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: 0052787

Facility Name: Warren Barr North Shore

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

County: Lake

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 North Shore # 0052787 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	215	Skilled (SNF)	215	78,475	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,888	6,395	17,402	50,685	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,888	6,395	17,402	50,685	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.59%

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 07/01/2014

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 215 and days of care provided 14,429

Medicare Intermediary CGS Administrators LLC

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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	496,358	55,648	7,877	559,883		559,883		559,883			1
2	Food Purchase		501,827		501,827		501,827	(33,296)	468,531			2
3	Housekeeping	282,960	47,590	211	330,761		330,761	286	331,047			3
4	Laundry	33,096	21,269	117,607	171,972		171,972	8	171,980			4
5	Heat and Other Utilities			234,999	234,999		234,999	(11,136)	223,863			5
6	Maintenance	110,890	18,243	243,024	372,157		372,157	96,379	468,536			6
7	Other (specify):*											7
8	TOTAL General Services	923,304	644,577	603,718	2,171,599		2,171,599	52,240	2,223,839			8
	B. Health Care and Programs											
9	Medical Director			114,993	114,993		114,993	877	115,870			9
10	Nursing and Medical Records	4,432,108	157,399	50,215	4,639,722		4,639,722	(10,464)	4,629,258			10
10a	Therapy	236,462			236,462		236,462		236,462			10a
11	Activities	132,285	14,427	864	147,576		147,576	6,666	154,242			11
12	Social Services	247,058	41,860	2,616	291,534		291,534	2,394	293,928			12
13	CNA Training											13
14	Program Transportation			126,598	126,598		126,598		126,598			14
15	Other (specify):*			2,640	2,640		2,640	22,876	25,516			15
16	TOTAL Health Care and Programs	5,047,913	213,686	297,926	5,559,525		5,559,525	22,349	5,581,874			16
	C. General Administration											
17	Administrative	178,997			178,997		178,997	229,215	408,212			17
18	Directors Fees											18
19	Professional Services			396,283	396,283	(306)	395,977	(259,491)	136,486			19
20	Dues, Fees, Subscriptions & Promotions			172,023	172,023		172,023	(131,774)	40,249			20
21	Clerical & General Office Expenses	642,724	10,931	744,763	1,398,418		1,398,418	(759,028)	639,390			21
22	Employee Benefits & Payroll Taxes			960,700	960,700		960,700	(99,592)	861,108			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,730	3,730		3,730	2,644	6,374			24
25	Other Admin. Staff Transportation			1,312	1,312		1,312		1,312			25
26	Insurance-Prop.Liab.Malpractice			288,710	288,710		288,710	4,874	293,584			26
27	Other (specify):*							95,937	95,937			27
28	TOTAL General Administration	821,721	10,931	2,567,521	3,400,173	(306)	3,399,867	(917,215)	2,482,651			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,792,938	869,194	3,469,165	11,131,297	(306)	11,130,991	(842,627)	10,288,364			29

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

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

Facility Name & ID Number Warren Barr North Shore #0052787 Report Period Beginning: 01/01/17 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			502,328	502,328		502,328	365,314	867,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,007	91,007		91,007	1,103,728	1,194,735			32
33	Real Estate Taxes			192,000	192,000	306	192,306	198,172	390,478			33
34	Rent-Facility & Grounds			1,458,534	1,458,534		1,458,534	(1,453,789)	4,745			34
35	Rent-Equipment & Vehicles			29,796	29,796		29,796	(4,236)	25,560			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,273,665	2,273,665	306	2,273,971	209,188	2,483,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		955,391	2,262,507	3,217,898		3,217,898		3,217,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,484	345,484		345,484		345,484			42
43	Other (specify):*			892,939	892,939		892,939	(892,939)	(0)			43
44	**TOTAL Special Cost Centers**		955,391	3,500,930	4,456,321		4,456,321	(892,939)	3,563,382			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,792,938	1,824,585	9,243,760	17,861,283		17,861,283	(1,526,377)	16,334,906			45

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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	(12,803)	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	(121,663)	30		9
10	Interest and Other Investment Income	(13,249)	32		10
11	Discounts, Allowances, Rebates & Refunds	(32,752)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(633)	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	(18,745)	21		18
19	Entertainment	(3,149)	21		19
20	Contributions	(84,575)	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	(304,863)	21		24
25	Fund Raising, Advertising and Promotional	(39,390)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,187,103)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,818,925)		$	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)	292,548		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 292,548		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,526,377)		37

