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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0053892

Facility Name: Warren Barr Lincoln Park

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,894	3,194	8,262	28,350	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,894	3,194	8,262	28,350	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.26%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/1/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 109 and days of care provided 6,114

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	309,621	17,033		326,654		326,654	732	327,386			1
2	Food Purchase		211,027		211,027		211,027	(20,843)	190,184			2
3	Housekeeping	147,984	29,342	74	177,400		177,400	1,151	178,551			3
4	Laundry		21,305	86,081	107,386		107,386	(2,486)	104,900			4
5	Heat and Other Utilities			94,624	94,624		94,624	(7,765)	86,859			5
6	Maintenance	49,875	10,635	117,414	177,924		177,924	13,543	191,467			6
7	Other (specify):*											7
8	TOTAL General Services	507,480	289,342	298,193	1,095,015		1,095,015	(15,669)	1,079,346			8
	B. Health Care and Programs											
9	Medical Director			16,477	16,477		16,477		16,477			9
10	Nursing and Medical Records	2,291,228	126,635	25,221	2,443,084		2,443,084	44,288	2,487,372			10
10a	Therapy	118,473			118,473		118,473		118,473			10a
11	Activities	103,216	4,911	2,112	110,239		110,239	46	110,285			11
12	Social Services	141,964		5,600	147,564		147,564	2,849	150,413			12
13	CNA Training											13
14	Program Transportation			54,127	54,127		54,127		54,127			14
15	Other (specify):*							5,247	5,247			15
16	TOTAL Health Care and Programs	2,654,881	131,546	103,537	2,889,964		2,889,964	52,430	2,942,394			16
	C. General Administration											
17	Administrative	89,884			89,884		89,884	60,593	150,477			17
18	Directors Fees											18
19	Professional Services			74,958	74,958	(300)	74,658	(5,420)	69,238			19
20	Dues, Fees, Subscriptions & Promotions			75,210	75,210		75,210	(48,204)	27,006			20
21	Clerical & General Office Expenses	110,863	3,731	382,001	496,595		496,595	(41,690)	454,905			21
22	Employee Benefits & Payroll Taxes			514,398	514,398		514,398		514,398			22
23	Inservice Training & Education											23
24	Travel and Seminar			408	408		408	2,007	2,415			24
25	Other Admin. Staff Transportation			1,012	1,012		1,012		1,012			25
26	Insurance-Prop.Liab.Malpractice			145,683	145,683		145,683	3,675	149,358			26
27	Other (specify):*							38,398	38,398			27
28	TOTAL General Administration	200,747	3,731	1,193,670	1,398,148	(300)	1,397,848	9,360	1,407,208			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,363,108	424,619	1,595,400	5,383,127	(300)	5,382,827	46,121	5,428,948			29

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

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

Facility Name & ID Number Warren Barr Lincoln Park #0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							1,146,885	1,146,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,717	66,717		66,717	902,397	969,114			32
33	Real Estate Taxes			174,000	174,000	300	174,300	3,103	177,403			33
34	Rent-Facility & Grounds			1,492,141	1,492,141		1,492,141	(1,467,939)	24,202			34
35	Rent-Equipment & Vehicles			6,256	6,256		6,256	2,739	8,995			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,739,114	1,739,114	300	1,739,414	587,186	2,326,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		328,720	946,931	1,275,651		1,275,651		1,275,651			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			188,946	188,946		188,946		188,946			42
43	Other (specify):*			442,168	442,168		442,168	(442,168)				43
44	**TOTAL Special Cost Centers**		328,720	1,578,045	1,906,765		1,906,765	(442,168)	1,464,597			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,363,108	753,339	4,912,559	9,029,006		9,029,006	191,138	9,220,144			45

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(8,450)	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	1,146,885	30		9
10	Interest and Other Investment Income	(42,582)	32		10
11	Discounts, Allowances, Rebates & Refunds	(20,617)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(238)	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	(14,569)	21		18
19	Entertainment				19
20	Contributions	(15,167)	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	(206,877)	21		24
25	Fund Raising, Advertising and Promotional	(22,983)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,400)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(757,039)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 56,963		$	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)	134,175		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 134,175		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 191,138		37

