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: 0052787

Facility Name: Warren Barr North Shore

Address: 2773 Skokie Valley Road (Number) Highland Park (City) 60035 (Zip Code)

County: Lake

Telephone Number: (847) 266-9266 **Fax #** (847) 266-9240

HFS ID Number:

Date of Initial License for Current Owners: 7/1/2014

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 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	215	Skilled (SNF)	215	78,475	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	215	TOTALS	215	78,475	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	19,467	4,443	19,432	43,342	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,467	4,443	19,432	43,342	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.23%

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 07/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 215 and days of care provided 15,996

Medicare Intermediary CGS Administrators, LLC

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 North Shore # 0052787 **Report Period Beginning:** 01/01/15 **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	443,526	67,693	31	511,250		511,250		511,250			1
2	Food Purchase		348,212		348,212		348,212	(544)	347,668			2
3	Housekeeping	233,241	76,604		309,845		309,845	144	309,989			3
4	Laundry	87,070	23,803		110,873		110,873		110,873			4
5	Heat and Other Utilities			303,894	303,894		303,894	(11,326)	292,568			5
6	Maintenance	110,360	1,019	310,934	422,313		422,313	62,377	484,690			6
7	Other (specify):*											7
8	**TOTAL General Services**	874,197	517,331	614,859	2,006,387		2,006,387	50,651	2,057,038			8
	B. Health Care and Programs											
9	Medical Director			93,840	93,840		93,840		93,840			9
10	Nursing and Medical Records	3,890,558	556,314	78,654	4,525,526		4,525,526	38,842	4,564,368			10
10a	Therapy	136,545	1,707	3,409	141,661		141,661		141,661			10a
11	Activities	142,657	6,706	1,728	151,091		151,091	291	151,382			11
12	Social Services	360,873		1,635	362,508		362,508	49,037	411,545			12
13	CNA Training											13
14	Program Transportation			15,585	15,585		15,585		15,585			14
15	Other (specify):*							11,580	11,580			15
16	**TOTAL Health Care and Programs**	4,530,633	564,727	194,851	5,290,211		5,290,211	99,750	5,389,961			16
	C. General Administration											
17	Administrative	134,779		2,205	136,984		136,984	75,080	212,064			17
18	Directors Fees											18
19	Professional Services			479,033	479,033	(136)	478,897	(306,930)	171,966			19
20	Dues, Fees, Subscriptions & Promotions			338,998	338,998		338,998	(275,007)	63,991			20
21	Clerical & General Office Expenses	367,898	9,710	688,227	1,065,835		1,065,835	(436,956)	628,879			21
22	Employee Benefits & Payroll Taxes			977,262	977,262		977,262		977,262			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,689	13,689		13,689	1,396	15,085			24
25	Other Admin. Staff Transportation			15,858	15,858		15,858		15,858			25
26	Insurance-Prop.Liab.Malpractice			162,037	162,037		162,037	5,082	167,119			26
27	Other (specify):*							49,071	49,071			27
28	**TOTAL General Administration**	502,677	9,710	2,677,309	3,189,696	(136)	3,189,560	(888,263)	2,301,297			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,907,507	1,091,768	3,487,019	10,486,294	(136)	10,486,158	(737,862)	9,748,296			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 North Shore #0052787 Report Period Beginning: 01/01/15 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			325,676	325,676		325,676	472,022	797,698			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,506	84,506		84,506	1,093,877	1,178,383			32
33	Real Estate Taxes			190,000	190,000	136	190,136	2,770	192,906			33
34	Rent-Facility & Grounds			1,448,000	1,448,000		1,448,000	(1,448,000)	0			34
35	Rent-Equipment & Vehicles			24,094	24,094		24,094	4,855	28,949			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,072,276	2,072,276	136	2,072,412	125,524	2,197,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,179,096	2,181,090	3,360,186		3,360,186		3,360,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			282,749	282,749		282,749		282,749			42
43	Other (specify):*			827,497	827,497		827,497	(827,497)				43
44	**TOTAL Special Cost Centers**		1,179,096	3,291,336	4,470,432		4,470,432	(827,497)	3,642,935			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,907,507	2,270,864	8,850,631	17,029,002		17,029,002	(1,439,834)	15,589,168			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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,876)	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	466,949	30		9
10	Interest and Other Investment Income	(2,757)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(357)	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	(716)	21		18
19	Entertainment				19
20	Contributions	(99,200)	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	(361,718)	21		24
25	Fund Raising, Advertising and Promotional	(170,114)	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	(1,439,466)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,620,255)		$	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)	180,421		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 180,421		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,439,834)		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 North Shore