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

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

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

Warren Barr North Shore

ID# 0052787

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (15,953)	10	1
2	Bank Charges	(17,535)	21	2
3	Sequestration	(172,079)	21	3
4	Business Cards	(2,330)	21	4
5	Miscellaneous Income	(12,976)	21	5
6	Dietary Allocation to ALF	(169)	43	6
7	Non-Allowable Auto Lease	(10,305)	35	7
8	Non-Allowable Legal	(14,008)	19	8
9	PAC Dues	(9,224)	20	9
10	Non-Allowable Expense	(892,770)	43	10
11	Additional R&M	30,317	06	11
12	Building Company - Misc Fees Expense	(8,321)	21	12
13	Building Company - Professional Fees - Accounting	(2,200)	19	13
14	Building Company - Professional Fees - Loan	(59,550)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,187,103)		49

Warren Barr North Shore

ID# 0052787

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 North Shore # 0052787 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	(33,385)		64	25								(33,296)	2
3	Housekeeping			286									286	3
4	Laundry			8									8	4
5	Heat and Other Utilities	(12,803)				1,667							(11,136)	5
6	Maintenance	30,317		3,858	60,096	2,107							96,379	6
7	Other (specify):*													7
8	TOTAL General Services	(15,871)		4,216	60,121	3,774							52,240	8
	B. Health Care and Programs													
9	Medical Director			877									877	9
10	Nursing and Medical Records	(15,953)		54	6,704		(1,269)						(10,464)	10
10a	Therapy													10a
11	Activities			6,641	25								6,666	11
12	Social Services			105	2,289								2,394	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				22,876								22,876	15
16	TOTAL Health Care and Programs	(15,953)		7,677	31,894		(1,269)						22,349	16
	C. General Administration													
17	Administrative			30,186	199,029								229,215	17
18	Directors Fees													18
19	Professional Services	(75,758)	61,750	(239,492)	502	419			(6,912)				(259,491)	19
20	Fees, Subscriptions & Promotions	(133,189)		1,166	245	3							(131,774)	20
21	Clerical & General Office Expenses	(539,998)	8,321	239,481	(466,834)	1							(759,028)	21
22	Employee Benefits & Payroll Taxes				(99,592)								(99,592)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,541	1,103								2,644	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,293	3,150	432							4,874	26
27	Other (specify):*			49,140	46,797								95,937	27
28	TOTAL General Administration	(748,944)	70,071	83,316	(315,601)	855			(6,912)				(917,215)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(780,769)	70,071	95,209	(223,586)	4,629	(1,269)		(6,912)				(842,627)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Warren Barr North Shore** **# 0052787** **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	(121,663)	485,870		1,107								365,314	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,249)	1,109,422	25		7,530							1,103,728	32
33	Real Estate Taxes		192,000			6,172							198,172	33
34	Rent-Facility & Grounds		(1,454,000)	59,755	86	(59,630)							(1,453,789)	34
35	Rent-Equipment & Vehicles	(10,305)		4,376	1,694								(4,236)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(145,217)	333,292	64,155	2,887	(45,929)							209,188	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):*	(892,939)											(892,939)	43
44	**TOTAL Special Cost Centers**	(892,939)											(892,939)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,818,925)	403,364	159,364	(220,699)	(41,300)	(1,269)		(6,912)				(1,526,377)	45

Facility Name & ID Number Warren Barr North Shore # 0052787 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 [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,454,000	Half Day Property Holdings LLC	100.00%	$	$ (1,454,000)	1
2	V	21	Misc Fees Expense		Half Day Property Holdings LLC	100.00%	8,321	8,321	2
3	V	19	Professional Fees - Accounting		Half Day Property Holdings LLC	100.00%	2,200	2,200	3
4	V	19	Professional Fees - Loan		Half Day Property Holdings LLC	100.00%	59,550	59,550	4
5	V	32	Interest Expense - Mortgage A		Half Day Property Holdings LLC	100.00%	740,773	740,773	5
6	V	32	Interest Expense - Note A		Half Day Property Holdings LLC	100.00%	329,542	329,542	6
7	V	32	Interest Expense - CapEx		Half Day Property Holdings LLC	100.00%	39,108	39,108	7
8	V	30	Depreciation Expense		Half Day Property Holdings LLC	100.00%	485,870	485,870	8
9	V	33	Real Estate Tax		Half Day Property Holdings LLC	100.00%	192,000	192,000	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,454,000			$ 1,857,364	$ * 403,364	14