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

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

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

Warren Barr Lincoln Park

ID# 0053892

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (2,670)	10	1
2	Meals & Entertainment	(2,221)	21	2
3	Bank Charges	(323)	21	3
4	Sequestration Expense	(70,030)	21	4
5	Additional R&M	7,366	06	5
6	PAC Dues	(10,473)	20	6
7	Non-Allowable Expense	(442,168)	43	7
8	Non-Allowable Legal	(11,133)	19	8
9	Bldg Co - Title Fees	(11,877)	21	9
10	Bldg Co - Accounting	(4,124)	19	10
11	Bldg Co - Legal	(9,297)	19	11
12	Bldg Co - Loan	(49,647)	19	12
13	Bldg Co - Management Fees	(150,437)	17	13
14	Bldg Co - Bank Fees	(5)	21	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**	(757,039)		49

Warren Barr Lincoln Park

ID# 0053892

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			732									732	1
2	Food Purchase	(20,855)		12									(20,843)	2
3	Housekeeping			1,151									1,151	3
4	Laundry			7						(2,493)			(2,486)	4
5	Heat and Other Utilities	(8,450)				685							(7,765)	5
6	Maintenance	7,366		5,746		921	(491)						13,543	6
7	Other (specify):*													7
8	**TOTAL General Services**	(21,939)		7,648		1,606	(491)			(2,493)			(15,669)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,670)		47,152					(194)				44,288	10
10a	Therapy													10a
11	Activities			46									46	11
12	Social Services			2,849									2,849	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,247								5,247	15
16	**TOTAL Health Care and Programs**	(2,670)		50,046	5,247				(194)				52,430	16
	C. General Administration													
17	Administrative	(150,437)	150,437	60,593									60,593	17
18	Directors Fees													18
19	Professional Services	(74,201)	63,068	7,366		29		(1,682)					(5,420)	19
20	Fees, Subscriptions & Promotions	(48,623)		419		0							(48,204)	20
21	Clerical & General Office Expenses	(307,302)	11,882	253,505		225							(41,690)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,007									2,007	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			3,411		264							3,675	26
27	Other (specify):*			38,398									38,398	27
28	**TOTAL General Administration**	(580,563)	225,387	365,699		519		(1,682)					9,360	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(605,172)	225,387	423,393	5,247	2,125	(491)	(1,682)	(194)	(2,493)			46,121	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	1,146,885											1,146,885	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(42,582)	941,697	22		3,261							902,397	32
33	Real Estate Taxes					3,103							3,103	33
34	Rent-Facility & Grounds		(1,468,044)	28,300		(28,195)							(1,467,939)	34
35	Rent-Equipment & Vehicles				2,739								2,739	35
36	Other (specify):*													36
37	TOTAL Ownership	1,104,303	(526,348)	28,322	2,739	(21,831)							587,186	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):*	(442,168)											(442,168)	43
44	TOTAL Special Cost Centers	(442,168)											(442,168)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	56,963	(300,961)	451,716	7,987	(19,706)	(491)	(1,682)	(194)	(2,493)			191,138	45

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Rent	$ 1,468,044	Lincoln Park PropCo		$	$ (1,468,044)	1
2	V	21	Bank Fees		Lincoln Park PropCo		5	5	2
3	V	21	Title Fees		Lincoln Park PropCo		11,877	11,877	3
4	V	19	Professional Fees - Accounting		Lincoln Park PropCo		4,124	4,124	4
5	V	19	Professional Fees - Legal		Lincoln Park PropCo		9,297	9,297	5
6	V	19	Professional Fees - Loan		Lincoln Park PropCo		49,647	49,647	6
7	V	17	Property Management Fees		Lincoln Park PropCo		150,437	150,437	7
8	V	32	Interest Expense - Mortgage A		Lincoln Park PropCo		941,697	941,697	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,468,044			$ 1,167,083	$ * (300,961)	14

