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: 0052787

Facility Name: Warren Barr North Shore

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

County: Lake

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	215	Skilled (SNF)	215	78,475	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,205	6,728	17,738	49,671	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,205	6,728	17,738	49,671	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.30%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2014

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 215 and days of care provided 14,199

Medicare Intermediary CGS Administrators LLC

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	470,828	68,834	103,065	642,727		642,727	1,443	644,170			1
2	Food Purchase		420,288		420,288		420,288	(35,347)	384,941			2
3	Housekeeping	270,368	53,758	35,742	359,868		359,868	2,270	362,138			3
4	Laundry	34,883	25,779	115,051	175,713		175,713	(3,209)	172,504			4
5	Heat and Other Utilities			253,190	253,190		253,190	(11,649)	241,541			5
6	Maintenance	111,931	25,400	280,548	417,879		417,879	27,851	445,730			6
7	Other (specify):*											7
8	TOTAL General Services	888,010	594,059	787,596	2,269,665		2,269,665	(18,641)	2,251,024			8
	B. Health Care and Programs											
9	Medical Director			101,443	101,443		101,443		101,443			9
10	Nursing and Medical Records	4,349,234	152,623	59,177	4,561,034		4,561,034	(92,762)	4,468,272			10
10a	Therapy	234,867			234,867		234,867		234,867			10a
11	Activities	132,019	17,403	2,604	152,026		152,026	90	152,116			11
12	Social Services	245,572	40,964	1,934	288,470		288,470	5,619	294,089			12
13	CNA Training											13
14	Program Transportation			65,271	65,271		65,271		65,271			14
15	Other (specify):*							10,350	10,350			15
16	TOTAL Health Care and Programs	4,961,692	210,990	230,429	5,403,111		5,403,111	(76,702)	5,326,409			16
	C. General Administration											
17	Administrative	223,594			223,594		223,594	119,519	343,113			17
18	Directors Fees											18
19	Professional Services			251,081	251,081		251,081	(3,962)	247,119			19
20	Dues, Fees, Subscriptions & Promotions			162,414	162,414		162,414	(102,556)	59,858			20
21	Clerical & General Office Expenses	688,981	6,854	711,374	1,407,209		1,407,209	(642,970)	764,239			21
22	Employee Benefits & Payroll Taxes			995,092	995,092		995,092	(115,895)	879,197			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,406	4,406		4,406	3,959	8,365			24
25	Other Admin. Staff Transportation			1,342	1,342		1,342		1,342			25
26	Insurance-Prop.Liab.Malpractice			386,381	386,381		386,381	7,248	393,629			26
27	Other (specify):*							75,739	75,739			27
28	TOTAL General Administration	912,575	6,854	2,512,090	3,431,519		3,431,519	(658,917)	2,772,602			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,762,277	811,903	3,530,115	11,104,295		11,104,295	(754,260)	10,350,035			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Warren Barr North Shore #0052787 Report Period Beginning: 01/01/18 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			589,753	589,753		589,753	288,761	878,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,027	62,027		62,027	881,988	944,015			32
33	Real Estate Taxes			192,000	192,000		192,000	6,121	198,121			33
34	Rent-Facility & Grounds			1,412,130	1,412,130		1,412,130	(1,409,793)	2,337			34
35	Rent-Equipment & Vehicles			22,607	22,607		22,607	5,403	28,010			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,278,517	2,278,517		2,278,517	(227,519)	2,050,998			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		731,946	2,206,081	2,938,027		2,938,027		2,938,027			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			327,059	327,059		327,059		327,059			42
43	Other (specify):*			860,423	860,423		860,423	(860,423)	0			43
44	**TOTAL Special Cost Centers**		731,946	3,393,563	4,125,509		4,125,509	(860,423)	3,265,086			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,762,277	1,543,849	9,202,195	17,508,321		17,508,321	(1,842,202)	15,666,119			45

