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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053892

Facility Name: Warren Barr Lincoln Park

Address: 2732 North Hampden Court (Number) Chicago (City) 60614 (Zip Code)

County: Cook

Telephone Number: (773) 248-6000 **Fax #** (773) 248-9703

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2008

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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	18,038	2,774	8,318	29,130	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,038	2,774	8,318	29,130	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.22%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 9/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 109 and days of care provided 7,092

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	244,670	19,645		264,315		264,315		264,315			1
2	Food Purchase		209,780		209,780		209,780	(31,137)	178,643			2
3	Housekeeping	147,594	27,292	144	175,030		175,030	145	175,175			3
4	Laundry		20,654	84,679	105,333		105,333	4	105,337			4
5	Heat and Other Utilities			90,760	90,760		90,760	(6,469)	84,291			5
6	Maintenance	43,896	7,399	153,326	204,621		204,621	46,405	251,026			6
7	Other (specify):*											7
8	**TOTAL General Services**	436,160	284,770	328,909	1,049,839		1,049,839	8,947	1,058,786			8
	B. Health Care and Programs											
9	Medical Director			26,400	26,400		26,400	445	26,845			9
10	Nursing and Medical Records	2,294,504	92,736	33,670	2,420,910		2,420,910	69,946	2,490,856			10
10a	Therapy	146,733	3,450		150,183		150,183	(3,450)	146,733			10a
11	Activities	109,455	7,812	192	117,459		117,459	3,379	120,838			11
12	Social Services	109,858		5,158	115,016		115,016	1,214	116,230			12
13	CNA Training											13
14	Program Transportation			46,607	46,607		46,607		46,607			14
15	Other (specify):*							11,598	11,598			15
16	**TOTAL Health Care and Programs**	2,660,550	103,998	112,027	2,876,575		2,876,575	83,132	2,959,707			16
	C. General Administration											
17	Administrative	46,572			46,572		46,572	116,207	162,779			17
18	Directors Fees											18
19	Professional Services			97,935	97,935	(155)	97,780	(6,130)	91,650			19
20	Dues, Fees, Subscriptions & Promotions			61,320	61,320		61,320	(27,744)	33,576			20
21	Clerical & General Office Expenses	155,601	4,878	384,884	545,363		545,363	(153,123)	392,240			21
22	Employee Benefits & Payroll Taxes			554,392	554,392		554,392		554,392			22
23	Inservice Training & Education											23
24	Travel and Seminar			768	768		768	1,340	2,108			24
25	Other Admin. Staff Transportation			15,197	15,197		15,197		15,197			25
26	Insurance-Prop.Liab.Malpractice			115,183	115,183		115,183	2,471	117,654			26
27	Other (specify):*							48,638	48,638			27
28	**TOTAL General Administration**	202,173	4,878	1,229,679	1,436,730	(155)	1,436,575	(18,341)	1,418,234			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,298,883	393,646	1,670,615	5,363,144	(155)	5,362,989	73,738	5,436,727			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 Lincoln Park #0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			97,943	97,943		97,943	92,014	189,957			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,097	54,097		54,097	823,199	877,296			32
33	Real Estate Taxes			174,000	174,000	155	174,155	3,129	177,284			33
34	Rent-Facility & Grounds			1,688,195	1,688,195		1,688,195	(1,668,942)	19,253			34
35	Rent-Equipment & Vehicles			14,225	14,225		14,225	(1,762)	12,463			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,028,460	2,028,460	155	2,028,615	(752,363)	1,276,252			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		469,321	1,022,414	1,491,735		1,491,735		1,491,735			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,017	185,017		185,017		185,017			42
43	Other (specify):*			457,482	457,482		457,482	(457,482)				43
44	**TOTAL Special Cost Centers**		469,321	1,664,913	2,134,234		2,134,234	(457,482)	1,676,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,298,883	862,967	5,363,988	9,525,838		9,525,838	(1,136,107)	8,389,731			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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	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	(7,314)	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	91,453	30		9
10	Interest and Other Investment Income	(4,053)	32		10
11	Discounts, Allowances, Rebates & Refunds	(30,984)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(197)	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	(3,588)	21		18
19	Entertainment	(3,369)	21		19
20	Contributions	(2,650)	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	(190,531)	21		24
25	Fund Raising, Advertising and Promotional	(20,531)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,800)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,008,537)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,183,101)		$	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)	46,995		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 46,995		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,136,106)		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 Lincoln Park