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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%	$ 64	$ 64	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	286	286	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	8	8	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	16	16	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,842	3,842	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	877	877	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	54	54	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	6,641	6,641	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	105	105	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	30,186	30,186	24
25	V	19	PROFESSIONAL FEES	260,000	Legacy Healthcare Financial Services	100.00%	20,508	(239,492)	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,166	1,166	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	233,041	233,041	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	6,440	6,440	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,541	1,541	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,293	1,293	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	49,140	49,140	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	25	25	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	59,630	59,630	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	125	125	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	30	30	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	4,345	4,345	36
37	V								37
38	V								38
39	Total			$ 260,000			$ 419,364	$ * 159,364	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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%	$ 25	$ 25	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	59,917	59,917	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	179	179	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	147,204	147,204	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	25	25	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	2,283	2,283	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	5	5	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	22,876	22,876	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	199,029	199,029	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	502	502	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	245	245	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	42,184	42,184	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	450	450	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	1,103	1,103	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	46,797	46,797	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	3,150	3,150	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	1,107	1,107	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	86	86	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,694	1,694	33
34	V								34
35	V	10	NURSING SALARY	140,500	Progressive Healthcare Consulting	100.00%		(140,500)	35
36	V	21	ADMINISTRATIVE SALARY	509,468	Progressive Healthcare Consulting	100.00%		(509,468)	36
37	V	22	REIMBURSED PAYROLL TAXES	99,592	Progressive Healthcare Consulting	100.00%		(99,592)	37
38	V								38
39	Total			$ 749,560			$ 528,861	$ * (220,699)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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%	$ 1,667	$ 1,667	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,107	2,107	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	419	419	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	3	3	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%	432	432	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	7,530	7,530	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	6,172	6,172	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	59,630	CF ST. LOUIS, LLC	100.00%		(59,630)	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			$ 59,630			$ 18,330	$ * (41,300)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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	$ 26,998	ReMED Services LLC		$ 25,729	$ (1,269)	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			$ 26,998			$ 25,729	$ * (1,269)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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	$ 19,500	ML Group Design and Development		$ 19,500	$	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			$ 19,500			$ 19,500	$ *	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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 Processing	$ 28,799	ProPay HR	24.00%	$ 21,887	$ (6,912)	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			$ 28,799			$ 21,887	$ * (6,912)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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 North Shore # 0052787 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 North Shore # 0052787 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 North Shore # 0052787 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	CHAIM RAJCHENBACH	31.65%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	HALF DAY PROPERTY HOLDINGS LLC		BUILDING CO	1
2	MENACHEM SHABAT	31.65%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3	THE RAJCHENBACH FAMILY TRUST	11.65%	AVANTARA PARK RIDGE	PARK RIDGE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	3
4	RONALD SHABAT	5.06%	AZRIA MIDTOWN	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	4
5	YAIR ZUCKERMAN	10.00%	AZRIA MONTCLAIR	OMAHA, NE	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	5
6	ROSS BOTTNER	10.00%	AZRIA OLATHE	OLATHE, KS	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	6
7			BETHANY TERRACE	MORTON GROVE	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	PROPAY HR	EVANSTON	PAYROLL PROCESSING	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS	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 LIVING AND REHAB	CHICAGO				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Warren Barr North Shore # 0052787 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 North Shore # 0052787 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 North Shore # 0052787 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 North Shore # 0052787 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	$	78,475	$ 64	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		78,475	286	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		78,475	8	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		78,475	16	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		78,475	3,842	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		78,475	877	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		78,475	54	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		78,475	6,641	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		78,475	105	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	78,475	30,186	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		78,475	20,508	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		78,475	1,166	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	78,475	233,041	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		78,475	6,440	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		78,475	1,541	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		78,475	1,293	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		78,475	49,140	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		78,475	25	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		78,475	59,630	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		78,475	125	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		78,475	30	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		78,475	4,345	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 419,364	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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	$	78,475	$ 25	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	78,475	59,917	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		78,475	179	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	78,475	147,204	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		78,475	25	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		78,475	2,283	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		78,475	5	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		78,475	22,876	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	78,475	199,029	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		78,475	502	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		78,475	245	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	78,475	42,184	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		78,475	450	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		78,475	1,103	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		78,475	46,797	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		78,475	3,150	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		78,475	1,107	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		78,475	86	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		78,475	1,694	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 528,861	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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	$	78,475	$ 1,667	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		78,475	2,107	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		78,475	419	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		78,475	3	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		78,475	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		78,475	432	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		78,475	7,530	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		78,475	6,172	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	$		$ 18,330	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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			$	$		$ 25,729	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					$	$		$ 25,729	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 Design 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	06	Maintenance	Direct			$	$		$ 19,500	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					$	$		$ 19,500	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: ((847) 905-3268
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 Processing	Direct			$	$		$ 21,887	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					$	$		$ 21,887	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 North Shore # 0052787 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 North Shore # 0052787 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 North Shore # 0052787 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor		X	Mortgage Payable			$	$ 11,642,957			$ 740,773	1
2	Member Loan		X	Member Loan Payable				2,018,093				2
3	Note Payable		X	Seller Note Payable				3,800,000			329,542	3
4	CapEx		X	Line of Credit				1,401,581			39,108	4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				1,165,000			91,007	6
7												7
8												8
9	TOTAL Facility Related						$	$ 20,027,630			$ 1,200,430	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,249)	10
11	Allocated from Legacy HC		X								25	11
12	Allocated from CF St. Louis LLC		X								7,530	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,694)	14
15	TOTALS (line 9+line14)						$	$ 20,027,630			$ 1,194,737	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/17 **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.**	$ 23,126	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.)		$ 162,913	2
3. Under or (over) accrual (line 2 minus line 1).		$ 139,787	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 250,384	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 306	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.		$ 390,478	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	131,644	8
	2013	135,169	9
	2014	139,473	10
	2015	153,877	11
	2016	156,742	12

