		FOR BHF USE					

LL1

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

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.

I. IDPH License ID Number: 0053587

Facility Name: Warren Barr Lincolnshire

Address: 150 Jamestown Lane (Number) Lincolnshire (City) 60069 (Zip Code)

County: Lake

Telephone Number: (847) 883-9000 **Fax #** (847) 883-9028

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2015

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 1/1/18 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) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	144	Skilled (SNF)	144	52,560	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	144	TOTALS	144	52,560	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			11,183	11,183	8
9	SNF/PED					9
10	ICF	25,263	4,566		29,829	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,263	4,566	11,183	41,012	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.03%

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] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 05/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 144 and days of care provided 8,336

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.

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	636,176	105,220	25,383	766,779		766,779	(35,748)	731,031			1
2	Food Purchase		21,117		21,117		21,117	16	21,133			2
3	Housekeeping	-	6,378	269,580	275,958		275,958	1,521	277,479			3
4	Laundry	60,529	13,584	-	74,113		74,113	9	74,122			4
5	Heat and Other Utilities			198,062	198,062		198,062	904	198,966			5
6	Maintenance	192,302	90,817	280,768	563,887		563,887	7,616	571,503			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	889,007	237,116	773,793	1,899,916		1,899,916	(25,682)	1,874,234			8
	B. Health Care and Programs											
9	Medical Director	-	-	47,905	47,905		47,905	-	47,905			9
10	Nursing and Medical Records	4,438,063	291,801	270,638	5,000,502		5,000,502	(47,663)	4,952,839			10
10a	Therapy	127,317	-	-	127,317		127,317	-	127,317			10a
11	Activities	201,090	12,145	28,661	241,896		241,896	60	241,956			11
12	Social Services	137,511	-	5,339	142,850		142,850	3,764	146,614			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	62,730	62,730		62,730	-	62,730			14
15	Other (specify):* Alloc. Mgmt. Bene	-	-	-				6,932	6,932			15
16	**TOTAL Health Care and Programs**	4,903,981	303,946	415,273	5,623,200		5,623,200	(36,907)	5,586,293			16
	C. General Administration											
17	Administrative	107,688	-	625,634	733,322		733,322	(625,634)	107,688			17
18	Directors Fees			-				-				18
19	Professional Services			139,149	139,149		139,149	(23,647)	115,502			19
20	Dues, Fees, Subscriptions & Promotions			33,837	33,837		33,837	554	34,391			20
21	Clerical & General Office Expenses	178,869	-	69,061	247,930		247,930	77,399	325,329			21
22	Employee Benefits & Payroll Taxes			798,599	798,599		798,599	(67,174)	731,425			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			-				2,652	2,652			24
25	Other Admin. Staff Transportation		-	84	84		84	-	84			25
26	Insurance-Prop.Liab.Malpractice			161,574	161,574		161,574	4,855	166,429			26
27	Other (specify):* Alloc. Mgmt. Bene	-	-	-				50,727	50,727			27
28	**TOTAL General Administration**	286,557		1,827,938	2,114,495		2,114,495	(580,268)	1,534,227			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,079,545	541,062	3,017,004	9,637,611		9,637,611	(642,857)	8,994,754			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 Lincolnshire #0053587 Report Period Beginning: 1/1/18 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			322,251	322,251		322,251	(183,527)	138,724			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			171,942	171,942		171,942	(5,241)	166,701			32
33	Real Estate Taxes			162,000	162,000		162,000	4,100	166,100			33
34	Rent-Facility & Grounds			1,050,487	1,050,487		1,050,487	37,387	1,087,874			34
35	Rent-Equipment & Vehicles			50,882	50,882		50,882	3,619	54,501			35
36	Other (specify):*			-				-				36
37	TOTAL Ownership			1,757,562	1,757,562		1,757,562	(143,662)	1,613,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	393,121	1,250,007	1,643,128		1,643,128	-	1,643,128			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			281,182	281,182		281,182	-	281,182			42
43	Other (specify):* Non-Allowable Cos	90,408	-	595,299	685,707		685,707	(685,707)				43
44	TOTAL Special Cost Centers	90,408	393,121	2,126,488	2,610,017		2,610,017	(685,707)	1,924,310			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,169,953	934,183	6,901,054	14,005,190		14,005,190	(1,472,226)	12,532,964			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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	(9,155)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(183,527)	30		9
10	Interest and Other Investment Income	(9,578)	32		10
11	Discounts, Allowances, Rebates & Refunds	(36,715)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,437)	43		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	(9,438)	43		18
19	Entertainment	(210)	43		19
20	Contributions	(12,700)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(303,053)	43		24
25	Fund Raising, Advertising and Promotional	(37,720)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(335,437)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (939,970)		$	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)	(532,256)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (532,256)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,472,226)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Warren Barr Lincolnshire

