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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0052787

Facility Name: Warren Barr North Shore

Address: 2773 Skokie Vally Rd (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: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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: 01/01/16 Ending: 12/31/16

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	78,690	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	78,690	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	26,121	4,822	19,662	50,605	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,121	4,822	19,662	50,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.31%

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 16,872

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	452,124	50,192		502,316		502,316		502,316			1
2	Food Purchase		466,698		466,698		466,698	(146)	466,552			2
3	Housekeeping	290,740	58,561	2,519	351,820		351,820	150	351,970			3
4	Laundry	41,398	25,896	98,893	166,187		166,187		166,187			4
5	Heat and Other Utilities			284,716	284,716		284,716	(19,166)	265,550			5
6	Maintenance	116,325	5,540	254,892	376,757		376,757	77,268	454,025			6
7	Other (specify):*											7
8	TOTAL General Services	900,587	606,887	641,020	2,148,494		2,148,494	58,106	2,206,600			8
	B. Health Care and Programs											
9	Medical Director			111,745	111,745		111,745		111,745			9
10	Nursing and Medical Records	4,420,439	113,326	127,156	4,660,921		4,660,921	75,600	4,736,521			10
10a	Therapy	223,012		580	223,592		223,592	(10,579)	213,013			10a
11	Activities	120,040	8,587	864	129,491		129,491		129,491			11
12	Social Services	264,217	41,860	3,385	309,462		309,462	149,520	458,982			12
13	CNA Training											13
14	Program Transportation			81,525	81,525		81,525	9	81,534			14
15	Other (specify):*			6,500	6,500		6,500	18,381	24,881			15
16	TOTAL Health Care and Programs	5,027,708	163,773	331,755	5,523,236		5,523,236	232,931	5,756,167			16
	C. General Administration											
17	Administrative	219,674		9,658	229,332		229,332	(90,608)	138,724			17
18	Directors Fees											18
19	Professional Services			391,362	391,362	(962)	390,400	(223,096)	167,304			19
20	Dues, Fees, Subscriptions & Promotions			163,867	163,867		163,867	(108,005)	55,862			20
21	Clerical & General Office Expenses	639,644	11,910	780,344	1,431,898		1,431,898	(340,975)	1,090,923			21
22	Employee Benefits & Payroll Taxes			1,156,371	1,156,371		1,156,371		1,156,371			22
23	Inservice Training & Education											23
24	Travel and Seminar			47,120	47,120		47,120	2,958	50,078			24
25	Other Admin. Staff Transportation			5,920	5,920		5,920		5,920			25
26	Insurance-Prop.Liab.Malpractice			196,099	196,099		196,099	6,167	202,266			26
27	Other (specify):*							68,652	68,652			27
28	TOTAL General Administration	859,318	11,910	2,750,741	3,621,969	(962)	3,621,007	(684,907)	2,936,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,787,613	782,570	3,723,516	11,293,699	(962)	11,292,737	(393,870)	10,898,867			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: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							838,765	838,765			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,367	71,367		71,367	1,068,440	1,139,807			32
33	Real Estate Taxes			192,000	192,000	962	192,962	2,342	195,304			33
34	Rent-Facility & Grounds			1,527,287	1,527,287		1,527,287	(1,524,872)	2,415			34
35	Rent-Equipment & Vehicles			33,356	33,356		33,356	(18,342)	15,014			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,824,010	1,824,010	962	1,824,972	366,332	2,191,304			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,149,579	2,618,520	3,768,099		3,768,099		3,768,099			39
40	Barber and Beauty Shops			1,172	1,172		1,172		1,172			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			317,938	317,938		317,938		317,938			42
43	Other (specify):*			957,566	957,566		957,566	(957,566)	0			43
44	**TOTAL Special Cost Centers**		1,149,579	3,895,196	5,044,775		5,044,775	(957,566)	4,087,209			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,787,613	1,932,149	9,442,722	18,162,484		18,162,484	(985,104)	17,177,380			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: 01/01/16 Ending: 12/31/16