ID# 0052787

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (175,905)	21	1
2	Patient Personal Items	(19,483)	10	2
3	Meals	(15,536)	21	3
4	Bank Charges	(29,650)	21	4
5	Discount	(2,241)	02	5
6	Prior Period Expense	(8,892)	21	6
7	Additional R&M	70,841	06	7
8	Capitalized R&M	(12,829)	06	8
9	Equipment Rental-Chiller	14,014	35	9
10	Non Allowable Vehicle Rental	(12,000)	35	10
11				11
12	PAC Dues	(7,083)	20	12
13	Professional Fees Refund	(40,054)	19	13
14	Non Allowable Legal Fees	(56,695)	19	14
15	Bldg Co - Amortization	(285,000)	36	15
16	Bldg Co - Loan Fees	(28,557)	36	16
17	Bldg Co - Professional Fees	(2,900)	19	17
18	Non Allowable Expense	(827,497)	43	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**	(1,439,466)		49

Warren Barr North Shore

ID# 0052787

Report Period Beginning: 01/01/15

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 A

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/15 **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	(2,598)				2,054							(544)	2
3	Housekeeping			144									144	3
4	Laundry													4
5	Heat and Other Utilities	(12,876)		1,550									(11,326)	5
6	Maintenance	58,012		3,537		828							62,377	6
7	Other (specify):*													7
8	**TOTAL General Services**	42,538		5,231		2,882							50,651	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(19,483)				58,325							38,842	10
10a	Therapy													10a
11	Activities			291									291	11
12	Social Services					49,037							49,037	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,580							11,580	15
16	**TOTAL Health Care and Programs**	(19,483)		291		118,942							99,750	16
	C. General Administration													
17	Administrative			2,205		72,876							75,080	17
18	Directors Fees													18
19	Professional Services	(99,649)	2,900	(210,867)		686							(306,930)	19
20	Fees, Subscriptions & Promotions	(276,397)		1,284		106							(275,007)	20
21	Clerical & General Office Expenses	(592,416)		159,574		(4,115)							(436,956)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,293		103							1,396	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			980		4,102							5,082	26
27	Other (specify):*			39,956		9,115							49,071	27
28	**TOTAL General Administration**	(968,462)	2,900	(5,575)		82,874							(888,263)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(945,407)	2,900	(53)		204,698							(737,862)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Warren Barr North Shore** **#** **0052787** **Report Period Beginning:** **01/01/15** **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	466,949		2,193	2,880								472,022	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,757)	1,095,059	17	1,559								1,093,877	32
33	Real Estate Taxes			2,770									2,770	33
34	Rent-Facility & Grounds		(1,448,000)	10,308	(10,308)								(1,448,000)	34
35	Rent-Equipment & Vehicles	2,014		2,000		841							4,855	35
36	Other (specify):*	(313,557)	313,557											36
37	**TOTAL Ownership**	152,649	(39,384)	17,288	(5,869)	841							125,524	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):*	(827,497)											(827,497)	43
44	**TOTAL Special Cost Centers**	(827,497)											(827,497)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,620,255)	(36,484)	17,235	(5,869)	205,539							(1,439,834)	45