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	(12,999)	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	288,761	30		9
10	Interest and Other Investment Income	(111,848)	32		10
11	Discounts, Allowances, Rebates & Refunds	(34,803)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(568)	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	(700)	21		18
19	Entertainment	(2,171)	21		19
20	Contributions	(36,000)	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	(337,692)	21		24
25	Fund Raising, Advertising and Promotional	(55,703)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,141,195)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,444,918)		$	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)	(397,285)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (397,285)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,842,203)		37

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

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

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

Warren Barr North Shore

ID# 0052787

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (63,326)	21	1
2	Patient Personal Items	(12,624)	10	2
3	Business Cards	(542)	21	3
4	Bank Charges	(15,186)	21	4
5	Sequestration	(162,862)	21	5
6	Rebates	(5,959)	21	6
7	Bldg Co - Accounting	(3,384)	19	7
8	Bldg Co - Legal	(8,356)	19	8
9	Non Allowable Expense	(859,138)	43	9
10	Additional R&M	16,075	06	10
11	PAC Dues	(11,680)	20	11
12	Non Allowable Legal	(10,341)	19	12
13	Non Allowable Professional Fees	(1,285)	43	13
14	Collections	(66)	21	14
15	Pharmacy Discounts	(2,521)	10	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,141,195)		49

Warren Barr North Shore

ID# 0052787

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 North Shore # 0052787 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			1,443									1,443	1
2	Food Purchase	(35,371)		24									(35,347)	2
3	Housekeeping			2,270									2,270	3
4	Laundry			14						(3,223)			(3,209)	4
5	Heat and Other Utilities	(12,999)				1,350							(11,649)	5
6	Maintenance	16,075		11,334		1,817	(1,376)						27,851	6
7	Other (specify):*													7
8	**TOTAL General Services**	(32,295)		15,085		3,168	(1,376)			(3,223)			(18,641)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,145)		93,006	(170,364)				(259)				(92,762)	10
10a	Therapy													10a
11	Activities			90									90	11
12	Social Services			5,619									5,619	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				10,350								10,350	15
16	**TOTAL Health Care and Programs**	(15,145)		98,715	(160,014)				(259)				(76,702)	16
	C. General Administration													
17	Administrative			119,519									119,519	17
18	Directors Fees													18
19	Professional Services	(22,081)	11,740	14,530		56		(8,207)					(3,962)	19
20	Fees, Subscriptions & Promotions	(103,383)		826		1							(102,556)	20
21	Clerical & General Office Expenses	(588,504)		500,032	(554,942)	445							(642,970)	21
22	Employee Benefits & Payroll Taxes				(115,895)								(115,895)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,959									3,959	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			6,727		521							7,248	26
27	Other (specify):*			75,739									75,739	27
28	**TOTAL General Administration**	(713,968)	11,740	721,333	(670,837)	1,022		(8,207)					(658,917)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(761,408)	11,740	835,133	(830,851)	4,190	(1,376)	(8,207)	(259)	(3,223)			(754,260)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr North Shore # 0052787 **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 D. Ownership	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)	
30	Depreciation	288,761											288,761	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(111,848)	987,360	44		6,432							881,988	32
33	Real Estate Taxes					6,121							6,121	33
34	Rent-Facility & Grounds		(1,410,000)	55,821		(55,614)							(1,409,793)	34
35	Rent-Equipment & Vehicles				5,403								5,403	35
36	Other (specify):*													36
37	**TOTAL Ownership**	176,913	(422,640)	55,865	5,403	(43,061)							(227,519)	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):*	(860,423)											(860,423)	43
44	**TOTAL Special Cost Centers**	(860,423)											(860,423)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,444,918)	(410,900)	890,999	(825,448)	(38,871)	(1,376)	(8,207)	(259)	(3,223)			(1,842,202)	45