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	01	DIETICIAN SALARY	$	Legacy Healthcare Financial Services		$ 690	$ 690	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		42	42	16
17	V	02	FOOD		Legacy Healthcare Financial Services		12	12	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		1,151	1,151	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		7	7	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		4,893	4,893	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		853	853	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		45,247	45,247	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		1,853	1,853	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		52	52	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		2,832	2,832	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		46	46	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		17	17	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		60,593	60,593	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		7,366	7,366	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		419	419	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		246,378	246,378	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		7,126	7,126	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		2,007	2,007	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		3,411	3,411	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		38,398	38,398	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		22	22	36
37	V	34	RENT		Legacy Healthcare Financial Services		28,195	28,195	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		105	105	38
39	Total			$			$ 451,716	$ * 451,716	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		147	$ 147	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		2,592	2,592	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		5,247	5,247	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 7,987	$ * 7,987	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 685	$ 685	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		921	921	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		29	29	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		0	0	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		225	225	19
20	V	26	INSURANCE		CF St. Louis LLC		264	264	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		3,261	3,261	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		3,103	3,103	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	28,195	CF St. Louis LLC			(28,195)	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			$ 28,195			$ 8,489	$ * (19,706)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 6,600	ML Group Design and Development		$ 6,109	$ (491)	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			$ 6,600			$ 6,109	$ * (491)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 6,426	ProPay		$ 4,744	$ (1,682)	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			$ 6,426			$ 4,744	$ * (1,682)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 6,750	ReMed Services		$ 6,556	$ (194)	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			$ 6,750			$ 6,556	$ * (194)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	04	Laundry Services	$ 106,984	EcoBrite Linen		$ 104,491	$ (2,493)	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			$ 106,984			$ 104,491	$ * (2,493)	39

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	$ 33,257	$ 33,257	39,785	$ 690	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		39,785	42	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		39,785	12	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		39,785	1,151	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		39,785	7	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	39,785	4,893	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		39,785	853	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	39,785	45,247	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		39,785	1,853	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		39,785	52	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	39,785	2,832	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		39,785	46	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		39,785	17	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	39,785	60,593	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		39,785	7,366	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		39,785	419	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	39,785	246,378	17
18	21	CLERICAL AND OFFICE EXPE	AVAIL. BED DAYS	1,918,919	34	343,715		39,785	7,126	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		39,785	2,007	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		39,785	3,411	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008		39,785	38,398	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		39,785	22	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		39,785	28,195	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		39,785	105	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 451,716	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088		39,785	147	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		39,785	2,592	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		39,785	5,247	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					$ 385,208	$		$ 7,987	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,916,917	34	$ 32,982	$	39,785	$ 685	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		39,785	921	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		39,785	29	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		39,785	0	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		39,785	225	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		39,785	264	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		39,785	3,261	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		39,785	3,103	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					$ 408,994	$		$ 8,489	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Desing and Development
Street Address: 3424 Oakton Street
City / State / Zip Code: Skokie, IL
Phone Number: (847) 676-5300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 6,109	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					$	$		$ 6,109	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St
City / State / Zip Code: Evanston, IL 60202
Phone Number: (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 Services				$	$		$ 4,744	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					$	$		$ 4,744	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 6,556	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					$	$		$ 6,556	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
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	4	Laundry Services	Direct			$	$		$ 104,491	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					$	$		$ 104,491	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	10 Pack Tenant		X	Note Payable			$	$ 1,551,983			$ 66,717	1
2	Mortgage		X	Mortgage				14,814,263			941,697	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 16,366,246			$ 1,008,414	9
	B. Non-Facility Related*											
10	Interest Income		X								(42,582)	10
11	Allocated from Legacy HC Financial		X								22	11
12	Allocated from CF. St. Louis, LLC		X								3,261	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (39,299)	14
15	TOTALS (line 9+line14)						$	$ 16,366,246			$ 969,114	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 194,858	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.)		$ 206,437	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,579	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 165,525	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.)**		$ 300	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 177,404	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	135,199	8
	2014	141,174	9
	2015	173,085	10
	2016	189,183	11
	2017	203,333	12

2018 Accrual = $203,333 x 0.81 = $165,525
Alocated from CF. St. Louis, LLC $3,103
Beginning accrual adjusted for the journal entry made after the 2017 cost report was prepared.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincoln Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053892

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-308-008-0000	Long Term Care Property	$ 203,333.27	$ 203,333.27
2.	Allocated from CF. St. Louis, LLC	Home Office	$ 492,481.94	$ 3,103.40
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 695,815.21	$ 206,436.67

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincoln Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053892

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from CF St. Louis			$ 4,096	1
2	Facility			690,000	2
3	TOTALS			$ 694,096	3

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	109		2015	1969	$ 19,193,193	$	35	$ 548,377	$ 548,377	$ 2,193,508	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	34,490		20	1,725	1,725	18,970	9
10	Various			2009	579,416		20	32,715	32,715	327,146	10
11	Various			2010	36,209		20	1,810	1,810	16,294	11
12	Various			2011	116,529		20	5,826	5,826	46,612	12
13	Various			2012	71,395		20	3,570	3,570	24,988	13
14	Various			2013	80,916		20	4,046	4,046	24,275	14
15	Various			2014	241,336		20	12,067	12,067	48,267	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		162,331			7,644	7,644	22,757	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 20,515,815	$		$ 617,779	$ 617,779	$ 2,722,815	70