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	(22,126)	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	835,636	30		9
10	Interest and Other Investment Income	(4,458)	32		10
11	Discounts, Allowances, Rebates & Refunds	(659)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(445)	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	(13,154)	21		18
19	Entertainment	(6,516)	21		19
20	Contributions	(91,547)	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	(331,931)	21		24
25	Fund Raising, Advertising and Promotional	(15,065)	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	(1,199,183)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (849,448)		$	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)	(135,656)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (135,656)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (985,104)		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: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (13,282)	10	1
2	Marketing	(47,833)	43	2
3	Bank Charges	(29,742)	21	3
4	Sequestration	(182,627)	21	4
5	Therapy Discounts	(10,579)	10A	5
6	Non-Allowable Auto Lease	(18,422)	35	6
7	Non-Allowable Legal	(9,906)	19	7
8	PAC Dues	(4,186)	20	8
9	Annual Report	(500)	20	9
10	Non-Allowable Expense	(901,352)	43	10
11	Additional R&M	51,002	06	11
12	Business Cards	(946)	21	12
13	Miscellaneous Income	(15,964)	21	13
14	Building Company - Professional Fees	(6,465)	19	14
15	Media Consultation	(8,381)	43	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,199,183)		49

Warren Barr North Shore

ID# 0052787

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,104)		210		748							(146)	2
3	Housekeeping			150									150	3
4	Laundry													4
5	Heat and Other Utilities	(22,126)		658			2,302						(19,166)	5
6	Maintenance	51,002		8,730		14,957	2,579						77,268	6
7	Other (specify):*													7
8	**TOTAL General Services**	27,772		9,748		15,705	4,881						58,106	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(13,282)				88,882							75,600	10
10a	Therapy	(10,579)											(10,579)	10a
11	Activities													11
12	Social Services					149,520							149,520	12
13	CNA Training													13
14	Program Transportation					9							9	14
15	Other (specify):*					18,381							18,381	15
16	**TOTAL Health Care and Programs**	(23,861)				256,792							232,931	16
	C. General Administration													
17	Administrative			13,570		(104,178)							(90,608)	17
18	Directors Fees													18
19	Professional Services	(16,371)	6,465	(209,154)	89	2,204	1,042	(7,371)					(223,096)	19
20	Fees, Subscriptions & Promotions	(111,298)		2,675		615	4						(108,005)	20
21	Clerical & General Office Expenses	(580,880)		237,641		2,231	33						(340,975)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,777		1,181							2,958	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,533		4,171	463						6,167	26
27	Other (specify):*			51,407		17,244							68,652	27
28	**TOTAL General Administration**	(708,550)	6,465	99,450	89	(76,531)	1,541	(7,371)					(684,907)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(704,638)	6,465	109,198	89	195,966	6,422	(7,371)					(393,870)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	835,636		705	2,424								838,765	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,458)	1,066,850	11	878		5,159						1,068,440	32
33	Real Estate Taxes			1,247			1,095						2,342	33
34	Rent-Facility & Grounds		(1,525,000)	66,050		50	(65,973)						(1,524,872)	34
35	Rent-Equipment & Vehicles	(18,422)		80									(18,342)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	812,756	(458,150)	68,093	3,302	50	(59,719)						366,332	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):*	(957,566)											(957,566)	43
44	**TOTAL Special Cost Centers**	(957,566)											(957,566)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(849,448)	(451,685)	177,291	3,391	196,016	(53,297)	(7,371)					(985,104)	45

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 1,525,000	Half Day Property Holdings LLC	100.00%	$	$ (1,525,000)	1
2	V	32	Interest	292	Half Day Property Holdings LLC	100.00%	1,067,142	1,066,850	2
3	V	19	Professional Fees		Half Day Property Holdings LLC	100.00%	6,465	6,465	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,525,292			$ 1,073,607	$ * (451,685)	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: 01/01/16 Ending: 12/31/16