ID# 0053892

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (4,358)	10	1
2	Sequestration	(87,458)	21	2
3	Therapy Discount	(3,450)	10A	3
4	Non-allowable Auto Lease	(4,840)	35	4
5	PAC Dues	(5,280)	20	5
6	Non-Allowable Legal	(14,212)	19	6
7	Capitalized R&M	(4,047)	06	7
8	Building Co - Accounting	(2,884)	19	8
9	Building Co - Legal	(9,297)	19	9
10	Building Co - Professional Fees - Loan	(49,647)	19	10
11	Additional R&M	16,960	06	11
12	Misc Income	(1,163)	21	12
13	Bank Charges	(7,241)	21	13
14	Bldg Co - Tax extension fee	(3,500)	21	14
15	Bldg Co - Title Fees	(11,877)	21	15
16	Bldg Co - Property Management Fees	(358,763)	17	16
17	Non-Allowable Expense	(457,482)	43	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**	(1,008,537)		49

Warren Barr Lincoln Park

ID# 0053892

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Lincoln Park **#** 0053892 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(31,181)		32	12								(31,137)	2
3	Housekeeping			145									145	3
4	Laundry			4									4	4
5	Heat and Other Utilities	(7,314)				845							(6,469)	5
6	Maintenance	12,913		1,956	30,467	1,068							46,405	6
7	Other (specify):*													7
8	**TOTAL General Services**	(25,582)		2,137	30,479	1,913							8,947	8
	B. Health Care and Programs													
9	Medical Director			445									445	9
10	Nursing and Medical Records	(4,358)		28	74,629		(352)						69,946	10
10a	Therapy	(3,450)											(3,450)	10a
11	Activities			3,367	13								3,379	11
12	Social Services			53	1,160								1,214	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				11,598								11,598	15
16	**TOTAL Health Care and Programs**	(7,808)		3,892	87,400		(352)						83,132	16
	C. General Administration													
17	Administrative	(358,763)	358,763	15,304	100,903								116,207	17
18	Directors Fees													18
19	Professional Services	(76,040)	61,828	10,397	255	212			(2,782)				(6,130)	19
20	Fees, Subscriptions & Promotions	(28,461)		591	124	2							(27,744)	20
21	Clerical & General Office Expenses	(311,526)	15,377	121,411	21,614	1							(153,123)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			781	559								1,340	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			655	1,597	219							2,471	26
27	Other (specify):*			24,913	23,725								48,638	27
28	**TOTAL General Administration**	(774,790)	435,967	174,053	148,777	434			(2,782)				(18,341)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(808,180)	435,967	180,082	266,656	2,347	(352)		(2,782)				73,738	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Warren Barr Lincoln Park** **# 0053892** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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	91,453			561								92,014	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,053)	823,422	12		3,817							823,199	32
33	Real Estate Taxes					3,129							3,129	33
34	Rent-Facility & Grounds		(1,669,049)	30,294	43	(30,231)							(1,668,942)	34
35	Rent-Equipment & Vehicles	(4,840)		2,218	859								(1,762)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	82,560	(845,627)	32,525	1,463	(23,285)							(752,363)	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):*	(457,482)											(457,482)	43
44	**TOTAL Special Cost Centers**	(457,482)											(457,482)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,183,101)	(409,660)	212,607	268,119	(20,938)	(352)		(2,782)				(1,136,107)	45

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,669,049	Lincoln Park PropCo	100.00%	$	$ (1,669,049)	1
2	V	21	Tax extension fee		Lincoln Park PropCo	100.00%	3,500	3,500	2
3	V	21	Title Fees		Lincoln Park PropCo	100.00%	11,877	11,877	3
4	V	19	Professional Fees - Accounting		Lincoln Park PropCo	100.00%	2,884	2,884	4
5	V	19	Professional Fees - Legal		Lincoln Park PropCo	100.00%	9,297	9,297	5
6	V	19	Professional Fees - Loan		Lincoln Park PropCo	100.00%	49,647	49,647	6
7	V	17	Property Management Fees		Lincoln Park PropCo	100.00%	358,763	358,763	7
8	V	32	Interest Expense - Mortgage A		Lincoln Park PropCo	100.00%	823,422	823,422	8
9	V					100.00%			9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,669,049			$ 1,259,389	$ * (409,660)	14