Facility Name & ID Number Warren Barr North Shore # 0052787 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	Rental Income	$ 1,410,000	Half Day Property Holdings LLC		$	$ (1,410,000)	1
2	V	19	Professional Fees - Accounting		Half Day Property Holdings LLC		3,384	3,384	2
3	V	19	Professional Fees - Legal		Half Day Property Holdings LLC		8,356	8,356	3
4	V	32	Interest Expense - Mortgage A		Half Day Property Holdings LLC		708,902	708,902	4
5	V	32	Interest Expense - Note A		Half Day Property Holdings LLC		278,458	278,458	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,410,000			$ 999,100	$ * (410,900)	14

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 1,360	$ 1,360	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		83	83	16
17	V	02	FOOD		Legacy Healthcare Financial Services		24	24	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		2,270	2,270	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		14	14	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		9,651	9,651	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,683	1,683	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		89,248	89,248	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		3,655	3,655	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		102	102	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		5,587	5,587	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		90	90	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		33	33	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		119,519	119,519	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		14,530	14,530	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		826	826	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		485,975	485,975	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		14,056	14,056	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		3,959	3,959	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		6,727	6,727	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		75,739	75,739	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		44	44	36
37	V	34	RENT		Legacy Healthcare Financial Services		55,614	55,614	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		207	207	38
39	Total			$			$ 890,999	$ * 890,999	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		290	$ 290	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		5,113	5,113	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		10,350	10,350	17
18	V								18
19	V	10	NURSING SALARY	170,364	Legacy Healthcare Financial Services			(170,364)	19
20	V	21	REIMB SALARIES - ADMINISTRATIVE	554,942	Legacy Healthcare Financial Services			(554,942)	20
21	V	22	REIMB PAYROLL TAXES	115,895	Legacy Healthcare Financial Services			(115,895)	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			$ 841,201			$ 15,753	$ * (825,448)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 1,350	$ 1,350	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		1,817	1,817	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		56	56	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		445	445	19
20	V	26	INSURANCE		CF St. Louis LLC		521	521	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		6,432	6,432	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		6,121	6,121	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	55,614	CF St. Louis LLC			(55,614)	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			$ 55,614			$ 16,743	$ * (38,871)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	$ 18,500	ML Group Design and Development		$ 17,124	$ (1,376)	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			$ 18,500			$ 17,124	$ * (1,376)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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 Processing	$ 31,350	ProPay HR LLC		$ 23,143	$ (8,207)	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			$ 31,350			$ 23,143	$ * (8,207)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	$ 9,000	ReMED Services		$ 8,741	$ (259)	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			$ 9,000			$ 8,741	$ * (259)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	$ 138,323	EcoBrite Linen		$ 135,100	$ (3,223)	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			$ 138,323			$ 135,100	$ * (3,223)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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 North Shore # 0052787 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 North Shore # 0052787 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	CHAIM RAJCHENBACH	31.65%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	HALF DAY PROPERTY HOLDINGS LLC		BUILDING CO	1
2	MENACHEM SHABAT	31.65%	AVANTARA BILLINGS	BILLINGS, MT	LEGACY HC & FINANCIAL SERV	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3	THE RAJCHENBACH FAMILY TRUST	11.65%	AVANTARA ELGIN	ELGIN	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	3
4	RONALD SHABAT	5.06%	AVANTARA LONG GROVE	LONG GROVE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	4
5	YAIR ZUCKERMAN	10.00%	AVANTARA PARK RIDGE	PARK RIDGE	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	5
6	ROSS BOTTNER	10.00%	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			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				20
21			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				21
22			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				22
23			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				23
24			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				24
25			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				25
26			VALLEY SKILLED NURSING FACILITY	BILLINGS, MT				26
27			WARREN BARR LIVING AND REHAB	CHICAGO				27
28			WARREN BARR SOUTH LOOP	CHICAGO				28
29								29
30								30