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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. [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)	
1	V	34	Rental Income	$ 1,448,000	Half Day Property Holdings LLC	100.00%	$	$ (1,448,000)	1
2	V	32	Interest	593	Half Day Property Holdings LLC	100.00%	1,095,652	1,095,059	2
3	V	36	Amortization		Half Day Property Holdings LLC	100.00%	285,000	285,000	3
4	V	36	Loan Fees		Half Day Property Holdings LLC	100.00%	28,557	28,557	4
5	V	19	Professional Fees		Half Day Property Holdings LLC	100.00%	2,900	2,900	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			$ 1,448,593			$ 1,412,109	$ * (36,484)	14

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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%	$ 144	$ 144	15
16	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,550	1,550	16
17	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,537	3,537	17
18	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	291	291	18
19	V	17	MANAGEMENT FEES - Y. ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	2,205	2,205	19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	29,133	29,133	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,284	1,284	21
22	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	144,863	144,863	22
23	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	14,712	14,712	23
24	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,293	1,293	24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	980	980	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	39,956	39,956	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	2,193	2,193	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	17	17	28
29	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	2,770	2,770	29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	10,308	10,308	30
31	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	2,000	2,000	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	19	BOOKKEEPING FEES	240,000	Legacy Healthcare Financial Services	100.00%		(240,000)	36
37	V								37
38	V								38
39	Total			$ 240,000			$ 257,235	$ * 17,235	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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%	2,880	$ 2,880	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	1,559	1,559	16
17	V								17
18	V								18
19	V	34	RENT	10,308	Legacy Real Properties	100.00%		(10,308)	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			$ 10,308			$ 4,439	$ * (5,869)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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%	$ 2,054	$ 2,054	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	4	4	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	1,133	1,133	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	3	3	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	78,514	78,514	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	13	13	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	1,987	1,987	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	91,330	91,330	22
23	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	14,585	14,585	23
24	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	96,418	96,418	24
25	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	686	686	25
26	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	106	106	26
27	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,360	1,360	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	103	103	28
29	V	27	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	18,280	18,280	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	4,102	4,102	30
31	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	841	841	31
32	V	17	ADMINISTRATOR	23,542	Progressive Healthcare Consulting	100.00%		(23,542)	32
33	V	10	NURSING	20,192	Progressive Healthcare Consulting	100.00%		(20,192)	33
34	V	12	SOCIAL SERVICE	44,292	Progressive Healthcare Consulting	100.00%		(44,292)	34
35	V	06	MAINTENANCE	310	Progressive Healthcare Consulting	100.00%		(310)	35
36	V	21	CLERICAL	5,475	Progressive Healthcare Consulting	100.00%		(5,475)	36
37	V	15	PAYROLL TAXES-NURSING	3,005	Progressive Healthcare Consulting	100.00%		(3,005)	37
38	V	27	PAYROLL TAXES	9,165	Progressive Healthcare Consulting	100.00%		(9,165)	38
39	Total			$ 105,981			$ 311,520	$ * 205,539	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	CHAIM RAJCHENBACH	31.645%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	HALF DAY PROPERTY HOLDINGS LLC		BUILDING CO	1
2	MENACHEM SHABAT	31.645%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3	THE RAJCHENBACH FAMILY TRUST	11.650%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	3
4	RONALD SHABAT	5.060%	CHALET SKILLED NURSING FACILITY LLC	CHICAGO	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5	YAIR ZUCKERMAN	10.000%	ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6	ROSS BOTTNER	10.000%	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	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	9
10			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				10
11			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				11
12			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				12
13			AVANTARA LONG GROVE	LONG GROVE				13