Beginning Accrual Adjusted
2017 Accrual: $156,742 x 1.59 = $250,384 (Rounded)
Allocated from CF St. Louis LLC: $6,172

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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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.	16-16-401-005	Long Term Care Property	$ 156,741.94	$ 156,741.94
2.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 6,171.54
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 620,181.42	$ 162,913.48

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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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 North Shore # 0052787 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 1,508,714	1
2	Allocated from CF St. Louis LLC			28,509	2
3	TOTALS			$ 1,537,223	3

Facility Name & ID Number Warren Barr North Shore # 0052787 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	215		2014	1997	$ 16,827,972	$ 485,870	35	$ 480,799	$ (5,071)	$ 1,760,339	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		342,704			16,137	16,137	31,937	68
69	Financial Statement Depreciation			502,328			(502,328)		69
70	TOTAL (lines 4 thru 69)		$ 17,170,676	$ 988,198		$ 496,936	$ (491,262)	$ 1,792,276	70

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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		$ 17,170,676	$ 988,198		$ 496,936	$ (491,262)	$ 1,792,276	1
2	Landscaping	2014	13,184		20	659	659	2,033	2
3	Bedside Sconces	2014	21,285		20	1,064	1,064	3,193	3
4	Sprinkler System	2015	13,275		20	664	664	1,991	4
5	Light Fixtures And Wall Sconce - 2Nd & 3Rd Floor	2015	23,309		20	1,165	1,165	3,496	5
6	Installed Pressure Backflow In Laundry Room	2015	6,120		20	306	306	918	6
7	Signs For Bathroom/Exits/Corridors	2015	12,917		20	646	646	1,938	7
8	Repaired Sprinkler System Valves	2015	3,125		20	156	156	469	8
9	2Nd-3Rd Fl Carpentry/Flooring/Painting/Nurse Call/Electrical/Do	2015	2,127,551		20	106,378	106,378	331,932	9
10	Repaired Sprinkler System Valves	2015	3,125		20	156	156	469	10
11	Signage For Facility	2015	22,681		20	1,134	1,134	3,402	11
12	Installed Elevator Signage	2015	5,421		20	271	271	813	12
13	Bathroom Glass Mount Bracket	2015	2,692		20	135	135	404	13
14	Security System	2015	47,800		20	2,390	2,390	7,170	14
15	Chiller Replacement	2015	42,969		20	2,148	2,148	6,445	15
16	Pump Replacment	2015	3,298		20	165	165	495	16
17	Installed New Fan Coil In Resid Rms	2015	3,448		20	172	172	517	17
18	Security System	2015	14,936		20	747	747	2,240	18
19	Repaired Chiller	2015	6,340		20	317	317	951	19
20	Pump Replacement In Kitchen	2015	2,863		20	143	143	429	20
21	Repaired Condensing Unit	2015	4,130		20	207	207	620	21
22	Repaired Elevator	2015	8,700		20	435	435	1,305	22
23	Chandelier And Lights	2015	13,542		20	1,354	1,354	4,063	23
24	Heating Pump Repair	2015	3,334		20	167	167	500	24
25	Install Ventilation System In Tv Receiver Room	2015	3,975		20	199	199	596	25
26	Walk In Cooler Repair	2015	5,520		20	276	276	828	26
27	Repaired Roof	2016	86,630		20	4,332	4,332	8,663	27
28	Repaired Or Replaced Screen Windows On Building	2016	11,016		20	551	551	1,102	28
29	Replaced 1515 Sq Ft Of Sidewalk/Curb/Gutter/Electric Box	2016	19,588		20	979	979	1,959	29
30	1St Floor Stairwell & Elevator - Installed 2 Power Transfer Hinge	2016	2,815		20	141	141	282	30
31	Installed Fire Alarm System Devices/Repaired Valves	2016	5,762		20	288	288	576	31
32	Elevator Pit Ladder Repair	2016	2,768		20	138	138	277	32
33	Installed New Fan Motors And Blower Wheels For Heating Unit	2016	3,161		20	158	158	316	33
34	TOTAL (lines 1 thru 33)		$ 19,717,956	$ 988,198		$ 624,977	$ (363,221)	$ 2,182,667	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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		$ 19,717,956	$ 988,198		$ 624,977	$ (363,221)	$ 2,182,667	1
2	Boiler Room - Removed Existing Tempering Valve Station	2016	7,992		20	400	400	799	2
3	Fire Rated Fixture Protectors	2016	10,989		20	549	549	1,099	3
4	2Nd And 3Rd Floor Lounge - New Counter And Filing Cabinets	2016	4,275		20	214	214	428	4
5	Repaired Pump And Gasket	2016	4,341		20	217	217	434	5
6	Installed New Fence	2016	3,269		20	163	163	327	6