ID# 0053587

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (3,386)	43	1
2	Labs-Part A	(27,140)	43	2
3	X-Rays-Part A	(25,795)	43	3
4	Consolidated Billing charges	(23,626)	43	4
5	Valet Services	(33,146)	43	5
6	Sequestration Expense	(107,493)	43	6
7	Misc. Income	18	21	7
8	Expense LHI to maintenance		6	8
9	Admissions salary	(90,408)	43	9
10	Non-allowable legal	(24,462)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(335,437)		49

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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-Supplemen		

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	100%	$ 911	$ 911	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services	100%	56	56	16
17	V	02	FOOD		Legacy Healthcare Financial Services	100%	16	16	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services	100%	1,521	1,521	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100%	9	9	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100%	6,464	6,464	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services	100%	1,127	1,127	21
22	V	10	NURSING SALARY	109,955	Legacy Healthcare Financial Services	100%	59,775	(50,180)	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services	100%	2,448	2,448	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100%	69	69	24
25	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100%	60	60	25
26	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services	100%	3,742	3,742	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100%	22	22	27
28	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services	100%	6,932	6,932	28
29	V	17	CFO/ADMINISTRATIVE SALARY	625,634	Legacy Healthcare Financial Services	100%	80,050	(545,584)	29
30	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100%	9,732	9,732	30
31	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services	100%	553	553	31
32	V	21	CLERICAL AND GENERAL WAGES	337,873	Legacy Healthcare Financial Services	100%	325,491	(12,382)	32
33	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services	100%	9,415	9,415	33
34	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services	100%	2,652	2,652	34
35	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services	100%	4,506	4,506	35
36	V	27	NON-NURSING PAYROLL TAXES/BENI	67,174	Legacy Healthcare Financial Services	100%	50,727	(16,447)	36
37	V	32	INTEREST		Legacy Healthcare Financial Services	100%	29	29	37
38	V	34	RENT		Legacy Healthcare Financial Services	100%	37,248	37,248	38
39	Total			$ 1,140,636			$ 603,555	$ * (537,081)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	34	OFFSITE STORAGE/PARKING	$	Legacy Healthcare Financial Services	100%	$ 139	$ 139	15
16	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100%	194	194	16
17	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100%	3,425	3,425	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,758	$ * 3,758	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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			$			$ 0	$ *	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	100%	$ 904	$ 904	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100%	1,217	1,217	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100%	38	38	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100%	1	1	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100%	298	298	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100%	349	349	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100%	4,308	4,308	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100%	4,100	4,100	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 11,214	$ * 11,214	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	6	Repairs and Maintenance	$ 39,298	ReMed Services, LLC	1%	$ 38,166	$ (1,132)	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			$ 39,298			$ 38,166	$ * (1,132)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	$ 34,206	ProPay HR LLC	24%	$ 25,251	$ (8,955)	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			$ 34,206			$ 25,251	$ * (8,955)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	6	Repairs and Maintenance	$ 813	ML Group Design and Development		$ 753	$ (60)	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			$ 813			$ 753	$ * (60)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	YAIR ZUCKERMAN	10%	Astoria Place Living & Rehab	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	MENACHEM SHABAT	3%	Bella Terra Morton Grove	Morton Grove	Financial Srvcs, LLC			2
3	MENACHEM & AHUVA SHABAT DESC	28%	Chalet Living & Rehab Center	Chicago				3
4	CHAIM RAJCHENBACH	8%	Elmbrook Nursing	Elmhurst	Legacy Real	Skokie	Real Estate	4
5	GPN FAMILY TRUST	23%	The Grove of Evanston, LLC	Evanston	Properties, LLC			5
6	DAVID M. FRIEDMAN	5%	The Villa at Evergreen	Evergreen Park				6
7	RONALD SHABAT	10%	The Grove of Fox Valley	Aurora	Grove Healthcare	Skokie	Real Estate	7
8	THE RAJCHENBACH 2015 FAMILY TR	10%	The Grove of LaGrange Park LLC	LaGrange Park	Properties, LLC			8
9	ROSS BOTTNER	3%	The Grove at the Lake	Zion				9
10			Lakefront Nursing & Rehab Center, LLC	Chicago	ReMED Services,	Skokie	Medical	10
11			The Grove at Lincoln Park Living & Rehab	Chicago	LLC		Equipment Sales	11
12			Avantara Long-Grove	Long Grove				12
13			The Grove North Living & Rehab Center	Skokie	Progressive	Skokie	Consulting	13
14			The Grove of Northbrook	Northbrook	Healthcare			14
15			Warren Barr North Shore	Highland Park	Consulting			15
16			Avantara Park Ridge	Park Ridge				16
17			Peterson Park Associates Ltd. Partnetship	Chicago	MG Property	Morton Grove	Real Estate	17
18			Warren Barr South Loop	Chicago	Holdings, LLC			18
19			Warren Barr	Chicago				19
20			Aurora Supportive Living	Aurora	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21								21
22					ProPay	Evanston	Payroll Services	22
23								23
24					ML Group Design	Skokie	Asset Mgmt Fees	24
25								25
26					ML Enterprise	Skokie	Asset Mgmt Fees	26
27								27
28					CF St.Louis Inc	Skokie	Management Co.	28
29								29
30								30

