16
17	Maintenance Workers	6,635	6,811	154,563	22.69	17
18	Housekeepers	9,450	9,680	105,297	10.88	18
19	Laundry	3,658	3,800	40,582	10.68	19
20	Administrator	1,469	1,501	52,383	34.90	20
21	Assistant Administrator	1,091	1,115	30,311	27.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,096	11,490	190,296	16.56	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	71	72	1,308	18.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,835	2,911	54,728	18.80	33
34	TOTAL (lines 1 - 33)	184,521	190,284	$ 3,647,373 *	$ 19.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 47,814	01-03	35
36	Medical Director	Monthly	26,152	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	16,470	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,836	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Clergy	Per Visit	418	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 92,690		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 413	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	122	6,081	10-03	52
53	TOTAL (lines 50 - 52)	129	$ 6,494		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeannette Allen	Administrator	0.00%	$ 55,039
Ryan Gapsis	Assist Admin	0.00%	27,655
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,694

B. Administrative - Other

Description	Amount
Yair Zuckerman - Management Fees	$ 485
TOTAL (agree to Schedule V, line 17, col. 3)	$ 485
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 17,300
Legacy Healthcare	Bookkeeping	120,000
Creative Technology	Data Processing	14,598
E-Health Data Solutions	Data Processing	630
Health Data Systems	Data Processing	3,500
Prime Care Technology	Data Processing	330
Wescom Solutions	Data Processing	21,825
Documentation Solutions	Compliance Audit	5,317
Paycor	Payroll Processing	19,352
Achieve Accreditation	Joint Commission Consult	7,166
ADP	Payroll Processing	679
See Supplemental Schedule		45,148
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 255,844

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,546
Unemployment Compensation Insurance	59,476
FICA Taxes	277,571
Employee Health Insurance	74,209
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	883
Employee Physical Exam	14,638
Other Employee Benefits	35,790
TOTAL (agree to Schedule V, line 22, col.8)	$ 572,114

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	50
Health Care Worker Background Check	3,620
(Indicate # of checks performed 362)	
Patient Background Checks	
Dues and Subscriptions	3,866
License and Permits	9,109
Allocated from Legacy HC Financial Serv	283
Allocated from Progressive HC	23
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,952

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,755
Allocated from Legacy HC Financial Serv	285
Allocated from Progressive HC	23
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,063

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 05/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 **Report Period Beginning:** 05/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,918** 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. $ **143,106**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.