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	$	Legacy Healthcare Financial Services	100.00%	$ 210	$ 210	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	150	150	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	658	658	17
18	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	6,562	6,562	18
19	V	6	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100.00%	2,168	2,168	19
20	V	17	CFO SALARY		Legacy Healthcare Financial Services	100.00%	13,570	13,570	20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	30,846	30,846	21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	2,675	2,675	22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	205,811	205,811	23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	31,830	31,830	24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,777	1,777	25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,533	1,533	26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	51,407	51,407	27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	705	705	28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	11	11	29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	1,247	1,247	30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	65,973	65,973	31
32	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	77	77	32
33	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	80	80	33
34	V								34
35	V	17	MANAGEMENT FEES	9,658	Legacy Healthcare Financial Services	100.00%		(9,658)	35
36	V	19	BOOKKEEPING FEES	240,000	Legacy Healthcare Financial Services	100.00%		(240,000)	36
37	V	17	MANAGEMENT FEES - YAIR ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	9,658	9,658	37
38	V								38
39	Total			$ 249,658			$ 426,949	$ * 177,291	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: 01/01/16 Ending: 12/31/16

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	19	PROFESSIONAL FEES	$	Legacy Real Properties	100.00%	$ 89	$ 89	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	2,424	2,424	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	878	878	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			$			$ 3,391	$ * 3,391	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: 01/01/16 Ending: 12/31/16

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%	$ 748	$ 748	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	14,443	14,443	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	514	514	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	200	200	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	143,699	143,699	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	180	180	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	2,608	2,608	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	146,732	146,732	22
23	V	14	PATIENT TRANSPORTATION		Progressive Healthcare Consulting	100.00%	9	9	23
24	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	21,513	21,513	24
25	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	150,951	150,951	25
26	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	2,204	2,204	26
27	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	615	615	27
28	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	2,231	2,231	28
29	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	1,181	1,181	29
30	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	44,566	44,566	30
31	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	4,171	4,171	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	50	50	32
33	V								33
34	V	10	NURSING	55,017	Progressive Healthcare Consulting	100.00%		(55,017)	34
35	V	17	ADMINISTRATIVE	255,129	Progressive Healthcare Consulting	100.00%		(255,129)	35
36	V	15	PAYROLL TAXES - NURSING	3,132	Progressive Healthcare Consulting	100.00%		(3,132)	36
37	V	27	PAYROLL TAXES - NON-NURSING	27,322	Progressive Healthcare Consulting	100.00%		(27,322)	37
38	V								38
39	Total			$ 340,600			$ 536,616	$ * 196,016	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: 01/01/16 Ending: 12/31/16

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	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 2,302	$ 2,302	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,579	2,579	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	1,042	1,042	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	4	4	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	33	33	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	463	463	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	5,159	5,159	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	1,095	1,095	22
23	V								23
24	V	34	RENT	65,973	CF ST. LOUIS, LLC	100.00%		(65,973)	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			$ 65,973			$ 12,676	$ * (53,297)	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: 01/01/16 Ending: 12/31/16

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	19	Payroll Services	$ 30,715	ProPay HR LLC	24.00%	$ 23,344	$ (7,371)	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			$ 30,715			$ 23,344	$ * (7,371)	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	31.65%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	HALF DAY PROPERTY HOLDINGS LLC		BUILDING CO	1
2	MENACHEM SHABAT	31.65%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3	THE RAJCHENBACH FAMILY TRUST	11.65%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	3
4	RONALD SHABAT	5.06%	ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5	YAIR ZUCKERMAN	10.00%	EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6	ROSS BOTTNER	10.00%	GROVE OF FOX VALLEY	AURORA	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	9
10			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE	CF ST. LOUIS	SKOKIE	BUILDING CO	11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			CHALET SKILLED NURSING FACILITY LLC	CHICAGO				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			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT				20
21			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				21
22			CLARK SKILLED NURSING FACILITY	CHICAGO				22
23			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				23
24			AZRIA MONTCLAIR	OMAHA, NE				24
25			AZRIA OLATHE	OLATHE, KS				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yair Zuckerman	Owner	Administrative	10.00%	See Attached	2.41	4.82%	Mgmt Fees	$ 9,658	17-3	1
2	Ross Bottner	Owner	Administrative	10.00%	See Attached	1.93	4.83%	Alloc Salary	9,658	17-7	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	$ 19,316		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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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