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 32	$ 32	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	145	145	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	4	4	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	8	8	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	1,948	1,948	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	445	445	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	28	28	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	3,367	3,367	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	53	53	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	15,304	15,304	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	10,397	10,397	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	591	591	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	118,147	118,147	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	3,265	3,265	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	781	781	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	655	655	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	24,913	24,913	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	12	12	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	30,231	30,231	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	63	63	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	15	15	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	2,203	2,203	36
37	V								37
38	V								38
39	Total			$			$ 212,607	$ * 212,607	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 12	$ 12	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	30,377	30,377	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	91	91	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	74,629	74,629	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	13	13	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,158	1,158	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	3	3	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	11,598	11,598	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	100,903	100,903	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	255	255	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	124	124	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	21,386	21,386	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	228	228	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	559	559	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	23,725	23,725	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	1,597	1,597	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	561	561	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	43	43	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	859	859	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 268,119	$ * 268,119	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 845	$ 845	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,068	1,068	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	212	212	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	219	219	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	3,817	3,817	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	3,129	3,129	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	30,231	CF ST. LOUIS, LLC	100.00%		(30,231)	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			$ 30,231			$ 9,293	$ * (20,938)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	10	Medical Supplies	$ 7,499	ReMed Services		$ 7,147	$ (352)	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			$ 7,499			$ 7,147	$ * (352)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	06	Maintenance	$ 13,200	ML Group Design and Development		$ 13,200	$	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			$ 13,200			$ 13,200	$ *	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 11,592	ProPay	24.00%	$ 8,810	$ (2,782)	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			$ 11,592			$ 8,810	$ * (2,782)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLN PARK PROPCO	CHICAGO	BUILDING CO	1
2	Doros Generation Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	PROPAY HR LLC	EVANSTON	PAYROLL PROCESSING	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	10
11			CLARK SKILLED NURSING FACILITY	CHICAGO				11
12			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				12
13			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				13
14			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				14
15			GROVE OF FOX VALLEY	AURORA				15
16			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				16
17			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				18
19			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				19
20			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				20
21			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				21
22			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				22
23			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				23
24			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27			WARREN BARR LIVING AND REHAB	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,789,215	30	$ 1,460	$	39,785	$ 32	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		39,785	145	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		39,785	4	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		39,785	8	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		39,785	1,948	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		39,785	445	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		39,785	28	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		39,785	3,367	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		39,785	53	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	39,785	15,304	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		39,785	10,397	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		39,785	591	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	39,785	118,147	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		39,785	3,265	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		39,785	781	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		39,785	655	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		39,785	24,913	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		39,785	12	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		39,785	30,231	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		39,785	63	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		39,785	15	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		39,785	2,203	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 212,607	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,374,590	21	$ 432	$	39,785	$ 12	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	39,785	30,377	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		39,785	91	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	39,785	74,629	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		39,785	13	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		39,785	1,158	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		39,785	3	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		39,785	11,598	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	39,785	100,903	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		39,785	255	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		39,785	124	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	39,785	21,386	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		39,785	228	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		39,785	559	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		39,785	23,725	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		39,785	1,597	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		39,785	561	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		39,785	43	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		39,785	859	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 268,119	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,789,215	30	$ 37,998	$	39,785	$ 845	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		39,785	1,068	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		39,785	212	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		39,785	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		39,785	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		39,785	219	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		39,785	3,817	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		39,785	3,129	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					$ 417,927	$		$ 9,293	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Remed Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
Fax Number: (