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	No owners from this facility received any compensation.										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	30	$ 33,257	$ 33,257	52,560	$ 911	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	30	2,031		52,560	56	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	30	595		52,560	16	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	30	55,512		52,560	1,520	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	30	343		52,560	9	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	30	235,999	235,999	52,560	6,464	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	30	41,154		52,560	1,127	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	30	2,182,345	2,182,345	52,560	59,775	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	30	89,384		52,560	2,448	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	30	2,503		52,560	69	10
11	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	30	2,204		52,560	60	11
12	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	30	136,611	136,611	52,560	3,742	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	30	800		52,560	22	13
14	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	30	253,092		52,560	6,932	14
15	17	CFO/ADMINISTRATIVE SALAI	AVAIL. BED DAYS	1,918,919	30	2,922,553	2,922,553	52,560	80,050	15
16	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	30	355,302		52,560	9,732	16
17	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	30	20,207		52,560	553	17
18	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	30	11,883,371		52,560	325,491	18
19	21	CLERICAL AND OFFICE EXPE	AVAIL. BED DAYS	1,918,919	30	343,715		52,560	9,415	19
20	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	30	96,819		52,560	2,652	20
21	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	30	164,496		52,560	4,506	21
22	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	30	1,852,008		52,560	50,727	22
23	32	INTEREST	AVAIL. BED DAYS	1,918,919	30	1,074		52,560	29	23
24	34	RENT	AVAIL. BED DAYS	1,918,919	30	1,359,900		52,560	37,248	24
25	TOTALS					$ 22,035,274	$ 5,510,765		$ 603,554	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	34	OFFSITE STORAGE/PARKING	Bed Days Available	1,918,919	30	$ 5,072	$	52,560	$ 139	1
2	35	EQUIPMENT RENTAL	Bed Days Available	1,918,919	30	7,088		52,560	194	2
3	35	AUTO RENTAL	Bed Days Available	1,918,919	30	125,028		52,560	3,425	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					$ 137,189	$		$ 3,758	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	30	$ 32,982	$	52,560	$ 904	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	30	44,396		52,560	1,217	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	30	1,378		52,560	38	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	30	23		52,560	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	30	10,860		52,560	298	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	30	12,721		52,560	349	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	30	157,106		52,560	4,308	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	30	149,528		52,560	4,100	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	$		$ 11,215	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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: 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	6	Repairs & Maintenance	Direct Allocation			$	$		$ 38,166	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					$	$		$ 38,166	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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 Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 25,251	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					$	$		$ 25,251	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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 instruct YES X NO

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

Name of Related Organization: ML Group Design and Development
Street Address: 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	6	Repairs and Maintenance	Direct Allocation			$	$		$ 753	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					$	$		$ 753	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	CapEx		8/19/2017	2,500,000	1,646,794	1/1/2019	Libor + 4.75%	171,942	6
7												7
8												8
9	TOTAL Facility Related						$ 2,500,000	$ 1,646,794			$ 171,942	9
	B. Non-Facility Related*											
10												10
11								Interest Income			(9,578)	11
12												12
13								Allocated from Mgmt Co.			4,337	13
14	TOTAL Non-Facility Related						$	$			$ (5,241)	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 1,646,794			$ 166,701	15

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

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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.**		$ 14,352	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.)	2017	$ 176,352	2
3. Under or (over) accrual (line 2 minus line 1).		$ 162,000	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.)**		$	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.)**	Alloc Fr. Mgmt Co. 4,100	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 166,100	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	168518	8
	2014	172509	9
	2015	166492	10
	2016	169516	11
	2017	176,352	12