	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	1,629,488	29	$ 4,354	$	78,690	$ 210	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,629,488	29	3,107		78,690	150	2
3	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	13,622		78,690	658	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	135,883		78,690	6,562	4
5	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,629,488	29	44,897	44,897	78,690	2,168	5
6	17	CFO SALARY	AVAIL. BED DAYS	1,629,488	29	281,003	281,003	78,690	13,570	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	638,760		78,690	30,846	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	55,387		78,690	2,675	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,629,488	29	4,261,866	4,261,866	78,690	205,811	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,629,488	29	659,124		78,690	31,830	10
11	24	SEMINARS	AVAIL. BED DAYS	1,629,488	29	36,800		78,690	1,777	11
12	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	31,752		78,690	1,533	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,629,488	29	1,064,526		78,690	51,407	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	14,600		78,690	705	14
15	32	INTEREST	AVAIL. BED DAYS	1,629,488	29	234		78,690	11	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	25,813		78,690	1,247	16
17	34	RENT	AVAIL. BED DAYS	1,629,488	29	1,366,146		78,690	65,973	17
18	34	STORAGE	AVAIL. BED DAYS	1,629,488	29	1,600		78,690	77	18
19	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,629,488	29	1,654		78,690	80	19
20										20
21	17	MANAGEMENT FEES- Y. ZUC	AVG HOURS WKD	50	29	200,000		3	9,658	21
22										22
23										23
24										24
25	TOTALS					$ 8,841,129	$ 4,587,766		$ 426,949	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	$ 1,852	$	78,690	$ 89	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	50,196		78,690	2,424	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	18,179		78,690	878	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					$ 70,227	$		$ 3,391	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	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	21	$ 11,123	$	78,475	$ 748	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	21	214,912	214,912	78,475	14,443	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	21	7,646		78,475	514	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	21	2,971		78,475	200	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	21	2,138,189	2,138,189	78,475	143,699	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	21	2,679		78,475	180	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	21	38,812	38,812	78,475	2,608	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	21	2,183,313	2,183,313	78,475	146,732	8
9	14	PATIENT TRANSPORTATION	AVAIL. BED DAYS	1,167,679	21	128		78,475	9	9
10	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	21	320,111		78,475	21,513	10
11	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	21	2,246,090	2,246,090	78,475	150,951	11
12	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	21	32,793		78,475	2,204	12
13	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	21	9,154		78,475	615	13
14	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	21	33,203		78,475	2,231	14
15	24	SEMINARS	AVAIL. BED DAYS	1,167,679	21	17,580		78,475	1,181	15
16	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,167,679	21	663,131		78,475	44,566	16
17	26	INSURANCE	AVAIL. BED DAYS	1,167,679	21	62,063		78,475	4,171	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,167,679	21	750		78,475	50	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,984,649	$ 6,821,317		$ 536,616	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1 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	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	$ 47,675	$	78,690	$ 2,302	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	53,400		78,690	2,579	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	21,572		78,690	1,042	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	76		78,690	4	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,629,488	29	678		78,690	33	5
6	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	9,585		78,690	463	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	106,824		78,690	5,159	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	22,674		78,690	1,095	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					$ 262,484	$		$ 12,676	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: ProPay HR LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, IL 60202
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	19	Payroll Services	Direct			$	$		$ 23,344	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 23,344	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor		X	Mortgage			$	$ 12,074,957			$ 701,909	1
2	Member Loan		X	Member Loan Payable				2,018,093				2
3	Note Payable		X	Seller Note Payable				3,800,000			285,025	3
4												4
5					-							5
	Working Capital											
6	The Private Bank		X	Line of Credit				1,696,368			71,367	6
7	CapEx		X	Line of Credit				1,426,581			80,208	7
8	See Supplemental Schedule				-						6,048	8
9	TOTAL Facility Related						$	$ 21,015,998			$ 1,144,557	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,458)	10
11	Interest Income - Bldg Co		X								(292)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (4,750)	14
15	TOTALS (line 9+line14)						$	$ 21,015,998			$ 1,139,807	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: 01/01/16 Ending: 12/31/16