Facility Name & ID Number Warren Barr North Shore # 0052787 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 North Shore # 0052787 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											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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 North Shore # 0052787 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	78,475	$ 1,360	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		78,475	83	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		78,475	24	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		78,475	2,270	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		78,475	14	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	78,475	9,651	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		78,475	1,683	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	78,475	89,248	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		78,475	3,655	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		78,475	102	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	78,475	5,587	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		78,475	90	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		78,475	33	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	78,475	119,519	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		78,475	14,530	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		78,475	826	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	78,475	485,975	17
18	21	CLERICAL AND OFFICE EXPEI	AVAIL. BED DAYS	1,918,919	34	343,715		78,475	14,056	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		78,475	3,959	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		78,475	6,727	20
21	27	NON-NURSING PAYROLL TAXI	AVAIL. BED DAYS	1,918,919	34	1,852,008		78,475	75,739	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		78,475	44	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		78,475	55,614	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		78,475	207	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 890,999	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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: 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		78,475	290	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		78,475	5,113	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		78,475	10,350	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	$		$ 15,753	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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	$	78,475	$ 1,350	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		78,475	1,817	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		78,475	56	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		78,475	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		78,475	445	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		78,475	521	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		78,475	6,432	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		78,475	6,121	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	$		$ 16,743	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 Design and Development
Street Address: 3424 Oakton Street
City / State / Zip Code: Skokie, IL
Phone Number: ((847) 676-5300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct			$	$		$ 17,124	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					$	$		$ 17,124	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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: ProPay HR LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: ((847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 23,143	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 23,143	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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			$	$		$ 8,741	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 8,741	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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			$	$		$ 135,100	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					$	$		$ 135,100	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 North Shore # 0052787 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 North Shore # 0052787 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	Cole Taylor		X	Mortgage Payable			$	$ 12,612,538			$ 708,902	1
2	Note Payable		X	Seller Note Payable				3,800,000			278,458	2
3	Member Loan		X	Member Loan Payable				2,390,043				3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				1,350,000			62,027	6
7												7
8												8
9	TOTAL Facility Related						$	$ 20,152,581			$ 1,049,387	9
	B. Non-Facility Related*											
10	Interest Income		X								(111,848)	10
11	Allocated from Legacy & Progr	X									44	11
12	Allocated from CF St. Louis	X									6,432	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (105,372)	14
15	TOTALS (line 9+line14)						$	$ 20,152,581			$ 944,015	15

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

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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.**	$ 157,554	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.)		$ 166,810	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,256	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 188,865	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.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 198,121	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	135,169	8
	2014	139,473	9
	2015	153,877	10
	2016	156,742	11
	2017	160,689	12

2018 Accrual = $160,689 x 1.17 = $188,865
Allocated from CF St. Louis LLC: $6,121
Beginning Accrual Adjusted

	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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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.	16-16-401-005	Long Term Care Property	$ 160,688.59	$ 160,688.59
2.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 6,121.39
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 653,170.53	$ 166,809.98

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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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 North Shore # 0052787 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 1,508,714	1
2	Allocated from CF St. Louis LLC			8,079	2
3	TOTALS			$ 1,516,793	3

Facility Name & ID Number Warren Barr North Shore # 0052787 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	215		2014	1997	$ 16,827,972	$	35	$ 480,799	$ 480,799	$ 2,241,138	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	34,469		20	1,723	1,723	6,949	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											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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)		320,194			15,077	15,077	44,887	68
69	Financial Statement Depreciation			589,753			(589,753)		69
70	TOTAL (lines 4 thru 69)		$ 17,182,634	$ 589,753		$ 497,600	$ (92,153)	$ 2,292,974	70