Beginning Accrual Adjusted

Allocated from CF St. Louis LLC: $4,100

	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 Lincolnshire COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053587

CONTACT PERSON REGARDING THIS REPORT Moti Ninio

TELEPHONE (847) 676-5315 FAX #: (773) 248-9703

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.	15-15-200-062	LTCF	$ 176,351.89	$ 176,351.89
2.			$	$
3.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 4,099.91
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 668,833.83	$ 180,451.80

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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,477 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

Lincolnshire Assisted Living

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	-		$ 5,411	1
2					2
3	TOTALS			$ 5,411	3

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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					$	$ -		$ -	$	$	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9						-		-			9
10	Allocation C.F St. Louis, LLC				29,137	-		832	832	2,497	10
11						-		-			11
12						-		-			12
13						-		-			13
14						-		-			14
15						-		-			15
16						-		-			16
17						-		-			17
18						-		-			18
19						-		-			19
20						-		-			20
21						-		-			21
22						-		-			22
23						-		-			23
24						-		-			24
25						-		-			25
26						-		-			26
27						-		-			27
28						-		-			28
29						-		-			29
30						-		-			30
31						-		-			31
32						-		-			32
33						-		-			33
34						-		-			34
35						-		-			35
36						-		-			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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				-		-			67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		$ 29,137	$		$ 832	$ 832	$ 2,497	70