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 20,515,815	$		$ 617,779	$ 617,779	$ 2,722,815	1
2	Replacing Electrical Fixtures And Exit Signage, Concealing Exisitin	2015	15,800		20	790	790	3,160	2
3	Sprinkler And Fa Systems, Providing New Soffits And Atc	2015			20				3
4	Upgrading Hydaulic Calcs, Piping And Heads On 2Nd, 3Rd, & 4Th	2015			20				4
5	Preparing Design, Construction Documents, And Permit For 1St Fl	2015	10,120		20	506	506	2,024	5
6	Physical Therapy Center	2015			20				6
7	Demolition, Building New Wallsa Nd Soffits, Installing Window	2015	58,769		20	2,938	2,938	11,754	7
8	Seals, Ceramic Tiles, Eletrical Outlets And Lines And Railings,	2015			20				8
9	Repairing Heating Radiators For Third Floor Patient Rooms And I	2015			20				9
10	Setting Up New Temporary Station In Dining Room, Demo Existing	2015			20				10
11	Cabinets And Countertop, Repairing Walls, Building And Installing	2015	12,450		20	623	623	2,490	11
12	New Station For Nurses Station On Third Floor	2015			20				12
13	Installing Drop Ceiling On Three Floors	2015	17,550		20	878	878	3,510	13
14	Installing New Doors And Shades On 2Nd, 3Rd, And 4Th Floors	2015	21,650		20	1,083	1,083	4,330	14
15	Fire Protection Sprinkler Work On 3Rd And 4Th Floors	2015	15,295		20	765	765	3,059	15
16	Installing Alpha 110 With Upgrade To Audio/Visual Alert Nurse	2015	9,411		20	471	471	1,882	16
17	Call System On 4Th Floor	2015			20				17
18	Repair Phone Wiring And Nruse Call System For 2Nd And 3Rd Flo	2015	3,563		20	178	178	713	18
19	Moving Phone, Fax And Data Connection And Installing Speakers	2015	7,318		20	366	366	1,464	19
20	On The 3Rd Floor	2015			20				20
21	Replacing/Installing New Wiring For Nurse Call, Telephone And	2015	11,767		20	588	588	2,353	21
22	Cctv Systems On 2Nd, 3Rd And 4Th Floors	2015			20				22
23	Installing 2 Windows On 2Nd Floor Dining Room	2015	2,750		20	138	138	550	23
24	Retaining Wall Installation Outside Landscaping	2015	13,996		20	700	700	2,799	24
25	Interior Architecture Products-Handrails-2Nd, 3Rd And 4Th Floor	2015	5,517		20	276	276	1,103	25
26	Trend Painting & Decorating - 2Nd, 3Rd, 4Th Floor Renovation	2015	54,935		20	2,747	2,747	10,987	26
27	Trend Painting Invocies #2936,3055, And 3198	2015			20				27
28	4Th Floor Patient Rooms And Hallway Renovation - Demolition	2015	72,350		20	3,618	3,618	14,470	28
29	New Walls And Soffets, Window Seasls, Ceramic Tiles, Electric Wo	2015			20				29
30	Nurses Station 2Nd Floor - Demo & Build And Install New Station	2015			20				30
31	Six Bathrooms - Floor And Drop Ceiling	2015			20				31
32	Ongoing Sprinkler Work For 4Th Floor Closet And Bahtroom	2015	4,788		20	239	239	958	32
33	4Th Floor Rooms And Hallway, Closets And Cabinets Installation	2015	60,600		20	3,030	3,030	12,120	33
34	TOTAL (lines 1 thru 33)		$ 20,914,444	$		$ 637,711	$ 637,711	$ 2,802,541	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 20,914,444	$		$ 637,711	$ 637,711	$ 2,802,541	1
2	2Nd Floor Nurses Station - Fire Panel Replacement	2015	3,070		20	154	154	614	2
3	4Th Floor Rooms And Hallway, 7 Abthrooms Floor And Drop	2015	48,811		20	2,441	2,441	9,762	3
4	Ceiling, Plumbing And Fire Rated Glass	2015			20				4
5	2Nd Floor - Replace Hallway Nurse Call Lights	2015	2,800		20	140	140	560	5
6	Install Of Audio/Visual Nurse Call System On 4Th Floor	2015	19,229		20	961	961	3,846	6
7	Nurse Call System On The 3Rd Floor Installation	2015	11,041		20	552	552	2,208	7
8	Custom Ceiling Fixtures 2Nd, 3Rd, 4Th Floor Renovations	2015	16,741		20	837	837	3,348	8
9	Deposit On Tv Wirings	2015	5,000		20	250	250	1,000	9
10	Bathroom Paper Towel Dispensers, Grab Bars, Soap Dispensers	2015	2,996		20	150	150	599	10
11	3Rd Floor Patient Rooms Renovations, Demolition And Rebuilding	2015	32,550		20	1,628	1,628	6,510	11
12	Purchase Toilets And Installation Hardware	2015	7,041		20	352	352	1,408	12
13	Installation Of Emergency Exit Lighted Signs And Light Fixtures	2015	6,668		20	333	333	1,334	13
14	Flooring And Adhesive - 2Nd,3Rd, And 4Th Floor Renovations	2015	6,578		20	329	329	1,316	14
15	Flooring And Adhesive - 2Nd,3Rd, And 4Th Floor Renovations	2015	3,676		20	184	184	735	15
16	Instllation Of Chicago Approved Emergency Exited Lighted	2015	20,003		20	1,000	1,000	4,001	16
17	Signs, Can Lighting And Mounted Lamp Fixtures	2015			20				17
18	Fire Protection Sprinkler Work, Replace Baseboards	2015	41,454		20	2,073	2,073	8,291	18
19	28 Cubicle Curtain And Cubicle Tracks	2015	9,287		20	464	464	1,857	19