	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	10	Medical Supplies	Direct			$	$		$ 7,147	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					$	$		$ 7,147	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Desing and Development
Street Address: 3424 Oakton Street
City / State / Zip Code: Skokie, IL
Phone Number: (847) 676-5300
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	6	Maintenance	Direct			$	$		$ 13,200	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					$	$		$ 13,200	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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 St
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				$	$		$ 8,810	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 8,810	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	10 Pack Tenant		X	Note Payable			$	$ 891,983			$ 54,097	1
2	Mortgage		X	Mortgage				15,176,439			823,422	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 16,068,422			$ 877,519	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,053)	10
11	Allocated from Legacy HC Financial		X								12	11
12	Allocated from CF. St. Louis, LLC		X								3,817	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (224)	14
15	TOTALS (line 9+line14)						$	$ 16,068,422			$ 877,295	15

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

* 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 Lincoln Park # 0053892 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	181,738	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.)	$	192,312	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,574	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	166,555	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.)**	$	155	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.	$	177,284	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	136,539	8
	2013	135,199	9
	2014	141,174	10
	2015	173,085	11
	2016	189,183	12

2017 Accrual = $189,183 x 0.88 = $166,555
Alocated from CF. St. Louis, LLC $3,129
Beginning accrual adjusted

FOR BHF USE ONLY

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

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincoln Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053892

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-308-008-0000	Long Term Care Property	$ 189,182.81	$ 189,182.81
2.	Allocated from CF. St. Louis, LLC	Home Office	$ 463,439.48	$ 3,128.83
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 652,622.29	$ 192,311.64

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincoln Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053892

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,325 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from CF. St. Louis, LLC			$ 14,453	1
2					2
3	TOTALS			$ 14,453	3

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	34,490		20	1,725	1,725	17,245	9
10	Various			2009	579,416		20	32,715	32,715	294,431	10
11	Various			2010	36,209		20	1,810	1,810	14,484	11
12	Various			2011	116,529		20	5,826	5,826	40,785	12
13	Various			2012	71,395		20	3,570	3,570	21,419	13
14	Various			2013	80,916		20	4,046	4,046	20,229	14
15											15
16											16
17											17
18											18
19											19
20											20
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22											22
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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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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
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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)		173,742			8,180	8,180	16,191	68
69	Financial Statement Depreciation			97,943			(97,943)		69
70	TOTAL (lines 4 thru 69)		$ 1,092,697	$ 97,943		$ 57,872	$ (40,072)	$ 424,783	70