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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		$ 29,137	$		$ 832	$ 832	$ 2,497	1
2	Kitchen - Millwork/Countertop/Cabinet	2015	25,783	-	20	752	752	3,545	2
3	Resident Rm/Dining/Hallways - Wall Sconces/Light Fixtures	2015	20,930	-	20	610	610	2,703	3
4	Resident Rooms - Power Outlets/Cables/Plates	2015	4,200	-	20	123	123	525	4
5	Resident Rooms - Carpet/Flooring	2015	4,300	-	20	125	125	537	5
6	Tile In Riviera Wing	2015	6,400	-	20	187	187	800	6
7	Resident Room Carpet	2015	31,058	-	20	906	906	3,882	7
8	Wood/Fire Rated Door & Hinges For Corridor	2015	10,953	-	20	319	319	1,369	8
9	Glass Door	2015	7,730	-	20	225	225	966	9
10	Resident Room Flooring	2015	14,057	-	20	410	410	1,757	10
11	Cape Cod Unit Tile	2015	7,715	-	20	225	225	964	11
12	Double Egress Fire Doors	2015	2,992	-	20	87	87	374	12
13	Corridors Carpet/Flooring	2015	9,096	-	20	265	265	1,099	13
14	Cape Cod Unit Drapery/Curtains	2015	12,109	-	20	353	353	1,413	14
15	Cape Cod Unit Wallcovering	2015	3,102	-	20	90	90	362	15
16	Cape Cod Unit Glass Mount Bracket	2015	4,052	-	20	118	118	473	16
17	Cape Cod Unit Double Doors	2015	7,730	-	20	225	225	902	17
18	Corridor Signage	2015	3,855	-	20	112	112	530	18
19	Cape Cod Unit - New Frames/Doors	2015	3,647	-	20	106	106	410	19
20	New Compressor For Chiller	2015	8,897	-	20	259	259	1,075	20
21	Install Door Controls	2015	20,150	-	20	588	588	2,519	21
22	Drapery - Coventry/Palm Beach Wings	2015	6,000	-	20	175	175	675	22
23	Dining Area/Guest Room - Valance/Rods/Divider Panels	2015	33,300	-	20	971	971	4,579	23
24	Bathroom/Resident Rooms - Dividers/Doors	2015	17,820	-	20	520	520	2,450	24
25	Resident Rooms/Corridors - Painting	2015	16,900	-	20	493	493	2,183	25
26	Cape Cod Unit Wallcovering	2015	5,603	-	20	163	163	677	26
27	East Wing - Primer/Tile	2015	30,947	-	20	903	903	4,255	27
28	Dining Room, Hallway, Gym & Library - Painted Ceiling/Walls	2016	9,850	-	20	493	493	1,478	28
29	Hallways - Tiles & Carpet	2016	6,392	-	20	320	320	959	29
30	Cape Cod -Installed Roller Shades	2016	5,580	-	20	279	279	837	30
31	Wireless Access Point	2016	58,169	-	20	2,908	2,908	8,725	31
32	Security Cameras	2016	25,993	-	20	1,300	1,300	3,899	32
33	Hallways - Vinyl Tiles, Carpet	2016	4,100	-	20	205	205	615	33
34	TOTAL (lines 1 thru 33)		$ 458,547	$		$ 15,650	$ 15,650	$ 60,035	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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		$ 458,547	$		$ 15,650	$ 15,650	$ 60,035	1
2	Repaired Boiler	2016	2,732	-	20	137	137	410	2
3	Painted Resident Rooms/Bathrooms/Kitchen/Lounge/Office	2016	9,160	-	20	458	458	1,374	3
4	Installed Nurse Stations, Counters, Cabinets	2016	23,460	-	20	1,173	1,173	3,519	4
5	Tuscany Wing - Drywall & Nurses Station Repair	2016	2,633	-	20	132	132	395	5
6	Painted Dining Room And Hallways	2016	25,200	-	20	1,260	1,260	3,780	6
7	Architectural Fees - Wing Conversion	2016	12,000	-	20	600	600	1,800	7
8	Exterior Signage	2016	14,135	-	20	707	707	2,120	8
9	Tuscany/Barcelona Wing - Carpeting	2016	19,655	-	20	983	983	2,948	9
10	Unit Melbourne - Carpeting	2016	3,995	-	20	200	200	599	10
11	Painted 8 Regular And 4 Double Rooms	2016	11,957	-	20	598	598	1,794	11
12	Chiller Hook Up	2016	2,590	-	20	130	130	389	12
13	Repair Leaks In 4-Rtu Hydronic Coils	2016	6,646	-	20	332	332	997	13
14	Landscaping Including Shrubs & Ground Cover	2016	8,749	-	20	437	437	1,312	14
15	Installation Of Wiring For Kiosk, Nurse Station, And Speaker Loc	2016	4,496	-	20	524	524	1,873	15
16	Replaced Garbage Disposal	2016	3,250	-	20	379	379	1,138	16
17	Repaired Generator	2016	2,934	-	20	342	342	1,076	17
18	Repaired Pump	2016	4,902	-	20	327	327	980	18
19	Installed Light Fixtures For Melbourne, Tuscany & Sydney Wings	2016	3,853	-	20	502	502	1,864	19
20	Demolition Of 9 Fixtures & Can Lights For Nurse Stations	2016	3,610	-	20	182	182	598	20
21	Insulated Chilled Water Pipes/Mechanical Room Pipes	2016	10,875	-	20	544	544	1,631	21
22	Repaired Pump	2016	4,902	-	20	245	245	735	22
23	Removed And Replaced Garbage Disposal	2016	2,650	-	20	133	133	398	23
24	Repaired Fire Alarm System	2016	3,124	-	20	156	156	469	24
25	Repaired Valves On Boiler	2016	3,033	-	20	152	152	455	25
26	Cape Cod Unit - Demo/Carpentry/Drywall/Electical/Tiling.Paintin	2016	334,638	-	20	16,732	16,732	50,196	26
27	West Wing - Installed Nurse Station/Work Hub	2016	28,688	-	20	1,434	1,434	4,303	27
28	Installed New Chiller	2016	168,000	-	20	8,400	8,400	25,200	28
29	Repair cracks in curb, storm drain & wooden fence	2017	4,250	-	20	212	212	318	29
30	Cut down 47 trees, hauled away and ground stumps	2017	9,800	-	20	490	490	735	30
31				-		-			31
32	Replace high low pressure switch, fix compressor	2017	2,540	-	20	127	127	191	32
33	East boiler replaced and leaking water lines fixed	2017	7,907	-	20	395	395	593	33
34	TOTAL (lines 1 thru 33)		$ 1,204,910	$		$ 54,071	$ 54,071	$ 174,224	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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		$ 1,204,910	$ -		$ 54,071	$ 54,071	$ 174,224	1
2	Knock down frames or doors, preped hinges, install			-		-			2
3	hinges and double engress frames and doors	2017	7,761	-	20	388	388	582	3
4				-		-			4
5	Maintenance on 4 large slope roofs, cleaned gutters, fixed			-		-			5
6	damaged fascia and shingles	2017	6,300	-	20	315	315	473	6
7				-		-			7
8	Brick wall at the rear of the facility, wall need to be reinforced			-		-			8
9	bricks were cut out and put back in without gaps.	2018	2,650	-	20	66	66	66	9
10	Repair underground passage that connects Lincolnshire			-		-			10
11	to the Wellshire building. Water proof, crack sealer,			-		-			11
12	repair pipes.	2018	4,500	-	20	113	113	113	12
13	Spriklers in grass area, replace nozzles and rotaries	2018	5,565	-	20	139	139	139	13
14	Install glycol in 2 Aaon rooftop units, first floor Carrier			-		-			14
15	air handler coil, and 2 chillers	2018	3,445	-	20	86	86	86	15
16				-		-			16
17				-		-			17
18				-		-			18
19				-		-			19
20				-		-			20
21	To reconcile Current Book Depreciation			322,251		-	(322,251)		21
22				-		-			22
23				-		-			23
24				-		-			24
25				-		-			25
26				-		-			26
27				-		-			27
28				-		-			28
29	Allocated from Legacy	2018	216	-	20	11	11	11	29
30				-		-			30
31				-		-			31
32	Allocated from CF St. Louis LLC	2016	180,903	-	20	9,045	9,045	27,135	32
33	Allocated from CF St. Louis LLC	2017	4,199	-	20	210	210	420	33
34	TOTAL (lines 1 thru 33)		$ 1,420,449	$ 322,251		$ 64,444	$ (257,807)	$ 203,249	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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		$ 1,420,449	$ 322,251		$ 64,444	$ (257,807)	$ 203,249	1
2				-		-			2
3				-		-			3
4				-		-			4
5				-		-			5
6				-		-			6
7				-		-			7
8				-		-			8
9				-		-			9
10				-		-			10
11				-		-			11
12				-		-			12
13				-		-			13
14				-		-			14
15				-		-			15
16				-		-			16
17				-		-			17
18				-		-			18
19				-		-			19
20				-		-			20
21				-		-			21
22				-		-			22
23				-		-			23
24				-		-			24
25				-		-			25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 1,420,449	$ 322,251		$ 64,444	$ (257,807)	$ 203,249	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	$ 829,084	$	$ 69,614	$ 69,614	10	$ 205,426	71
72	Current Year Purchases	33,419		3,342	3,342	5	3,342	72
73	Fully Depreciated Assets				-			73
74	Allocation fr Mgmt	13,247		1,324	1,324		3,359	74
75	TOTALS	$ 875,750	$	$ 74,280	$ 74,280		$ 212,127	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	N/A			$	$ -	$ -	$ -		$	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)	$ 2,301,610	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 322,251	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 138,724	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (183,527)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 415,376	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	Assisted Living Addition - 2016	$ 53,025	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 53,025	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 15,800	92
93			93
94			94
95		$ 15,800	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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Cambridge Realty