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	Allocated from Legacy HC	X					$	$			$ 11	8
9	Alloc from Legacy Real Propert	X									878	9
10	Allocated from CF St. Louis	X									5,159	10
11												11
12												12
13												13
14	TOTAL Working Capital										6,048	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	180,261	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.)	$	156,219	2
3. Under or (over) accrual (line 2 minus line 1).	$	(24,042)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	218,384	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.)**	$	962	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	195,304	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	137,878	8
	2012	131,644	9
	2013	135,169	10
	2014	139,473	11
	2015	153,877	12

Beginning Accrual Adjusted
2016 Accrual: $153,877 x 1.42 = $218,384 (Rounded)
Allocated from Legacy HC: $1,247
Allocated from CF St. Louis, LLC: $1,095

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 153,877.32	$ 153,877.32
2.	10-35-104-076-0000	Home Office Allocation	$ 40,927.41	$ 1,976.44
3.	10-23-406-034-0000	Home Office Allocation	$ 440,762.19	$ 6,462.56
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 635,566.92	$ 162,316.32

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Facility			$ 1,508,714	1
2	Allocated from Legacy Real Properties			3,951	2
3	TOTALS			$ 1,512,665	3

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 16,827,972	$	35	$ 480,799	$ 480,799	$ 1,279,540	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
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21											21
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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: 01/01/16 Ending: 12/31/16

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
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		111,394	1,771		5,008	3,237	20,687	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 16,939,366	$ 1,771		$ 485,807	$ 484,036	$ 1,300,227	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: 01/01/16 Ending: 12/31/16