14			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				14
15			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	10.00%	See Attached	2.69	6.73%	Alloc Sal/Fee	$ 13,441	17-3/17-7	1
2	Ross Bottner	Owner	CFO	10.00%	See Attached	2.50	6.25%	Alloc. Salary	12,520	21-07	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	$ 25,961		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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	$	78,475	$ 144	1
2	5	UTILITIES	AVAIL. BED DAYS	1,253,624	23	24,766		78,475	1,550	2
3	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,253,624	23	56,504		78,475	3,537	3
4	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,253,624	23	4,642		78,475	291	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,253,624	23	465,391		78,475	29,133	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,253,624	23	20,516		78,475	1,284	6
7	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,253,624	23	2,314,153	2,314,153	78,475	144,863	7
8	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,253,624	23	235,020		78,475	14,712	8
9	24	SEMINARS	AVAIL. BED DAYS	1,253,624	23	20,662		78,475	1,293	9
10	26	INSURANCE	AVAIL. BED DAYS	1,253,624	23	15,655		78,475	980	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,253,624	23	638,286		78,475	39,956	11
12	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	35,040		78,475	2,193	12
13	32	INTEREST	AVAIL. BED DAYS	1,253,624	23	267		78,475	17	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,253,624	23	44,250		78,475	2,770	14
15	34	RENT	AVAIL. BED DAYS	1,253,624	23	164,669		78,475	10,308	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,253,624	23	31,945		78,475	2,000	16
17										17
18	17	MGMT FEES- Y. ZUCKERMAN	AVG HOURS WKD	50	20	32,807		3.36	2,205	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,106,869	$ 2,314,153		$ 257,235	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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		78,475	2,880	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,253,624	23	24,899		78,475	1,559	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	$		$ 4,439	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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	$	78,475	$ 2,054	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	65	65	78,475	4	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	20	16,865		78,475	1,133	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	47		78,475	3	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	1,168,252	1,168,252	78,475	78,514	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	187		78,475	13	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	29,559	29,559	78,475	1,987	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	1,358,960	1,358,960	78,475	91,330	8
9	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	217,026		78,475	14,585	9
10	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	1,434,659	1,434,659	78,475	96,418	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	10,207		78,475	686	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	1,577		78,475	106	12
13	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	20,243		78,475	1,360	13
14	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	1,535		78,475	103	14
15	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	272,007		78,475	18,280	15
16	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	61,041		78,475	4,102	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	1,167,679	20	12,512		78,475	841	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,635,301	$ 3,991,495		$ 311,520	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	Cole Taylor		X	Mortgage			$	$ 13,300,000			$ 743,841	1
2	Seller Note		X	Note Payable				3,800,000			265,271	2
3	Members		X	Loans Payable				2,018,093				3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				1,981,901			84,506	6
7	Capex		X	Line of Credit				1,481,581			86,540	7
8												8
9	TOTAL Facility Related						$	$ 22,581,574			$ 1,180,158	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,757)	10
11	Interest Income - Bldg Co		X								(593)	11
12	Allcoated from Legacy Real Pro	X									1,559	12
13	See Supplemental Schedule										17	13
14	TOTAL Non-Facility Related						$	$			$ (1,774)	14
15	TOTALS (line 9+line14)						$	$ 22,581,574			$ 1,178,384	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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	Allocated from Legacy HC	X					$	$			$ 17	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										17	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 North Shore # 0052787 **Report Period Beginning:** 01/01/15 **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.**	$	90,487	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.)	$	142,243	2
3. Under or (over) accrual (line 2 minus line 1).	$	51,756	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	141,014	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.**	$	136	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** $ 409 **For** 10-12 **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.	$	192,906	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	124,849	8
	2011	137,878	9
	2012	131,644	10
	2013	135,169	11
	2014	139,473	12