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 [X] 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:		144		$ 1,050,487			3
4	Additions							4
5								5
6	Alloc fr Mgmt				37,387			6
7	TOTAL		144		$ 1,087,874 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$ 1,854,747
13.	/2020	$ 1,867,652
14.	/2021	$ 1,880,814

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: $ 51,076 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	Alloc fr Mgmt			3,425	20
21	TOTAL		$	$ 3,425	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: **Warren Barr Lincolnshire**
IDPH License ID Number: **0053587**
Fiscal Year End: **12/31/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Durable Medical Equipment Rental	37,871
Oxygen Equipment Rental	2,417
Dietary Equipment Rental	3,150
Maintenance Equipment Rental	875
Office Equipment Rental-Postage	6,569
Alloc fr mgmt	194
Total - Line 16	**51,076**

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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

It is the policy of this facility to only hire certified nurses aides.

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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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(3)	hrs	$	7,188	$	517,544	$	7,188	$ 517,544	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,214		87,441		1,214	87,441	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39(3)	hrs		8,959		645,022		8,959	645,022	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescrpts					348,431		348,431	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): Oxygen	39(2)						44,690		44,690	12
13	Other (specify):										13
14	TOTAL			$	17,361	$	1,250,007	$ 393,121	17,361	$ 1,643,128	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 Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	$ 1,494	$ 1,494	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 766,036)	2,618,842	2,618,842	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,142	22,142	6
7	Other Prepaid Expenses	26,571	26,571	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	208,965	208,965	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,878,014	$ 2,878,014	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		5,411	13
14	Buildings, at Historical Cost		29,137	14
15	Leasehold Improvements, at Historical Cost	1,054,311	1,391,312	15
16	Equipment, at Historical Cost	1,167,192	875,750	16
17	Accumulated Depreciation (book methods)	(903,929)	(415,376)	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 (spe CIP	15,800	15,800	22
23	Other(specify): See Sch 17A	1,946,232	1,946,232	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,279,606	$ 3,848,266	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,157,620	$ 6,726,280	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,126,554	$ 1,126,554	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	292,661	292,661	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,045	13,045	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	6,548,300	6,548,300	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,980,560	$ 7,980,560	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,646,794	1,646,794	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,646,794	$ 1,646,794	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,627,354	$ 9,627,354	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,469,734)	$ (2,901,074)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,157,620	$ 6,726,280	48

*(See instructions.)