7	Parking Lot - Expanded 10-15 Spaces/Placed New Light Pole/Desi	2016	17,730		20	887	887	1,773	7
8	Dialysis Area - Demolished Office/Storage Areas/Pipes/Hvac/Idph	2016	46,912		20	2,346	2,346	4,691	8
9	Provided And Installed New Copper Piping And Fittings On The I	2017	3,870		20	129	129	129	9
10	Installed Of Parking And Building Lights	2017	3,125		20	143	143	143	10
11	Repaired Sprinkler Heads In Dialysis Unit	2017	8,725		20	254	254	254	11
12	Repaired Carpet - 2Nd And 3Rd Floor	2017	17,680		20	147	147	147	12
13	Repaired Fuel Pump	2017	3,437		20	29	29	29	13
14	Install Customer Millwork/Electrical - Resident Rooms	2017	11,988		20	50	50	50	14
15	Permit Fee For Dialysis Unit	2017	8,946		20	37	37	37	15
16	Repaired Heat Exchanger And Gas Valve	2017	8,250		20	34	34	34	16
17	Installed Vinyl Plank For Dialysis Unit	2017	7,524		20	31	31	31	17
18	Repaired Valves For Water Box-Dialysis Unit	2017	5,640		20	282	282	282	18
19	Installed 61 Fire Retardant Troffer Boxes-Therapy Rooms	2017	5,490		20	23	23	23	19
20	Installed Handrail For Dialysis Unit	2017	5,092		20	21	21	21	20
21	Installed Mixing Valves And Water Lines	2017	4,725		20	20	20	20	21
22	Site Design Fees For Dialysis Unit	2017	3,660		20	15	15	15	22
23	Installed 2Nd Floor Countertops	2017	3,360		20	56	56	56	23
24	Kitchen Equipment	2017	3,239		20	54	54	54	24
25	Installed Wiring For Dialysis Unit	2017	3,200		20	53	53	53	25
26	Carpeting For Common Areas	2017	5,748		20	287	287	287	26
27	Repaired Dialysis Unit/Carpet/Vinyl Wall Base/Pipe Lines	2017	270,677		20	13,534	13,534	13,534	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,197,839	$ 988,198		$ 644,952	$ (343,246)	$ 2,207,417	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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		$ 20,197,839	$ 988,198		$ 644,952	$ (343,246)	$ 2,207,417	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,197,839	$ 988,198		$ 644,952	$ (343,246)	$ 2,207,417	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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		$ 20,197,839	$ 988,198		$ 644,952	$ (343,246)	$ 2,207,417	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,197,839	$ 988,198		$ 644,952	$ (343,246)	$ 2,207,417	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 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
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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	46,609		35	1,332	1,332	2,663	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis LLC	2016	289,378		20	14,469	14,469	28,938	9
10	Allocated from CF St. Louis LLC	2017	6,717		20	336	336	336	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 342,704	$		$ 16,137	$ 16,137	$ 31,937	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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		$ 342,704	$		$ 16,137	$ 16,137	$ 31,937	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 342,704	$		$ 16,137	$ 16,137	$ 31,937	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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	$ 2,094,069	$ 1,106	$ 219,825	$ 218,719	10	$ 770,142	71
72	Current Year Purchases	57,336		2,864	2,864	10	2,864	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,151,404	$ 1,106	$ 222,689	$ 221,583		$ 773,006	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 23,886,466	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 989,304	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 867,641	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (121,663)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,980,422	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	$ 72,179	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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				4,534			5
6	Allocated from Legacy & Progressive HC				211			6
7	TOTAL				$ 4,745 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 17,523 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	GM	$ 200	$ 1,998	17
18	Allocated from Legacy HC			4,345	18
19	Allocated from Progressive HC			1,694	19
20					20
21	TOTAL		$ 200	$ 8,037	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/17 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.