2015 Accrual = $139, 473 x 1.01 = $141,014

Allocated from Legacy Healthcare Financial Services: $2,770

	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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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.	16-16-401-005	Long Term Care Property	$ 139,472.81	$ 139,472.81
2.	See Attached	Home Office Allocation	$ 39,271.59	$ 2,458.34
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 178,744.40	$ 141,931.15

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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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 North Shore # 0052787 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,108 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 3

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

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

D. Does the Operating Entity? [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).

None

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			$ 5,121	1
2	Facility			1,508,714	2
3	TOTALS			$ 1,513,835	3

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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	215		2014	1997	$ 13,977,972	$	35	$ 399,371	$ 399,371	$ 798,741	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 North Shore # 0052787 Report Period Beginning: 01/01/15 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
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63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		87,623	2,503		3,651	1,148	20,326	68
69	Financial Statement Depreciation			325,676			(325,676)		69
70	TOTAL (lines 4 thru 69)		$ 14,065,595	$ 328,179		$ 403,022	$ 74,843	$ 819,067	70

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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		$ 14,065,595	$ 328,179		$ 403,022	$ 74,843	$ 819,067	1
2	Landscaping	2014	13,184		20	659	659	714	2
3	23 Floor Coverings	2014	94,021		20	4,701	4,701	5,093	3
4	Signs With Logo	2014	14,650		20	1,465	1,465	2,075	4
5	Bedside Sconces	2014	6,188		20	309	309	309	5
6	Sprinkler System	2015	13,275		20	664	664	664	6
7	Wallcovering - 2Nd & 3Rd Floor	2015	38,715		20	1,936	1,936	1,936	7
8	Light Fixtures And Wall Sconce - 2Nd & 3Rd Floor	2015	23,309		20	1,165	1,165	1,165	8
9	2Nd & 3Rd Fl-Door Frames, Handrails, Flooring, Painting, Electr	2015	256,308		20	12,815	12,815	12,815	9
10	Installed Pressure Backflow In Laundry Room	2015	6,120		20	306	306	306	10
11	2Nd/3Rd Floor - Fooring/Electrical/Carpentry/Painting	2015	414,861		20	20,743	20,743	20,743	11
12	Signs For Bathroom/Exits/Corridors	2015	12,917		20	646	646	646	12
13	Repaired Sprinkler System Valves	2015	3,125		20	156	156	156	13
14	2Nd-3Rd Fl Carpentry/Flooring/Painting/Nurse Call/Electrical/Do	2015	2,401,101		20	120,055	120,055	120,055	14
15	Repaired Sprinkler System Valves	2015	3,125		20	156	156	156	15
16	Signage For Facility	2015	22,681		20	1,134	1,134	1,134	16
17	Installed Elevator Signage	2015	5,421		20	271	271	271	17
18	Bathroom Glass Mount Bracket	2015	2,692		20	135	135	135	18
19	Security System	2015	47,800		20	2,390	2,390	2,390	19
20	Chiller Replacement	2015	42,969		20	2,148	2,148	2,148	20
21	Pump Replacment	2015	3,298		20	165	165	165	21
22	Installed New Fan Coil In Resid Rms	2015	3,448		20	172	172	172	22
23	Security System	2015	14,936		20	747	747	747	23
24	Repaired Chiller	2015	6,340		20	317	317	317	24
25	Pump Replacement In Kitchen	2015	2,863		20	143	143	143	25
26	Repaired Condensing Unit	2015	4,130		20	207	207	207	26
27	Repaired Elevator	2015	8,700		20	435	435	435	27
28	2Nd & 3Rd Fl-Plumbing, Flooring, Electrical, Window Treatment	2015	254,499		20	12,725	12,725	12,725	28
29	Chandelier And Lights	2015	13,542		20	1,354	1,354	1,354	29
30	Heating Pump Repair	2015	3,334		20	167	167	167	30
31	Install Ventilation System In Tv Receiver Room	2015	3,975		20	199	199	199	31
32	Walk In Cooler Repair	2015	5,520		20	276	276	276	32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	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
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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)		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	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
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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)		$ 17,812,642	$ 328,179		$ 591,784	$ 263,605	$ 1,008,886	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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
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21									21
22									22
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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 North Shore # 0052787 Report Period Beginning: 01/01/15 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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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 North Shore # 0052787 Report Period Beginning: 01/01/15 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	39,679	1,350	35	1,323	(27)	8,597	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Real Properties	2009	22,533	334	20	1,127	793	6,478	9