20	60 Trans Globe Lighting Vanity Lights	2015	3,653		20	183	183	731	20
21	Conduit Wire Replacement, Reinstall Smoke Detectors	2015	4,100		20	205	205	820	21
22	Door Hinge And Handle Hardware	2015	14,007		20	700	700	2,801	22
23	Purchase Of Owner Approved Exit And Emergency Lighting And I	2015	11,167		20	558	558	2,233	23
24	Third Floor Patients Rooms And Hallfways (2Nd,3Rd,4Th Floor Re	2015	78,775		20	3,939	3,939	15,755	24
25	Demolition Of Rooms And Bathroom, New Walls And Soffets	2015			20				25
26	Repair Walls, Window Seals, Remove Baseboard And Railings	2015			20				26
27	New Showers (315 & 415), New Drop Ceiling In Bathrooms	2015			20				27
28	Ceramic Tile, Electrick Work - Wiring And Outlets, Install Railings	2015			20				28
29	21 Johnsonite Tile And Adhesive	2015	4,351		20	218	218	870	29
30	Furnish And Install Electric For Exterior Door Controls	2015	3,350		20	168	168	670	30
31	1 Door Keypad Replacement	2015	6,200		20	310	310	1,240	31
32	3Rd Floor Patient Rooms Renovations, Low Voltage For Tv, Fax	2015	89,445		20	4,472	4,472	17,889	32
33	Phone Wiring, Plumbing Water Lines For Shower And Sink	2015			20				33
34	TOTAL (lines 1 thru 33)		$ 21,366,437	$		$ 660,310	$ 660,310	$ 2,892,940	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 21,366,437	$		$ 660,310	$ 660,310	$ 2,892,940	1
2	Corner Guards And Caps	2015			20				2
3	Fabrication, Finish, Deliver And Install Room Dividers	2015	12,991		20	650	650	2,598	3
4	Satin Nickel Ceiling Light	2015	2,943		20	147	147	589	4
5	Fabrication, Finish, Deliver And Install Room Dividers	2015	5,350		20	268	268	1,070	5
6	Trend Painting And Decorating-2Nd,3Rd, And 4Th Floor	2015	26,390		20	1,320	1,320	5,278	6
7	Renovation-Inv#3375-4Th Floor Guest Rooms (315,403,405-415)	2015			20				7
8	Fire Alarms System Panel Replacements	2015	18,450		20	923	923	3,690	8
9	Fabrication, Finish, Deliver And Install Room Dividers	2015	7,794		20	390	390	1,559	9
10	Fabrication, Finish, Deliver And Install Room Dividers	2015	3,499		20	175	175	700	10
11	Architectural Sign Systems Door Signs, Evacuation Amps, Door Ids	2015	8,717		20	436	436	1,743	11
12	Handrails And Corner Guards 1St Floor Renovation	2015	2,671		20	134	134	534	12
13	Panel Replacement For Fire Alarm System	2015	10,250		20	513	513	2,050	13
14	Fabrication, Finish, Deliver And Install Room Dividers	2015	6,908		20	345	345	1,382	14
15	Various Capital Report Reclasses To Equipment	2015	(5,268)		20	(263)	(263)	(1,054)	15
16	Elevator-Furnish And Install New Oil Line	2017	8,591		20	286	286	572	16
17	Cubicle Curtains	2017	4,135		20	276	276	552	17
18	Furnish & Replace 3 Boiler Circulator Pumps	2017	4,274		20	285	285	570	18
19	Sewer Plumbing For Commercial Water Heater	2017	8,200		20	410	410	820	19
20	Masonry Work On Outside Of The Building	2017	3,050		20	153	153	305	20
21	Masonry Work On Outside Of The Building	2017	18,000		20	900	900	1,800	21
22	New Lights, Doors, Tiles-Office,Therapy Room, Front Desk	2017	33,995		20	1,700	1,700	3,400	22
23	Remove Defective Air Handler Heating Coil	2017	4,047		20	202	202	405	23
24	Door Handles, Hardware, And Sink Insulation (3,450)	2018	3,193		20	288	288	288	24
25	Faucet And Shut Off Valves (3,900)	2018	3,610		20	260	260	260	25
26	Mirrors (2,754)	2018	2,549		20	459	459	459	26
27	New Heater Installation (7,985)	2018	7,391		20	370	370	370	27
28	Generator Installation	2018	130,163		20	6,508	6,508	6,508	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 21,698,330	$		$ 677,441	$ 677,441	$ 2,929,386	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 21,698,330	$		$ 677,441	$ 677,441	$ 2,929,386	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
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19									19
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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)		$ 21,698,330	$		$ 677,441	$ 677,441	$ 2,929,386	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	22,055		35	630	630	1,890	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	136,934		20	6,847	6,847	20,540	9
10	Allocated from CF St. Louis, LLC	2017	3,178		20	159	159	318	10
11									11
12									12
13	Allocated from Legacy HC	2018	163		20	8	8	8	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)		$ 162,331	$		$ 7,644	$ 7,644	$ 22,757	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 162,331	$		$ 7,644	$ 7,644	$ 22,757	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 162,331	$		$ 7,644	$ 7,644	$ 22,757	34