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 1,092,697	$ 97,943		$ 57,872	$ (40,072)	$ 424,783	1
2	New Hvac Outdoor Units (Roof) Indoor Units (Patient Rooms)	2014	85,999		20	4,300	4,300	12,900	2
3	Install New Fire Rated Door, 10 Computer Kiosks, Er Lights	2014	5,750		20	288	288	863	3
4	(Kiosks/Er Lights Through Facility & Door On 1St Floor Pump R	2014			20				4
5	Addition To Nurse Call System - 2Nd Floor	2014	4,353		20	218	218	653	5
6	Remove Drop Ceiling & New Soffets On 2Nd, 3Rd, 4Th Floor	2014	14,700		20	735	735	2,205	6
7	Wallcoverings - Cafeteria	2014	9,315		20	466	466	1,397	7
8	Electrical Work - Outside Wall By Parking Lot	2014	8,891		20	445	445	1,334	8
9	4Th Floor Studie/Visual Nurse Call System Upgrade	2014	9,411		20	471	471	1,412	9
10	Retro Fit 4Th Floor Sprinkler System	2014	74,084		20	3,704	3,704	11,113	10
11	Wireless Network Addition For Kiosks-Throughout Facility	2014	28,833		20	1,442	1,442	4,325	11
12	Replacing Electrical Fixtures And Exit Signage, Concealing Exisiti	2015	15,800		20	790	790	2,370	12
13	Sprinkler And Fa Systems, Providing New Soffits And Atc	2015			20				13
14	Upgrading Hydaulic Calcs, Piping And Heads On 2Nd, 3Rd, & 4T	2015			20				14
15	Preparing Design, Construction Documents, And Permit For 1St F	2015	10,120		20	506	506	1,518	15
16	Physical Therapy Center	2015			20				16
17	Demolition, Building New Wallsa Nd Soffits, Installing Window	2015	58,769		20	2,938	2,938	8,815	17
18	Seals, Ceramic Tiles, Eletrical Outlets And Lines And Railings,	2015			20				18
19	Repairing Heating Radiators For Third Floor Patient Rooms And	2015			20				19
20	Setting Up New Temporary Station In Dining Room, Demo Existir	2015			20				20
21	Cabinets And Countertop, Repairing Walls, Building And Installi	2015	12,450		20	623	623	1,868	21
22	New Station For Nurses Station On Third Floor	2015			20				22
23	Installing Drop Ceiling On Three Floors	2015	17,550		20	878	878	2,633	23
24	Installing New Doors And Shades On 2Nd, 3Rd, And 4Th Floors	2015	21,650		20	1,083	1,083	3,248	24
25	Fire Protection Sprinkler Work On 3Rd And 4Th Floors	2015	15,295		20	765	765	2,294	25
26	Installing Alpha 110 With Upgrade To Audio/Visual Alert Nurse	2015	9,411		20	471	471	1,412	26
27	Call System On 4Th Floor	2015			20				27
28	Repair Phone Wiring And Nruse Call System For 2Nd And 3Rd F	2015	3,563		20	178	178	534	28
29	Moving Phone, Fax And Data Connection And Installing Speakers	2015	7,318		20	366	366	1,098	29
30	On The 3Rd Floor	2015			20				30
31	Replacing/Installing New Wiring For Nurse Call, Telephone And	2015	11,767		20	588	588	1,765	31
32	Cctv Systems On 2Nd, 3Rd And 4Th Floors	2015			20				32
33	Installing 2 Windows On 2Nd Floor Dining Room	2015	2,750		20	138	138	413	33
34	TOTAL (lines 1 thru 33)		$ 1,520,476	$ 97,943		$ 79,260	$ (18,683)	$ 488,950	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 1,520,476	$ 97,943		$ 79,260	$ (18,683)	$ 488,950	1
2	Retaining Wall Installation Outside Landscaping	2015	13,996		20	700	700	2,099	2
3	Interior Architecture Products-Handrails-2Nd, 3Rd And 4Th Floo	2015	5,517		20	276	276	828	3
4	Trend Painting & Decorating - 2Nd, 3Rd, 4Th Floor Renovation	2015	54,935		20	2,747	2,747	8,240	4
5	Trend Painting Invocies #2936,3055, And 3198	2015			20				5
6	4Th Floor Patient Rooms And Hallway Renovation - Demolition	2015	72,350		20	3,618	3,618	10,853	6
7	New Walls And Soffets, Window Seasls, Ceramic Tiles, Electric W	2015			20				7
8	Nurses Station 2Nd Floor - Demo & Build And Install New Station	2015			20				8
9	Six Bathrooms - Floor And Drop Ceiling	2015			20				9
10	Ongoing Sprinkler Work For 4Th Floor Closet And Bahtroom	2015	4,788		20	239	239	718	10
11	4Th Floor Rooms And Hallway, Closets And Cabinets Installation	2015	60,600		20	3,030	3,030	9,090	11
12	2Nd Floor Nurses Station - Fire Panel Replacement	2015	3,070		20	154	154	461	12
13	4Th Floor Rooms And Hallway, 7 Abthrooms Floor And Drop	2015	48,811		20	2,441	2,441	7,322	13
14	Ceiling, Plumbing And Fire Rated Glass	2015			20				14
15	2Nd Floor - Replace Hallway Nurse Call Lights	2015	2,800		20	140	140	420	15
16	Install Of Audio/Visual Nurse Call System On 4Th Floor	2015	19,229		20	961	961	2,884	16
17	Nurse Call System On The 3Rd Floor Installation	2015	11,041		20	552	552	1,656	17
18	Custom Ceiling Fixtures 2Nd, 3Rd, 4Th Floor Renovations	2015	16,741		20	837	837	2,511	18
19	Deposit On Tv Wirings	2015	5,000		20	250	250	750	19
20	Bathroom Paper Towel Dispensers, Grab Bars, Soap Dispensers	2015	2,996		20	150	150	449	20
21	3Rd Floor Patient Rooms Renovations, Demolition And Rebuildin	2015	32,550		20	1,628	1,628	4,883	21
22	Purchase Toilets And Installation Hardware	2015	7,041		20	352	352	1,056	22
23	Installation Of Emergency Exit Lighted Signs And Light Fixtures	2015	6,668		20	333	333	1,000	23
24	Flooring And Adhesive - 2Nd,3Rd, And 4Th Floor Renovations	2015	6,578		20	329	329	987	24
25	Flooring And Adhesive - 2Nd,3Rd, And 4Th Floor Renovations	2015	3,676		20	184	184	551	25
26	Instllation Of Chicago Approved Emergency Exited Lighted	2015	20,003		20	1,000	1,000	3,000	26
27	Signs, Can Lighting And Mounted Lamp Fixtures	2015			20				27
28	Fire Protection Sprinkler Work, Replace Baseboards	2015	41,454		20	2,073	2,073	6,218	28
29	28 Cubicle Curtain And Cubicle Tracks	2015	9,287		20	464	464	1,393	29
30	60 Trans Globe Lighting Vanity Lights	2015	3,653		20	183	183	548	30
31	Conduit Wire Replacement, Reinstall Smoke Detectors	2015	4,100		20	205	205	615	31
32	Door Hinge And Handle Hardware	2015	14,007		20	700	700	2,101	32
33	Purchase Of Owner Approved Exit And Emergency Lighting And	2015	11,167		20	558	558	1,675	33