10	Allocated from Legacy Real Properties	2010	6,852	101	20	274	173	1,509	10
11	Allocated from Legacy Real Properties	2011	9,739	144	20	487	343	2,435	11
12									12
13	Allocated from Legacy Healthcare Financial Services	2012	1,785	116	20	89	(27)	357	13
14	Allocated from Legacy Healthcare Financial Services	2013	5,709	372	20	285	(87)	856	14
15	Allocated from Legacy Healthcare Financial Services	2014	557	36	20	28	(8)	56	15
16	Allocated from Legacy Healthcare Financial Services	2015	769	50	20	38	(12)	38	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)		$ 87,623	$ 2,503		$ 3,651	$ 1,148	$ 20,326	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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		$ 87,623	$ 2,503		$ 3,651	$ 1,148	$ 20,326	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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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 87,623	$ 2,503		$ 3,651	$ 1,148	$ 20,326	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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	$ 820,616	$ 2,488	$ 92,479	$ 89,991	10	$ 223,016	71
72	Current Year Purchases	1,134,356	82	113,435	113,353	10	113,435	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,954,972	$ 2,570	$ 205,914	$ 203,344		$ 336,451	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)	$ 21,281,450	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 330,749	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 797,698	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 466,949	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,345,337	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: $ 28,108 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	Allocated from Progressive HC		$	$ 841	17
18					18
19					19
20					20
21	TOTAL		$	$ 841	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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 North Shore # 0052787 Report Period Beginning: 01/01/15 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 835,581	$		$ 835,581	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			204,039			204,039	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,027,655			1,027,655	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				1,064,499		1,064,499	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					113,815	114,597		228,412	13
14	TOTAL			$		$ 2,181,090	$ 1,179,096		$ 3,360,186	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 North Shore **#** 0052787 **Report Period Beginning:** 01/01/15 **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	$ 500	$ 955,448	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,149,044	4,149,044	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,996	157,996	6
7	Other Prepaid Expenses	35,489	35,489	7
8	Accounts Receivable (owners or related parties)	33,099	33,099	8
9	Other(specify):	54,788	54,788	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,430,916	$ 5,385,864	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,508,714	13
14	Buildings, at Historical Cost		13,977,972	14
15	Leasehold Improvements, at Historical Cost	2,499,438	2,538,456	15
16	Equipment, at Historical Cost	1,250,070	1,874,366	16
17	Accumulated Depreciation (book methods)	(338,175)	(768,621)	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):	134,413	2,490,494	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,545,746	$ 21,621,381	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,976,662	$ 27,007,245	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,146,779	$ 3,146,779	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,981,901	3,463,482	29
30	Accrued Salaries Payable	404,187	404,187	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,487	20,487	31
32	Accrued Real Estate Taxes(Sch.IX-B)		141,014	32
33	Accrued Interest Payable		156,032	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	628,856	1,000,806	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,182,210	$ 8,332,787	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		19,118,093	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,624,601	1,019,205	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,624,601	$ 20,137,298	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,806,811	$ 28,470,085	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (830,149)	$ (1,462,840)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,976,662	$ 27,007,245	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (273,078)	1
2	Restatements (describe):		2
3	**Advertising/Other Prof Fees/Legal Fees**	(116,043)	3
4	**Equipment/Depreciation/Sequestration**	(17,812)	4
5	**Bad Debt/Late Entry**	54,321	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (352,612)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(477,537)	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)**	$ (477,537)	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)**	$ (830,149)	24 *