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 17,182,634	$ 589,753		$ 497,600	$ (92,153)	$ 2,292,974	1
2	Sprinkler System	2015	13,275		20	664	664	2,655	2
3	Light Fixtures And Wall Sconce - 2Nd & 3Rd Floor	2015	23,309		20	1,165	1,165	4,662	3
4	Installed Pressure Backflow In Laundry Room	2015	6,120		20	306	306	1,224	4
5	Signs For Bathroom/Exits/Corridors	2015	12,917		20	646	646	2,583	5
6	Repaired Sprinkler System Valves	2015	3,125		20	156	156	625	6
7	2Nd-3Rd Fl Carpentry/Flooring/Painting/Nurse Call/Electrical/Doo	2015	2,127,551		20	106,378	106,378	438,309	7
8	Repaired Sprinkler System Valves	2015	3,125		20	156	156	625	8
9	Signage For Facility	2015	22,681		20	1,134	1,134	4,536	9
10	Installed Elevator Signage	2015	5,421		20	271	271	1,084	10
11	Bathroom Glass Mount Bracket	2015	2,692		20	135	135	538	11
12	Security System	2015	47,800		20	2,390	2,390	9,560	12
13	Chiller Replacement	2015	42,969		20	2,148	2,148	8,594	13
14	Pump Replacment	2015	3,298		20	165	165	660	14
15	Installed New Fan Coil In Resid Rms	2015	3,448		20	172	172	690	15
16	Security System	2015	14,936		20	747	747	2,987	16
17	Repaired Chiller	2015	6,340		20	317	317	1,268	17
18	Pump Replacement In Kitchen	2015	2,863		20	143	143	573	18
19	Repaired Condensing Unit	2015	4,130		20	207	207	826	19
20	Repaired Elevator	2015	8,700		20	435	435	1,740	20
21	Chandelier And Lights	2015	13,542		20	1,354	1,354	5,417	21
22	Heating Pump Repair	2015	3,334		20	167	167	667	22
23	Install Ventilation System In Tv Receiver Room	2015	3,975		20	199	199	795	23
24	Walk In Cooler Repair	2015	5,520		20	276	276	1,104	24
25	Repaired Roof	2016	86,630		20	4,332	4,332	12,995	25
26	Repaired Or Replaced Screen Windows On Building	2016	11,016		20	551	551	1,652	26
27	Replaced 1515 Sq Ft Of Sidewalk/Curb/Gutter/Electric Box	2016	19,588		20	979	979	2,938	27
28	1St Floor Stairwell & Elevator - Installed 2 Power Transfer Hinges	2016	2,815		20	141	141	422	28
29	Installed Fire Alarm System Devices/Repaired Valves	2016	5,762		20	288	288	864	29
30	Elevator Pit Ladder Repair	2016	2,768		20	138	138	415	30
31	Installed New Fan Motors And Blower Wheels For Heating Unit	2016	3,161		20	158	158	474	31
32	Boiler Room - Removed Existing Tempering Valve Station	2016	7,992		20	400	400	1,199	32
33	Fire Rated Fixture Protectors	2016	10,989		20	549	549	1,648	33
34	TOTAL (lines 1 thru 33)		$ 19,714,426	$ 589,753		$ 624,867	$ 35,114	$ 2,807,304	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 19,714,426	$ 589,753		$ 624,867	$ 35,114	$ 2,807,304	1
2	2Nd And 3Rd Floor Lounge - New Counter And Filing Cabinets	2016	4,275		20	214	214	641	2
3	Repaired Pump And Gasket	2016	4,341		20	217	217	651	3
4	Installed New Fence	2016	3,269		20	163	163	490	4
5	Parking Lot - Expanded 10-15 Spaces/Placed New Light Pole/Desig	2016	17,730		20	887	887	2,660	5
6	Dialysis Area - Demolished Office/Storage Areas/Pipes/Hvac/Idph	2016	46,912		20	2,346	2,346	7,037	6
7	Provided And Installed New Copper Piping And Fittings On The Fi	2017	3,870		20	129	129	258	7
8	Installed Of Parking And Building Lights	2017	3,125		20	143	143	286	8
9	Repaired Sprinkler Heads In Dialysis Unit	2017	8,725		20	254	254	508	9
10	Repaired Carpet - 2Nd And 3Rd Floor	2017	17,680		20	147	147	294	10
11	Repaired Fuel Pump	2017	3,437		20	29	29	58	11
12	Install Customer Millwork/Electrical - Resident Rooms	2017	11,988		20	50	50	100	12
13	Permit Fee For Dialysis Unit	2017	8,946		20	37	37	74	13
14	Repaired Heat Exchanger And Gas Valve	2017	8,250		20	34	34	68	14
15	Installed Vinyl Plank For Dialysis Unit	2017	7,524		20	31	31	62	15
16	Repaired Valves For Water Box-Dialysis Unit	2017	5,640		20	282	282	564	16
17	Installed 61 Fire Retardant Troffer Boxes-Therapy Rooms	2017	5,490		20	23	23	46	17
18	Installed Handrail For Dialysis Unit	2017	5,092		20	21	21	42	18
19	Installed Mixing Valves And Water Lines	2017	4,725		20	20	20	40	19