34	TOTAL (lines 1 thru 33)		$ 2,002,534	$ 97,943		$ 103,363	$ 5,420	$ 561,259	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 2,002,534	$ 97,943		$ 103,363	$ 5,420	$ 561,259	1
2	Third Floor Patients Rooms And Hallfways (2Nd,3Rd,4Th Floor R	2015	78,775		20	3,939	3,939	11,816	2
3	Demolition Of Rooms And Bathroom, New Walls And Soffets	2015			20				3
4	Repair Walls, Window Seals, Remove Baseboard And Railings	2015			20				4
5	New Showers (315 & 415), New Drop Ceiling In Bathrooms	2015			20				5
6	Ceramic Tile, Electrick Work - Wiring And Outlets, Install Railin	2015			20				6
7	21 Johnsonite Tile And Adhesive	2015	4,351		20	218	218	653	7
8	Furnish And Install Electric For Exterior Door Controls	2015	3,350		20	168	168	503	8
9	1 Door Keypad Replacement	2015	6,200		20	310	310	930	9
10	3Rd Floor Patient Rooms Renovations, Low Voltage For Tv, Fax	2015	89,445		20	4,472	4,472	13,417	10
11	Phone Wiring, Plumbing Water Lines For Shower And Sink	2015			20				11
12	Corner Guards And Caps	2015			20				12
13	Fabrication, Finish, Deliver And Install Room Dividers	2015	12,991		20	650	650	1,949	13
14	Satin Nickel Ceiling Light	2015	2,943		20	147	147	441	14
15	Fabrication, Finish, Deliver And Install Room Dividers	2015	5,350		20	268	268	803	15
16	Trend Painting And Decorating-2Nd,3Rd, And 4Th Floor	2015	26,390		20	1,320	1,320	3,959	16
17	Renovation-Inv#3375-4Th Floor Guest Rooms (315,403,405-415)	2015			20				17
18	Fire Alarms System Panel Replacements	2015	18,450		20	923	923	2,768	18
19	Fabrication, Finish, Deliver And Install Room Dividers	2015	7,794		20	390	390	1,169	19
20	Fabrication, Finish, Deliver And Install Room Dividers	2015	3,499		20	175	175	525	20
21	Architectural Sign Systems Door Signs, Evacuation Amps, Door Ic	2015	8,717		20	436	436	1,308	21
22	Handrails And Corner Guards 1St Floor Renovation	2015	2,671		20	134	134	401	22
23	Panel Replacement For Fire Alarm System	2015	10,250		20	513	513	1,538	23
24	Fabrication, Finish, Deliver And Install Room Dividers	2015	6,908		20	345	345	1,036	24
25	Various Capital Report Reclasses To Equipment	2015	(5,268)		20	(263)	(263)	(790)	25
26	Elevator-Furnish And Install New Oil Line	2017	8,591		20	286	286	286	26
27	Cubicle Curtains	2017	4,135		20	276	276	276	27
28	Furnish & Replace 3 Boiler Circulator Pumps	2017	4,274		20	285	285	285	28
29	Sewer Plumbing For Commercial Water Heater	2017	8,200		20	410	410	410	29
30	Masonry Work On Outside Of The Building	2017	3,050		20	153	153	153	30
31	Masonry Work On Outside Of The Building	2017	18,000		20	900	900	900	31
32	New Lights, Doors, Tiles-Office,Therapy Room, Front Desk	2017	33,995		20	1,700	1,700	1,700	32
33	Remove Defective Air Handler Heating Coil	2017	4,047		20	202	202	202	33
34	TOTAL (lines 1 thru 33)		$ 2,369,642	$ 97,943		$ 121,716	$ 23,773	$ 607,893	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 2,369,642	$ 97,943		$ 121,716	$ 23,773	$ 607,893	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
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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)		$ 2,369,642	$ 97,943		$ 121,716	$ 23,773	$ 607,893	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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
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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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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
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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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from CF. St. Louis, LLC	2016	23,630		35	675	675	1,350	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF. St. Louis, LLC	2016	146,707		20	7,335	7,335	14,671	9
10	Allocated from CF. St. Louis, LLC	2017	3,405		20	170	170	170	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 173,742	$		$ 8,180	$ 8,180	$ 16,191	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 173,742	$		$ 8,180	$ 8,180	$ 16,191	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)		$ 173,742	$		$ 8,180	$ 8,180	$ 16,191	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 669,271	$ 561	$ 66,220	$ 65,659	10	$ 270,899	71
72	Current Year Purchases	13,583		2,021	2,021	10	2,021	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 682,854	$ 561	$ 68,241	$ 67,680		$ 272,920	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)	$ 3,066,949	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,504	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 189,957	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 91,453	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 880,813	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	$ 42,807	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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/Parking				19,146			5
6	Allocated form Legacy HC/Progressive HC Consulting				106			6
7	TOTAL				$ 19,252 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 6,736 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota	$	$ 2,664	17
18	Allocated form Legacy HC Financial			2,203	18
19	Allocated form Progressive HC Consulting			859	19
20					20
21	TOTAL		$	$ 5,726	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 Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 393,771	$		$ 393,771	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			121,088			121,088	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			470,224			470,224	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				311,172		311,172	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					37,331	158,149		195,480	13
14	TOTAL			$		$ 1,022,414	$ 469,321		$ 1,491,735	14