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 4,691,197	$	$ 469,076	$ 469,076	10	$ 1,944,813	71
72	Current Year Purchases	4,465		368	368	10	368	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 4,695,662	$	$ 469,444	$ 469,444		$ 1,945,181	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)	$ 27,088,088	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,146,885	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,146,885	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,874,567	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage / Parking				24,097			5
6	Allocated form Legacy HC				105			6
7	TOTAL				$ 24,202 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 3,762 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota	$	$ 2,641	17
18	Allocated form Legacy HC Financial			2,592	18
19					19
20					20
21	TOTAL		$	$ 5,233	21

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Warren Barr Lincoln Park | STATE OF ILLINOIS # 0053892 | Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$		$ 348,723	$		$ 348,723	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			104,197			104,197	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			449,370			449,370	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				223,999		223,999	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					44,641	104,721		149,362	13
14	TOTAL			$		$ 946,931	$ 328,720		$ 1,275,651	14

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

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 905	$ 2,180	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,830,142	1,675,690	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,265	19,265	6
7	Other Prepaid Expenses	14,094	179,546	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	62,992	62,992	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,927,398	$ 1,939,673	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		638,434	13
14	Buildings, at Historical Cost		5,745,906	14
15	Leasehold Improvements, at Historical Cost	613,470	2,115,131	15
16	Equipment, at Historical Cost	400,174	2,596,609	16
17	Accumulated Depreciation (book methods)	(164,508)	(1,672,020)	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	247,803	2,739,492	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,096,939	$ 12,163,552	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,024,337	$ 14,103,225	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 143,912	$ 525,414	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,381	4,381	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,258	247,258	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,626	11,626	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,525	32
33	Accrued Interest Payable		81,064	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	94,100	94,100	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 501,277	$ 1,129,368	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,551,983	1,551,983	39
40	Mortgage Payable		14,814,263	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,337,395	1,337,395	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,889,378	$ 17,703,641	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,390,655	$ 18,833,009	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (366,318)	$ (4,729,784)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,024,337	$ 14,103,225	48

*(See instructions.)