20	Site Design Fees For Dialysis Unit	2017	3,660		20	15	15	30	20
21	Installed 2Nd Floor Countertops	2017	3,360		20	56	56	112	21
22	Kitchen Equipment	2017	3,239		20	54	54	108	22
23	Installed Wiring For Dialysis Unit	2017	3,200		20	53	53	106	23
24	Carpeting For Common Areas	2017	5,748		20	287	287	575	24
25	Repaired Dialysis Unit/Carpet/Vinyl Wall Base/Pipe Lines	2017	270,677		20	13,534	13,534	27,068	25
26	Removal And Replacment By S & H Paving Inc. (25,000)	2018	23,140		20	972	972	972	26
27	Installation Of A Mine Split 3 Ton In Dialysis Room In Basement (5	2018	4,628		20	208	208	208	27
28	Remove Tower Pump & Rebuild Seal Assy (4,271)	2018	3,953		20	178	178	178	28
29	Ceiling Tile, Ada Compliant Bathroom Fixtures (4,250)	2018	3,934		20	177	177	177	29
30	Kitchen Drop Ceiling (4,000)	2018	3,702		20	167	167	167	30
31	Installation Of Single Packing (2,850)	2018	2,638		20	95	95	95	31
32	Security Cameras Installation (6,003)	2018	5,556		20	175	175	175	32
33	Installation Of Fan And Motor Dolleys (3,152)	2018	2,917		20	105	105	105	33
34	TOTAL (lines 1 thru 33)		$ 20,225,798	$ 589,753		$ 645,969	$ 56,216	$ 2,851,258	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 20,225,798	$ 589,753		$ 645,969	$ 56,216	$ 2,851,258	1
2	Installation Of Digital Controlled Mixing Valve (3,250)	2018	3,008		20	379	379	379	2
3	Carpet And Lighting For Dialysis Room Conversion (6,252)	2018	5,787		20	1,042	1,042	1,042	3
4	Blinds For 2 Residents' Rooms (3,196)	2018	2,958		20	426	426	426	4
5	Dialysis Rm Painting, Flooring, New Electrical, Ceiling (18,370)	2018	17,003		20	1,684	1,684	1,684	5
6	Repair Water Main Break In Parking Lot (25,951)	2018	24,020		20	1,730	1,730	1,730	6
7	Repair Main Water Pipe In Parking Lot (10,818)	2018	10,013		20	721	721	721	7
8	Repair Of Bolts In Water Pipe (2,795)	2018	2,587		20	186	186	186	8
9	Replacing The Floors In All The First Floor Hallways (9,782)	2018	9,054		20	82	82	82	9
10	Seal Kit Replacement (6,405)	2018	5,928		20	427	427	427	10
11	Switch And Add Phone Extensions (3,595)	2018	3,328		20	300	300	300	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)		$ 20,309,485	$ 589,753		$ 652,946	$ 63,193	$ 2,858,235	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 20,309,485	$ 589,753		$ 652,946	$ 63,193	$ 2,858,235	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,309,485	$ 589,753		$ 652,946	$ 63,193	$ 2,858,235	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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 North Shore # 0052787 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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	43,504		35	1,243	1,243	3,729	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	270,098		20	13,505	13,505	40,515	9
10	Allocated from CF St. Louis, LLC	2017	6,269		20	313	313	627	10
11									11
12									12
13	Allocated from Legacy HC	2018	322		20	16	16	16	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)		$ 320,194	$		$ 15,077	$ 15,077	$ 44,887	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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		$ 320,194	$		$ 15,077	$ 15,077	$ 44,887	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)		$ 320,194	$		$ 15,077	$ 15,077	$ 44,887	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	$ 2,134,709	$	$ 221,019	$ 221,019	10	$ 989,639	71
72	Current Year Purchases	33,279		4,548	4,548	10	4,548	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,167,988	$	$ 225,567	$ 225,567		$ 994,187	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 23,994,266	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 589,753	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 878,514	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 288,761	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,852,422	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Design Fee for Renovation	$ 32,393	92
93			93
94			94
95		$ 32,393	95