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		$ 16,939,366	$ 1,771		$ 485,807	$ 484,036	$ 1,300,227	1
2	Landscaping	2014	13,184		20	659	659	1,373	2
3	Bedside Sconces	2014	21,285		20	1,064	1,064	2,128	3
4	Sprinkler System	2015	13,275		20	664	664	1,328	4
5	Light Fixtures And Wall Sconce - 2Nd & 3Rd Floor	2015	23,309		20	1,165	1,165	2,331	5
6	Installed Pressure Backflow In Laundry Room	2015	6,120		20	306	306	612	6
7	Signs For Bathroom/Exits/Corridors	2015	12,917		20	646	646	1,292	7
8	Repaired Sprinkler System Valves	2015	3,125		20	156	156	313	8
9	2Nd-3Rd Fl Carpentry/Flooring/Painting/Nurse Call/Electrical/Do	2015	2,127,551		20	106,378	106,378	225,554	9
10	Repaired Sprinkler System Valves	2015	3,125		20	156	156	313	10
11	Signage For Facility	2015	22,681		20	1,134	1,134	2,268	11
12	Installed Elevator Signage	2015	5,421		20	271	271	542	12
13	Bathroom Glass Mount Bracket	2015	2,692		20	135	135	269	13
14	Security System	2015	47,800		20	2,390	2,390	4,780	14
15	Chiller Replacement	2015	42,969		20	2,148	2,148	4,297	15
16	Pump Replacment	2015	3,298		20	165	165	330	16
17	Installed New Fan Coil In Resid Rms	2015	3,448		20	172	172	345	17
18	Security System	2015	14,936		20	747	747	1,494	18
19	Repaired Chiller	2015	6,340		20	317	317	634	19
20	Pump Replacement In Kitchen	2015	2,863		20	143	143	286	20
21	Repaired Condensing Unit	2015	4,130		20	207	207	413	21
22	Repaired Elevator	2015	8,700		20	435	435	870	22
23	Chandelier And Lights	2015	13,542		20	1,354	1,354	2,708	23
24	Heating Pump Repair	2015	3,334		20	167	167	334	24
25	Install Ventilation System In Tv Receiver Room	2015	3,975		20	199	199	398	25
26	Walk In Cooler Repair	2015	5,520		20	276	276	552	26
27	Repaired Roof	2016	86,630		20	4,332	4,332	4,332	27
28	Repaired Or Replaced Screen Windows On Building	2016	11,016		20	551	551	551	28
29	Replaced 1515 Sq Ft Of Sidewalk/Curb/Gutter/Electric Box	2016	19,588		20	979	979	979	29
30	1St Floor Stairwell & Elevator - Installed 2 Power Transfer Hinge	2016	2,815		20	141	141	141	30
31	Installed Fire Alarm System Devices/Repaired Valves	2016	5,762		20	288	288	288	31
32	Elevator Pit Ladder Repair	2016	2,768		20	138	138	138	32
33	Installed New Fan Motors And Blower Wheels For Heating Unit	2016	3,161		20	158	158	158	33
34	TOTAL (lines 1 thru 33)		$ 19,486,646	$ 1,771		$ 613,848	$ 612,077	$ 1,562,577	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: 01/01/16 Ending: 12/31/16

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		$ 19,486,646	$ 1,771		$ 613,848	$ 612,077	$ 1,562,577	1
2	Boiler Room - Removed Existing Tempering Valve Station	2016	7,992		20	400	400	400	2
3	Fire Rated Fixture Protectors	2016	10,989		20	549	549	549	3
4	2Nd And 3Rd Floor Lounge - New Counter And Filing Cabinets	2016	4,275		20	214	214	214	4
5	Repaired Pump And Gasket	2016	4,341		20	217	217	217	5
6	Installed New Fence	2016	3,269		20	163	163	163	6
7	Parking Lot - Expanded 10-15 Spaces/Placed New Light Pole/Desi	2016	17,730		20	887	887	887	7
8	Dialysis Area - Demolished Office/Storage Areas/Pipes/Hvac/Idph	2016	46,912		20	2,346	2,346	2,346	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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)		$ 19,582,153	$ 1,771		$ 618,624	$ 616,853	$ 1,567,352	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: 01/01/16 Ending: 12/31/16

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		$ 19,582,153	$ 1,771		$ 618,624	$ 616,853	$ 1,567,352	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)		$ 19,582,153	$ 1,771		$ 618,624	$ 616,853	$ 1,567,352	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: 01/01/16 Ending: 12/31/16

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		$ 19,582,153	$ 1,771		$ 618,624	$ 616,853	$ 1,567,352	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)		$ 19,582,153	$ 1,771		$ 618,624	$ 616,853	$ 1,567,352	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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: 01/01/16 Ending: 12/31/16

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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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: 01/01/16 Ending: 12/31/16

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	30,610	1,136	30	1,020	(116)	7,653	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Healthcare & Financial Services	2012	1,377	30	20	69	39	344	9
10	Allocated from Legacy Healthcare & Financial Services	2013	4,404	96	20	220	124	881	10
11	Allocated from Legacy Healthcare & Financial Services	2014	430	9	20	22	13	64	11
12	Allocated from Legacy Healthcare & Financial Services	2015	593	13	20	30	17	59	12
13									13
14	Allocated from Legacy Real Properties	2009	17,383	281	20	869	588	5,867	14
15	Allocated from Legacy Real Properties	2010	5,286	85	20	212	127	1,375	15
16	Allocated from Legacy Real Properties	2011	7,513	121	20	376	255	2,254	16
17									17
18	Allocated from CF St. Louis LLC	2016	43,798		20	2,190	2,190	2,190	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)		$ 111,394	$ 1,771		$ 5,008	$ 3,237	$ 20,687	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: 01/01/16 Ending: 12/31/16