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

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$ 7,780	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,927,815	1,755,898	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(10,768)	(10,768)	6
7	Other Prepaid Expenses	13,175	213,834	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	50,499	50,499	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,982,221	$ 2,017,243	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		638,434	13
14	Buildings, at Historical Cost		5,745,906	14
15	Leasehold Improvements, at Historical Cost	596,616	2,098,277	15
16	Equipment, at Historical Cost	218,245	2,414,680	16
17	Accumulated Depreciation (book methods)	(163,822)	(974,774)	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	224,911	2,757,799	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 875,950	$ 12,680,322	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,858,171	$ 14,697,565	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 359,126	$ 740,625	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		363,941	29
30	Accrued Salaries Payable	232,269	232,269	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,448	9,448	31
32	Accrued Real Estate Taxes(Sch.IX-B)		166,555	32
33	Accrued Interest Payable	4,090	79,412	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	24,636	24,636	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 629,569	$ 1,616,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	891,983	891,983	39
40	Mortgage Payable		14,812,498	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,394,698	1,394,698	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,286,681	$ 17,099,179	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,916,250	$ 18,716,065	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (58,079)	$ (4,018,500)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,858,171	$ 14,697,565	48

***(See instructions.)**

Facility Name & ID Number Warren Barr Lincoln Park **#** 0053892 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 280,357	1
2	Restatements (describe):		2
3	Rounding	(7)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 280,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(338,429)	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)**	$ (338,429)	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)**	$ (58,079)	24 *