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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				2,130			5
6	Allocated from Legacy HC				207			6
7	TOTAL				$ 2,337 **			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	$
13.	/2020	$
14.	/2021	$

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: $ 11,167 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	Nissan Infiniti LT	$ 977.50	$ 11,730	17
18	Allocated from Legacy HC			5,113	18
19					19
20					20
21	TOTAL		$ 977.50	$ 16,843	21

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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.

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	$		$ 712,471	$		$ 712,471	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,390			119,390	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			985,644			985,644	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				526,153		526,153	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					388,576	205,793		594,369	13
14	TOTAL			$		$ 2,206,081	$ 731,946		$ 2,938,027	14

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

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/18 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	$ 1,681	$ 80,546	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,775,554	1,775,554	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(21,076)	(21,076)	6
7	Other Prepaid Expenses	19,692	42,192	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	609,379	658,194	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,385,230	$ 2,535,410	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,508,714	13
14	Buildings, at Historical Cost		13,977,972	14
15	Leasehold Improvements, at Historical Cost	3,350,924	3,389,942	15
16	Equipment, at Historical Cost	1,728,166	2,352,462	16
17	Accumulated Depreciation (book methods)	(1,907,870)	(3,795,926)	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	1,104,709	3,295,228	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,275,929	$ 20,728,392	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,661,159	$ 23,263,802	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,545,086	$ 3,545,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,350,000	1,350,000	29
30	Accrued Salaries Payable	199,817	199,817	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,804	6,804	31
32	Accrued Real Estate Taxes(Sch.IX-B)		188,865	32
33	Accrued Interest Payable		46,827	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	992,805	994,186	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,094,512	$ 6,331,584	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,800,000	39
40	Mortgage Payable		15,002,581	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,881,014	750,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,881,014	$ 19,552,581	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,975,526	$ 25,884,165	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,314,367)	$ (2,620,363)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,661,159	$ 23,263,802	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,224,614)	1
2	Restatements (describe):		2
3	**Prior Year Depreciation**	(113,553)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,338,167)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	23,800	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)**	$ 23,800	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,314,367)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,572,453	1
2	Discounts and Allowances for all Levels	(10,404,332)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,168,121	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,493,880	6
7	Oxygen	77	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,493,957	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	546,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73,224	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	31,670	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 651,464	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	111,848	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 111,848	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	106,731	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 106,731	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,532,121	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,269,665	31
32	Health Care	5,403,111	32