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		$ 111,394	$ 1,771		$ 5,008	$ 3,237	$ 20,687	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)		$ 111,394	$ 1,771		$ 5,008	$ 3,237	$ 20,687	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,967,339	$ 1,219	$ 207,151	$ 205,932	10	$ 543,307	71
72	Current Year Purchases	129,897	138	12,989	12,851	10	12,989	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,097,236	$ 1,357	$ 220,141	$ 218,784		$ 556,297	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)	$ 23,192,054	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,128	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 838,764	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 835,636	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,123,649	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	Construction in Progress	$ 14,276	92
93			93
94			94
95		$ 14,276	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: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				2,287			5
6	Allocated from Legacy HC and Progressive HC				127			6
7	TOTAL				$ 2,414 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 15,014 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$ -	$	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: 01/01/16 Ending: 12/31/16

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.

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	$		$ 925,912	$		$ 925,912	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			175,422			175,422	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,105,828			1,105,828	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				893,443		893,443	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					411,358	256,136		667,494	13
14	TOTAL			$		$ 2,618,520	$ 1,149,579		$ 3,768,099	14

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

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,396,257	$ 1,630,963	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,264,551	2,264,551	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,159	151,159	6
7	Other Prepaid Expenses	195,646	309,646	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	198,452	198,452	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,206,065	$ 4,554,771	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	2,737,923	2,776,941	15
16	Equipment, at Historical Cost	1,519,258	2,143,554	16
17	Accumulated Depreciation (book methods)	(332,469)	(1,248,785)	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): See Attached Schedule	149,010	4,024,880	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,073,722	$ 23,183,276	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,279,787	$ 27,738,047	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,296,120	$ 3,296,120	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,696,368	3,122,949	29
30	Accrued Salaries Payable	412,936	412,936	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,695	21,695	31
32	Accrued Real Estate Taxes(Sch.IX-B)		218,384	32
33	Accrued Interest Payable		139,857	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	948,137	1,373,631	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,375,256	$ 8,585,572	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,018,093	39
40	Mortgage Payable		15,874,957	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,691,131	2,691,131	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,691,131	$ 20,584,181	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,066,387	$ 29,169,753	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (786,600)	$ (1,431,706)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,279,787	$ 27,738,047	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (830,149)	1
2	Restatements (describe):		2
3	**PY Depreciation**	(5,705)	3
4	**PY Advertising/Contributions**	(38,886)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (874,740)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	88,140	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)**	$ 88,140	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)**	$ (786,600)	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	$ 18,300,560	1
2	Discounts and Allowances for all Levels	(11,175,055)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,125,505	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,947,523	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,947,523	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	902,167	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	193,255	19
20	Radiology and X-Ray	26,435	20
21	Other Medical Services	24,079	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,145,936	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,458	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,458	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	27,202	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,202	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,250,624	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,148,494	31