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr North Shore # 0052787 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	$		$ 779,731	$		$ 779,731	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			179,010			179,010	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,028,190			1,028,190	4
5	Physician Care	39 - 03	visits			4,375			4,375	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				720,031		720,031	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					271,201	235,360		506,561	13
14	TOTAL			$		$ 2,262,507	$ 955,391		$ 3,217,898	14

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

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/17 **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	$ 3,058	$ 219,148	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,072,504	3,072,504	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,027	144,027	6
7	Other Prepaid Expenses	17,573	134,073	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	328,591	377,406	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,565,753	$ 3,947,158	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,508,714	13
14	Buildings, at Historical Cost		13,977,972	14
15	Leasehold Improvements, at Historical Cost	3,102,824	3,141,842	15
16	Equipment, at Historical Cost	1,602,913	2,227,209	16
17	Accumulated Depreciation (book methods)	(1,304,061)	(3,192,117)	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	272,253	3,663,585	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,673,929	$ 21,327,205	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,239,682	$ 25,274,363	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,785,385	$ 3,785,384	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,165,000	2,566,581	29
30	Accrued Salaries Payable	491,645	491,645	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,822	24,822	31
32	Accrued Real Estate Taxes(Sch.IX-B)		250,384	32
33	Accrued Interest Payable		225,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	803,931	1,175,881	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,270,783	$ 8,520,311	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,461,050	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,193,513	2,193,513	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,193,513	$ 19,654,563	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,464,296	$ 28,174,874	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,224,614)	$ (2,900,511)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,239,682	$ 25,274,363	48

***(See instructions.)**

Facility Name & ID Number Warren Barr North Shore # 0052787 **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**	$ (786,600)	1
2	Restatements (describe):		2
3	**Equity Restatement**	(491,077)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,277,677)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,063	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)**	$ 53,063	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)**	$ (1,224,614)	24 *