33	General Administration	3,431,519	33
	B. Capital Expense		
34	Ownership	2,278,517	34
	C. Ancillary Expense		
35	Special Cost Centers	3,798,450	35
36	Provider Participation Fee	327,059	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,508,321	40
41	**Income before Income Taxes (line 30 minus line 40)****	23,800	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 23,800	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,537,255	44
45	Private Pay - Net Inpatient Revenue	1,506,345	45
46	Medicare - Net Inpatient Revenue	1,054,565	46
47	Other-(specify) Insurance	69,956	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,168,121	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,162	$ 118,877	$ 54.98	1
2	Assistant Director of Nursing	1,233	1,383	53,187	38.46	2
3	Registered Nurses	27,222	29,630	1,035,412	34.94	3
4	Licensed Practical Nurses	44,318	47,990	1,411,441	29.41	4
5	CNAs & Orderlies	93,612	99,572	1,655,168	16.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,394	10,210	234,867	23.00	8
9	Activity Director	1,891	1,979	42,876	21.67	9
10	Activity Assistants	6,779	7,194	89,143	12.39	10
11	Social Service Workers	9,952	10,537	245,572	23.31	11
12	Dietician	1,704	1,784	48,331	27.09	12
13	Food Service Supervisor	3,339	3,500	85,601	24.46	13
14	Head Cook	7,524	7,981	117,684	14.75	14
15	Cook Helpers/Assistants	17,225	18,143	219,212	12.08	15
16	Dishwashers					16
17	Maintenance Workers	4,099	4,428	111,931	25.28	17
18	Housekeepers	19,714	21,234	270,368	12.73	18
19	Laundry	1,942	2,138	34,883	16.32	19
20	Administrator	1,940	2,122	140,466	66.20	20
21	Assistant Administrator	2,168	2,378	83,128	34.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	35,846	38,544	688,981	17.88	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	2,071	2,168	40,388	18.63	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,768	2,003	34,761	17.35	33
34	TOTAL (lines 1 - 33)	295,709	317,080	$ 6,762,277 *	$ 21.33	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	$ 103,065	01-03	35
36	Medical Director	Monthly	101,443	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,590	10-03	38
39	Pharmacist Consultant	Monthly	16,587	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	2,604	11-03	44
45	Social Service Consultant	35	1,934	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	35	$ 268,223		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Butler	Administrator	0	$ 59,307
Ashley Wilson	Administrator	0	81,159
Mayer Cohen	Asst. Admin	0	58,254
Marcus Shaw	Asst. Admin	0	24,873
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 223,594

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 36,892
See Attached	Legal Fees	125,719
Compliance Resources	Compliance Audit	270
Paycor	Payroll Processing	31,350
Agile MD Inc.	E.H.R. Consultant	672
Achieve Accreditation LLC	Accreditation	9,239
Compliagent	Compliance Consultant	6,389
Integra Scripts LLC	Data Processing	31,271
MTS Consulting	Tax Consultant	1,912
Personnel Planners	Unemployment Consultant	2,100
Adam Zollinger Interiors	Interior Design	1,500
See Supplemental Schedule		3,768
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 251,081

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 141,791
Unemployment Compensation Insurance	62,550
FICA Taxes	449,074
Employee Health Insurance	164,775
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	19,035
Employee Physical Exams	15,910
Other Employee Benefits	21,957
Voluntary Benefits	3,605
Employee Holiday Expenses	500
TOTAL (agree to Schedule V, line 22, col.8)	$ 879,197

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	$ 1,990
Advertising: Employee Recruitment	1,188
Health Care Worker Background Check	
(Indicate # of checks performed 1372)	13,727
Patient Background Checks 603	6,035
Dues & Subscriptions	32,662
Licenses & Permits	3,429
Allocated from Legacy HC	826
Allocated from CF St. Louis	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,858

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,406
Allocated from Legacy HC	3,959
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,365

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $23,360**

(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. $ **41,267** 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. $ **327,059**
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? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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