32	Health Care	5,523,236	32
33	General Administration	3,621,969	33
	B. Capital Expense		
34	Ownership	1,824,010	34
	C. Ancillary Expense		
35	Special Cost Centers	4,726,837	35
36	Provider Participation Fee	317,938	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,162,484	40
41	**Income before Income Taxes (line 30 minus line 40)****	88,140	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 88,140	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Various	7,116,024	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,116,024	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	1,892	2,056	$ 122,867	$ 59.76	1
2	Assistant Director of Nursing	1,535	1,669	78,917	47.28	2
3	Registered Nurses	40,750	44,293	1,517,556	34.26	3
4	Licensed Practical Nurses	33,438	36,346	1,016,674	27.97	4
5	CNAs & Orderlies	108,359	117,781	1,654,398	14.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,695	14,885	223,012	14.98	8
9	Activity Director	1,887	2,051	39,509	19.26	9
10	Activity Assistants	5,720	6,217	80,531	12.95	10
11	Social Service Workers	9,955	10,820	264,217	24.42	11
12	Dietician					12
13	Food Service Supervisor	1,065	1,158	28,391	24.52	13
14	Head Cook	9,338	10,150	147,605	14.54	14
15	Cook Helpers/Assistants	22,097	24,019	276,128	11.50	15
16	Dishwashers					16
17	Maintenance Workers	4,314	4,689	116,325	24.81	17
18	Housekeepers	21,432	23,296	290,740	12.48	18
19	Laundry	2,847	3,095	41,398	13.38	19
20	Administrator	3,731	4,056	185,577	45.75	20
21	Assistant Administrator	1,339	1,455	34,097	23.43	21
22	Other Administrative					22
23	Office Manager	1,769	1,923	47,082	24.48	23
24	Clerical	36,353	39,514	592,562	15.00	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	882	959	11,849	12.36	31
32	Other Health Care(specify)					32
33	Other(specify)	972	1,056	18,178	17.21	33
34	TOTAL (lines 1 - 33)	323,370	351,488	$ 6,787,613 *	$ 19.31	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		$		35
36	Medical Director	Monthly	111,745	09-03	36
37	Medical Records Consultant	Monthly	1,200	10-03	37
38	Nurse Consultant	Monthly	104,910	10-03	38
39	Pharmacist Consultant	Monthly	18,495	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	580	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	864	11-03	44
45	Social Service Consultant	55	3,385	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	1,235	10-03	47
48					48
49	TOTAL (lines 35 - 48)	55	$ 242,414		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	23	$ 1,156	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8	160	10-03	52
53	TOTAL (lines 50 - 52)	31	$ 1,316		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yitzchak Freund	Administrator	0.00%	$ 59,941
Saman Gabay	Administrator	0.00%	45,388
John Lindsey	Administrator	0.00%	11,400
Nichole Lockett	Administrator	0.00%	35,570
Ashley Wilson	Administrator	0.00%	33,278
Arielle Lewis	Assistant Admin	0.00%	4,185
See Supplemental Schedule			29,912
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 219,674

B. Administrative - Other

Description	Amount
Management Fees - Yair Zuckerman	$ 9,658
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 9,658

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 35,647
Achieve Accreditation	Joint Commission Consult	7,043
IL Rytes Corporation	Compliance	9,074
Ilona Zwierski	Design Consultant	6,928
Lexis Nexis	Data Processing	4,298
MTS Consulting	WTOC Services	1,551
ProPay HR LLC	Payroll Services	30,715
Personnel Planners	Unemployment Tax Consult	2,250
Legacy Healthcare	Bookkeeping	240,000
Documentation Solutions	Compliance Audit	9,466
See Atached	Legal	39,190
See Supplemental Schedule		5,199
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 391,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 194,299
Unemployment Compensation Insurance	116,786
FICA Taxes	519,252
Employee Health Insurance	270,611
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	13,879
Employee Physical Exams	10,407
Other Employee Benefits	31,135
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,156,369

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	8,065
(Indicate # of checks performed 807)	
Patient Background Checks	
Dues and Subscriptions	26,744
License and Permits	13,779
Allocated from Legacy HC	2,675
Allocated from Progressive HC	615
Allocated from CF St. Louis LLC	4
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,862

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	47,120
Allocated from Legacy HC	1,777
Allocated from Progressive HC	1,181
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50,078

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **IL Council on LTC $12,686**

(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. $ **48,095** 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. $ **317,938**
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