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

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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	$ 14,832,482	1
2	Discounts and Allowances for all Levels	(9,024,121)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,808,361	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,361,960	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,361,960	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,054,532	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	220,538	19
20	Radiology and X-Ray	40,460	20
21	Other Medical Services	20,562	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,336,092	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,757	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,757	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	42,295	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 42,295	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,551,465	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,006,387	31
32	Health Care	5,290,211	32
33	General Administration	3,189,696	33
	B. Capital Expense		
34	Ownership	2,072,276	34
	C. Ancillary Expense		
35	Special Cost Centers	4,187,683	35
36	Provider Participation Fee	282,749	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,029,002	40
41	**Income before Income Taxes (line 30 minus line 40)****	(477,537)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (477,537)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,641,178	44
45	Private Pay - Net Inpatient Revenue	1,331,814	45
46	Medicare - Net Inpatient Revenue	(240,837)	46
47	Other-(specify) Insurance	76,206	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,808,361	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.**

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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	2,286	2,326	$ 124,268	$ 53.43	1
2	Assistant Director of Nursing	1,976	2,024	90,981	44.95	2
3	Registered Nurses	40,747	41,596	1,363,204	32.77	3
4	Licensed Practical Nurses	30,217	31,021	852,088	27.47	4
5	CNAs & Orderlies	105,033	106,978	1,422,109	13.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,888	7,037	136,545	19.40	8
9	Activity Director	2,102	2,150	41,796	19.44	9
10	Activity Assistants	7,955	8,153	100,861	12.37	10
11	Social Service Workers	11,970	12,214	314,846	25.78	11
12	Dietician					12
13	Food Service Supervisor	2,865	2,928	71,081	24.28	13
14	Head Cook	10,102	10,315	139,330	13.51	14
15	Cook Helpers/Assistants	19,265	19,638	233,115	11.87	15
16	Dishwashers					16
17	Maintenance Workers	4,180	4,276	110,360	25.81	17
18	Housekeepers	18,206	18,551	233,241	12.57	18
19	Laundry	6,840	6,998	87,070	12.44	19
20	Administrator	2,240	2,296	128,889	56.14	20
21	Assistant Administrator	248	256	5,890	23.01	21
22	Other Administrative					22
23	Office Manager	3,468	3,548	81,144	22.87	23
24	Clerical	15,920	16,245	286,754	17.65	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,405	4,492	83,935	18.68	33
34	TOTAL (lines 1 - 33)	296,913	303,042	$ 5,907,507 *	$ 19.49	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	$ 31	01-03	35
36	Medical Director	Monthly	93,840	09-03	36
37	Medical Records Consultant	Monthly	2,800	10-03	37
38	Nurse Consultant	Monthly	55,737	10-03	38
39	Pharmacist Consultant	Monthly	943	10-03	39
40	Physical Therapy Consultant	16	1,129	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	2,280	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,728	11-03	44
45	Social Service Consultant	27	1,635	12-03	45
46	Other(specify) Dementia Care	Per Visit	3,172	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	43	$ 163,295		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	257	$ 12,852	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	150	3,150	10-03	52
53	TOTAL (lines 50 - 52)	407	$ 16,002		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Lindsey	Administrator	0	$ 16,498
Nichole Lockett	Administrator	0	11,084
Stephanie Sandor	Administrator	0	77,205
Ashleigh Henri	Administrator	0	24,102
Kevin O'Hare	Asst. Admin	0	5,890
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,779

B. Administrative - Other

Description	Amount
Yair Zuckerman-Management Fees	$ 2,205
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 2,205

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 27,200
PSD Solutions	Technology Consulting	2,080
Legacy Healthcare Financial	Bookkeeping	240,000
Document Solutions Inc	Compliance Audit	2,372
Creative Technology Solutions	Data Processing	16,630
Health Data Systems	Data Processing	6,854
Prime Care Technologies	Data Processing	1,815
Wescom Solutions	Data Processing	26,658
Telemedicine Solutions, LLC	Data Processing	16,119
National Datacare Corporation	Data Processing	1,510
Paycor	Payroll Processing	31,247
See Supplemental Schedule		106,548
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 479,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 175,119
Unemployment Compensation Insurance	122,384
FICA Taxes	435,248
Employee Health Insurance	199,256
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical Exams	2,760
Other Employee Benefits	34,493
401K Expense	8,002
TOTAL (agree to Schedule V, line 22, col.8)	$ 977,262

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	$ 1,990
Advertising: Employee Recruitment	2,149
Health Care Worker Background Check	
(Indicate # of checks performed 2138)	21,382
Patient Background Checks	
Dues & Subscriptions	19,291
Licenses & Permits	17,789
Allocated from Legacy HC	1,284
Allocated from Progressive HC	106
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,991

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,689
Allocated from Progressive HC	103
Allocated from Legacy HC	1,293
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,085

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/15 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													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/15 **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? **Yes**
If YES, give association name and amount. **ICLTC $21,463**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **60,423** 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. $ **282,749**
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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

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