Facility Name: **Warren Barr Lincolnshire**
IDPH License ID Number: **0053587**
Fiscal Year End: **12/31/18**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Refund	22,541	22,541
Insurance Refund Exchange	(12,621)	(12,621)
Escrow R&R	188,461	188,461
Payroll Clearing	4,821	4,821
Security Deposit	5,763	5,763
Total - Line 9	**208,965**	**208,965**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Resident Fund	(3,437)	(3,437)
Refund Transfer	91,547	91,547
Due To/From Warren Barr Lincolnshire & ALF	1,448,511	1,448,511
Due To/From South Loop & Warren Barr Lincolnshire	(96,636)	(96,636)
Due TO/From Warren Barr Lincolnshire & Bella Terra	196,632	196,632
Due to/From Prior Owner	156,232	156,232
Due to/From Medicare	150,412	150,412
Bad Debt Part A-MMAI	2,971	2,971
Total - Line 23	**1,946,232**	**1,946,232**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Exchange	(16,450)	(16,450)
Prepaid Insurance-Workmans Comp	19,756	19,756
Payroll Exchange	12,897	12,897
Rent Security Deposit	8,810	8,810
Due To/From Warren Barr Lincolnshire & Management	1,614,647	1,614,647
Due To/From Warren Barr South Loop & Warren Bar	113,996	113,996
Due To/From Warren Barr Lincolnshire & Avantar	(186)	(186)
Due to/from others	896,010	896,010
Due to/from Members Entities	1,000,000	1,000,000
Accrued Expense	161,468	161,468
Accrued Management Fees Entities	2,550,491	2,550,491
Accrued BCBS EE Insurance	30,025	30,025
Due to BCBS UPP	50,183	50,183
BCBS Accelerated Payment	106,653	106,653
Total - Line 36	**6,548,300**	**6,548,300**

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,027,206)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,027,206)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,442,528)	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)**	$ (1,442,528)	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)**	$ (3,469,734)	24 *

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	$ 14,004,015	1
2	Discounts and Allowances for all Levels	(7,737,613)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,266,402	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,733,402	6
7	Oxygen	201	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,733,603	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	402,611	17
18	Sale of Supplies to Non-Patients	42,267	18
19	Laboratory	68,049	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,836	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 515,763	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,578	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,578	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	37,316	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 37,316	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,562,662	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,899,916	31
32	Health Care	5,623,200	32
33	General Administration	2,114,495	33
	B. Capital Expense		
34	Ownership	1,757,562	34
	C. Ancillary Expense		
35	Special Cost Centers	2,328,835	35
36	Provider Participation Fee	281,182	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,005,190	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,442,528)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,442,528)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,761,358	44
45	Private Pay - Net Inpatient Revenue	927,767	45
46	Medicare - Net Inpatient Revenue	911,523	46
47	Other-(specify) Insurance	60,775	47
48	Other-(specify) Part B	(395,021)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,266,402	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

^ Entity is a cash basis taxpayer

Facility Name: **Warren Barr Lincolnshire**
IDPH License ID Number: **0053587**
Fiscal Year End: **12/31/18**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
DISCOUNTS EARNED	31,983
REBATES	4,732
MISC INCOME	(18)
RADIOLOGY - PRIOR PERIOD	(55)
LABORATORY - PRIOR PERIOD	(213)
STATE INCOME TAX	887
Total - Line 28	**37,316**