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (58,079)	1
2	Restatements (describe):		2
3	**Prior Year Depreciation**	(98,629)	3
4	**Prior Year Bad Debt Expense**	(90,836)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (247,544)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(118,774)	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)**	$ (118,774)	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)**	$ (366,318)	24 *

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,509,007	1
2	Discounts and Allowances for all Levels	(5,033,314)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,475,693	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,065,875	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,065,875	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	236,605	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,474	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,386	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 305,465	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,582	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42,582	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	20,617	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,617	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,910,232	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,095,015	31
32	Health Care	2,889,964	32
33	General Administration	1,398,148	33
	B. Capital Expense		
34	Ownership	1,739,114	34
	C. Ancillary Expense		
35	Special Cost Centers	1,717,819	35
36	Provider Participation Fee	188,946	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,029,006	40
41	**Income before Income Taxes (line 30 minus line 40)****	(118,774)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (118,774)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,179,113	44
45	Private Pay - Net Inpatient Revenue	794,900	45
46	Medicare - Net Inpatient Revenue	428,905	46
47	Other-(specify) Insurance	72,775	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,475,693	49

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

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2,016	2,168	$ 92,530	$ 42.68	1
2	Assistant Director of Nursing	1,768	2,040	89,501	43.87	2
3	Registered Nurses	21,594	23,247	712,890	30.67	3
4	Licensed Practical Nurses	15,913	17,529	495,886	28.29	4
5	CNAs & Orderlies	52,386	58,021	848,452	14.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,283	6,119	118,473	19.36	8
9	Activity Director	1,944	2,128	37,869	17.80	9
10	Activity Assistants	5,180	5,412	65,347	12.07	10
11	Social Service Workers	6,285	6,924	141,964	20.50	11
12	Dietician					12
13	Food Service Supervisor	3,537	3,852	88,713	23.03	13
14	Head Cook	4,792	5,032	74,646	14.83	14
15	Cook Helpers/Assistants	9,968	11,261	146,262	12.99	15
16	Dishwashers					16
17	Maintenance Workers	1,956	2,174	49,875	22.94	17
18	Housekeepers	10,455	11,664	147,984	12.69	18
19	Laundry					19
20	Administrator	1,944	2,213	89,884	40.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,343	9,064	110,863	12.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,200	34,349	15.61	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,112	1,190	17,620	14.81	33
34	TOTAL (lines 1 - 33)	156,452	172,238	$ 3,363,108 *	$ 19.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	16,477	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	8,383	10-03	38
39	Pharmacist Consultant	Monthly	7,829	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	2,112	11-03	44
45	Social Service Consultant	Monthly	5,600	12-03	45
46	Other(specify)				46
47	Physician Consultant	Monthly	9,009	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 49,410		49

C. CONTRACT NURSES

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Davis, Abbey E.	Administrator	0	$ 45,328
Martinez, Andrea	Administrator	0	44,556
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,884

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
See Attached	Legal Fees	$ 31,495
ProPay HR	Payroll Services	6,426
Marcum LLP	Accounting Services	25,317
Achieve Accreditation LLC	Accreditation	1,393
Adam Zollinger Interiors	Interior Decorator	263
Compliagent	Compliance	1,800
IIT/Sourcetech	Data Processing	1,395
Integra Scripts LLC	Pharma Management Services	500
ML Group Design	Building Design	1,920
Prospect Resources Inc	Risk Management	750
Sterling Valuation Of Illinois	Real Estate Appraisal	300
See Supplemental Schedule		3,399
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 74,957

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,727
Unemployment Compensation Insurance	19,298
FICA Taxes	250,426
Employee Health Insurance	157,688
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	25,988
Employee Benefits	8,753
401K Expense	11,024
Voluntary Benefit Contributions	3,444
Employee Physical Exams	7,050
TOTAL (agree to Schedule V, line 22, col.8)	$ 514,398

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,824
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,053
(Indicate # of checks performed 205)	
Patient Background Checks 71	710
Dues and Subscriptions	18,548
Licenses and Permits	3,452
Allocated from Legacy HC Financial	419
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,006

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	408
Allocated from Legacy HC Financial	2,007
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,415

**See instructions.

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $16,437.20; IHCA - $7,074.10**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,034** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **188,946**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

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

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

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