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

Facility Name & ID Number Warren Barr North Shore # 0052787 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	$ 18,135,710	1
2	Discounts and Allowances for all Levels	(10,276,682)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,859,028	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,122,028	6
7	Oxygen	35	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,122,063	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	710,081	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	122,561	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,636	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 874,278	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,249	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,249	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	45,728	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 45,728	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,914,346	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,171,599	31
32	Health Care	5,559,525	32
33	General Administration	3,400,173	33
	B. Capital Expense		
34	Ownership	2,273,665	34
	C. Ancillary Expense		
35	Special Cost Centers	4,110,837	35
36	Provider Participation Fee	345,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,861,283	40
41	**Income before Income Taxes (line 30 minus line 40)****	53,063	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 53,063	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Various	7,859,028	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,859,028	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 North Shore # 0052787 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	2,000	2,109	$ 117,428	$ 55.68	1
2	Assistant Director of Nursing	1,824	1,943	75,614	38.92	2
3	Registered Nurses	30,172	32,196	1,117,330	34.70	3
4	Licensed Practical Nurses	40,394	43,294	1,286,843	29.72	4
5	CNAs & Orderlies	104,450	110,887	1,754,723	15.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,798	10,404	236,462	22.73	8
9	Activity Director	1,814	2,060	43,909	21.32	9
10	Activity Assistants	6,704	7,108	88,376	12.43	10
11	Social Service Workers	10,590	11,100	247,058	22.26	11
12	Dietician					12
13	Food Service Supervisor	5,252	5,656	109,180	19.30	13
14	Head Cook	8,865	9,612	147,284	15.32	14
15	Cook Helpers/Assistants	17,827	18,710	239,894	12.82	15
16	Dishwashers					16
17	Maintenance Workers	4,169	4,529	110,890	24.48	17
18	Housekeepers	19,812	21,709	282,960	13.03	18
19	Laundry	1,883	2,052	33,096	16.13	19
20	Administrator	2,523	2,645	126,132	47.69	20
21	Assistant Administrator	1,608	1,676	52,865	31.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	33,759	37,572	642,724	17.11	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	2,089	2,261	36,906	16.32	31
32	Other Health Care(specify)					32
33	Other(specify)	2,136	2,378	43,264	18.19	33
34	TOTAL (lines 1 - 33)	307,669	329,901	$ 6,792,938 *	$ 20.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,877	01-03	35
36	Medical Director	Monthly	114,993	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	37,727	10-03	38
39	Pharmacist Consultant	Monthly	12,012	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	864	11-03	44
45	Social Service Consultant	43	2,616	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	43	$ 176,089		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9	$ 476	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	$ 476		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashley E. Wilson	Administrator	0.00%	$ 126,132
Marcus Shaw	Asst. Administrator	0.00%	52,865
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 178,997

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	Accouting Fees	$ 32,734
Legal Fees	See Schedule	42,441
Legal Fees - Compliance Audit	See Schedule	7,143
ProPay HR	Payroll Fees	28,799
Legacy Healthcare Financial Services	Bookkeeping	260,000
Achieve Accreditation, LLC	Joint Commission Consult	6,172
BlueOrange Compliance	Cybersecurity	1,771
Deborah D. Cole Goodwill	Business Services	500
Lexisnexis Risk Solutions	Data Processing	66
Integra Scripts, LLC	Pharmacy Benefit Management	6,406
McCabe Kirshner & Ballester, PC	Legal Services	1,176
See Supplemental Schedule		9,075
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 396,283

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 160,268
Unemployment Compensation Insurance	55,438
FICA Taxes	455,092
Employee Health Insurance	115,468
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	11,190
Employee Physical Exams	12,881
Other Employee Benefits	50,770
TOTAL (agree to Schedule V, line 22, col.8)	$ 861,108

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	
Health Care Worker Background Check	
(Indicate # of checks performed 817)	8,171
Patient Background Checks 392	3,920
Dues and Subscriptions	17,568
License and Permits	9,176
Allocated from Legacy HC	1,166
Allocated from Progressive HC	245
See Supplemental Schedule	3
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,249

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,729
Allocated from Legacy HC	1,541
Allocated from Progressive HC	1,103
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,373

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr North Shore # 0052787 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $18,447**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **42,027** 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 fo
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 Departmen
during this cost report period. $ **345,484**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

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

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