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	$ 9,814,901	1
2	Discounts and Allowances for all Levels	(5,633,439)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,181,462	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,607,374	6
7	Oxygen	28	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,607,402	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	299,894	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,750	19
20	Radiology and X-Ray		20
21	Other Medical Services	27,701	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 362,345	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,053	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,053	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	32,147	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,147	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,187,409	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,049,839	31
32	Health Care	2,876,575	32
33	General Administration	1,436,730	33
	B. Capital Expense		
34	Ownership	2,028,460	34
	C. Ancillary Expense		
35	Special Cost Centers	1,949,217	35
36	Provider Participation Fee	185,017	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,525,838	40
41	**Income before Income Taxes (line 30 minus line 40)****	(338,429)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (338,429)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,355,276	44
45	Private Pay - Net Inpatient Revenue	216,077	45
46	Medicare - Net Inpatient Revenue	1,341,809	46
47	Other-(specify) Insurance/Respite	268,300	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,181,462	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,249	$ 98,219	$ 43.67	1
2	Assistant Director of Nursing	3,464	3,636	158,905	43.70	2
3	Registered Nurses	17,852	19,988	606,801	30.36	3
4	Licensed Practical Nurses	19,286	20,910	516,172	24.69	4
5	CNAs & Orderlies	57,909	63,260	844,618	13.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,482	8,334	146,733	17.61	8
9	Activity Director	1,987	2,080	35,289	16.97	9
10	Activity Assistants	5,832	6,301	74,166	11.77	10
11	Social Service Workers	5,152	5,826	109,858	18.86	11
12	Dietician					12
13	Food Service Supervisor	1,556	1,741	28,234	16.22	13
14	Head Cook	4,117	4,507	59,819	13.27	14
15	Cook Helpers/Assistants	11,859	13,193	156,617	11.87	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,080	43,896	21.10	17
18	Housekeepers	11,192	12,444	147,594	11.86	18
19	Laundry					19
20	Administrator	1,296	1,320	46,572	35.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	744	1,026	52,812	51.47	23
24	Clerical	7,686	7,940	102,789	12.95	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	1,958	2,205	30,704	13.92	31
32	Other Health Care(specify)					32
33	Other(specify)	1,965	2,280	39,085	17.14	33
34	TOTAL (lines 1 - 33)	165,257	181,320	$ 3,298,883 *	$ 18.19	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	26,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	14,942	10-03	38
39	Pharmacist Consultant	Monthly	4,328	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	192	11-03	44
45	Social Service Consultant	Monthly	5,158	12-03	45
46	Other(specify)				46
47	Physician Consultant	Monthly	14,400	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 65,420		49

C. CONTRACT NURSES

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nichole Lockett	Administrator	0	$ 10,969
Andrea Martinez	Administrator	0	35,603
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,572

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum, LLP	Accounting	$ 19,892
RSM McGladery	Accounting	9,515
See Attached	Legal	34,154
Documentation Solutions	Compliance Audit	2,734
Compliance Resources Inc.	Compliance Audit	3,240
ProPay HR	Payroll Services	11,592
PSD Solutions	Technology	512
Achieve Accreditation	Accreditation	5,509
Adam Zollinger Interiors	Interior Decorator	1,247
Benjamin Kandelman	Accounting	58
BluOrange Compliance	Professional Services	450
See Supplemental Schedule		9,033
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 97,935

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,388
Unemployment Compensation Insurance	19,494
FICA Taxes	247,790
Employee Health Insurance	160,962
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	21,707
401K Expense	8,815
Voluntary Benefit Contributions	5,606
Employee Physical Exams	6,555
Other Employee Benefits	21,076
TOTAL (agree to Schedule V, line 22, col.8)	$ 554,392

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	644
Health Care Worker Background Check	
(Indicate # of checks performed 427)	4,271
Patient Background Checks 247	2,475
Dues and Subscriptions	13,597
Licenses	6,001
Permits	5,871
Allocated from Legacy HC Financial	591
See Supplemental Schedule	126
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,577

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	768
Allocated from Legacy HC Financial	781
Allocated from Progressive HC Consulting	559
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,108

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $9,815; IHCA $1,242**

(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. $ **29,305** 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. $ **185,017**
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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

(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