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 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	1,617	1,806	$ 112,000	$ 62.03	1
2	Assistant Director of Nursing	2,052	2,166	95,181	43.94	2
3	Registered Nurses	36,287	41,122	1,396,213	33.95	3
4	Licensed Practical Nurses	25,773	29,227	828,135	28.33	4
5	CNAs & Orderlies	108,691	118,398	1,812,580	15.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,585	6,176	127,317	20.62	8
9	Activity Director	2,734	2,786	64,694	23.23	9
10	Activity Assistants	9,473	10,302	136,396	13.24	10
11	Social Service Workers	6,052	6,351	137,511	21.65	11
12	Dietician					12
13	Food Service Supervisor	4,080	4,328	113,712	26.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,357	40,468	522,464	12.91	15
16	Dishwashers					16
17	Maintenance Workers	7,629	8,509	192,302	22.60	17
18	Housekeepers					18
19	Laundry	3,989	4,315	60,529	14.03	19
20	Administrator	2,039	2,188	107,688	49.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,705	10,572	178,869	16.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,068	2,080	38,430	18.48	31
32	Other Health C: See Sch 20A	4,027	4,223	155,523	36.83	32
33	Other(specify) See Sch 20A	3,745	3,990	90,408	22.66	33
34	TOTAL (lines 1 - 33)	272,903	299,006	$ 6,169,953 *	$ 20.63	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 25,383	1(3)	35
36	Medical Director	Monthly	47,905	9(3)	36
37	Medical Records Consultant	Monthly	400	10(3)	37
38	Nurse Consultant	Monthly	2,608	10(3)	38
39	Pharmacist Consultant	Monthly	11,708	10(3)	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	1,496	11(3)	44
45	Social Service Consultant	Monthly	5,339	12(3),(7)	45
46	Other(specify) Transitional	Monthly	6,000	10(3)	46
47	MDS Consultant	Monthly	33,794	10(3)	47
48	Wound Care	Monthly	20,336	10(3)	48
49	TOTAL (lines 35 - 48)		$ 154,969		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,782	$ 133,554	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,812	64,686	10(3)	52
53	TOTAL (lines 50 - 52)	5,595	$ 198,240		53

Facility Name: **Warren Barr Lincolnshire**
IDPH License ID Number: **0053587**
Fiscal Year End: **12/31/18**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS/Care Plan Coordinator LPN	2,064	2,080	75,368	$ 36.23
MDS/Care Plan Coordinator RN	1,955	2,139	79,865	$ 37.33
Total - Line 32 Other Health Care (specify):	**4,019**	**4,219**	**155,233**	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Coord(Asst/Clerk)	1,130	1,152	19,813	$ 17.19
Admissions Director	1,437	1,464	42,638	$ 29.12
Guest Services Director	1,177	1,373	27,956	$ 20.36
Total - Line 33 Other (specify):	**3,745**	**3,990**	**90,408**	

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Florczak, Michael	Administrator	0.00%	$ 49,135
Carrasco, Elizabeth	Administrator	0.00%	58,553
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,688

B. Administrative - Other

Description	Amount
Management Fees(elminated in column 7)	$ 625,634
TOTAL (agree to Schedule V, line 17, col. 3)	$ 625,634
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See schedule 21C	Various	$ 139,149
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 139,149

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,666
Unemployment Compensation Insurance	105,263
FICA Taxes	460,399
Employee Health Insurance	159,862
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	24,169
Employee Physical Exams	23,759
Other Employee Benefits	(13,519)
Allocated fr Mgmt	(67,174)
TOTAL (agree to Schedule V, line 22, col.8)	$ 731,425

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 64)	637
Patient Background Checks 114	1,135
Dues and Subscriptions	14,618
License and Permits	15,457
Allocated fr Mgmt	554
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,391

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
N/A	
In-State Travel	
N/A	
Seminar Expense	
Allocated fr Mgmt	2,652
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,652

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Warren Barr Lincolnshire**
IDPH License ID Number: **0053587**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Marcum LLP	Accounting	18,000
Compliance Resources Inc.	Compliance Legal	169
Broadcast Music Inc	Media	568
Inspection Group Inc	Compliance	550
Motion Picture Licensing Corp	Media	145
Pro Fee Accrual	Accrual	(268)
Legacy Reimbursements Pro Fees	Pro Fees	3,374
MTS Consulting	Tax Consulting	2,529
Personnel Planners	Unemployment Tax Consultant	1,710
Integra Scripts LLC	Perscription consulting	21,681
Adam Zollinger Interiors	Interior Design	525
Achieve Accreditation LLC	Joint Commission Consultant	10,616
Legal Accrual	Accrual	(1,507)
Department Of Homeland Sec	Legal	2,460
Legacy Reimbursement	Legal	2,394
Meyer Magence	Legal	3,375
Stone Pogrund & Korey LLC	Legal	1,553
Scott & Krauss LLC	Legal	9,364
Corporation Service Company	Legal	81
Stone, McGuire & Siegel	Legal	1,279
Ogletree Deakins Nash Smoak & Stewart, P	Legal	11,135
Kitch Drutchas Wagner Valitutt	Legal	74
RSM US LLP	Accounting	15,135
Paycor Inc.	Payroll Services	34,207
	Total (agree to Schedule V, line 19, column 3)	139,149

Allocated from Management Company	Legal Fees	
Allocated from Management Company	Professional Services	815
Less: Non-Allowable Legal Fees		(24,462)
	Total (agree to Schedule V, line 19, column 8)	115,502

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/1/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **74,164** 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. $ **281,182**
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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** 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 1**
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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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