

		FOR BHF USE			

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

<p>I. IDPH License ID Number: <u>0053892</u></p> <p>Facility Name: <u>Warren Barr Lincoln Park</u></p> <p>Address: <u>2732 N Hampden Court</u> <u>Chicago</u> <u>60614</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 248-6000</u> Fax # <u>(773) 248-9703</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9/1/2008</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="5" style="width: 15%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>05/09/2021</td> </tr> <tr> <td colspan="2">* Subject to the attached Accountants' Consulting Report (Date)</td> </tr> <tr> <td colspan="2">(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u></td> </tr> <tr> <td colspan="2">(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____		Paid Preparer	(Signed) _____	05/09/2021	* Subject to the attached Accountants' Consulting Report (Date)		(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																									
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Facility Name & ID Number Warren Barr Lincoln Park

0053892 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,586	1,819	6,635	25,040	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,586	1,819	6,635	25,040	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.77%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 109 and days of care provided 4,894

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		4,356	829,052	833,408		833,408	2,057	835,465		1
2	Food Purchase		1,233		1,233		1,233	3,913	5,146		2
3	Housekeeping	33,516	14,712	294,591	342,819		342,819	1,334	344,153		3
4	Laundry		23,177	76,583	99,760		99,760	91	99,851		4
5	Heat and Other Utilities			94,818	94,818		94,818	(5,835)	88,983		5
6	Maintenance	50,451	8,546	109,071	168,068		168,068	3,820	171,888		6
7	Other (specify):*										7
8	TOTAL General Services	83,967	52,024	1,404,115	1,540,106		1,540,106	5,380	1,545,486		8
	B. Health Care and Programs										
9	Medical Director			27,050	27,050		27,050		27,050		9
10	Nursing and Medical Records	2,620,147	163,816	42,995	2,826,958		2,826,958	65,701	2,892,659		10
10a	Therapy	147,143			147,143		147,143		147,143		10a
11	Activities	117,269	2,967	773	121,009		121,009	5	121,014		11
12	Social Services	197,863	42,832	2,288	242,983		242,983	3,574	246,557		12
13	CNA Training										13
14	Program Transportation			42,014	42,014		42,014		42,014		14
15	Other (specify):*							3,707	3,707		15
16	TOTAL Health Care and Programs	3,082,422	209,615	115,120	3,407,157		3,407,157	72,987	3,480,144		16
	C. General Administration										
17	Administrative	105,228			105,228		105,228	39,783	145,011		17
18	Directors Fees										18
19	Professional Services			331,048	331,048	(638)	330,410	1,206	331,615		19
20	Dues, Fees, Subscriptions & Promotions			63,180	63,180		63,180	(29,407)	33,773		20
21	Clerical & General Office Expenses	141,029	1,491	343,189	485,709		485,709	(69,045)	416,664		21
22	Employee Benefits & Payroll Taxes			532,249	532,249		532,249		532,249		22
23	Inservice Training & Education										23
24	Travel and Seminar			568	568		568	89	657		24
25	Other Admin. Staff Transportation			989	989		989	2,974	3,963		25
26	Insurance-Prop.Liab.Malpractice			243,240	243,240		243,240	19,588	262,828		26
27	Other (specify):*							15,945	15,945		27
28	TOTAL General Administration	246,257	1,491	1,514,463	1,762,211	(638)	1,761,573	(18,867)	1,742,706		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,412,646	263,130	3,033,698	6,709,474	(638)	6,708,836	59,501	6,768,336		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							1,183,672	1,183,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,120	28,120		28,120	443,849	471,969			32
33	Real Estate Taxes			9,632	9,632	638	10,270	200,074	210,345			33
34	Rent-Facility & Grounds			1,072,794	1,072,794		1,072,794	(1,050,306)	22,488			34
35	Rent-Equipment & Vehicles			4,374	4,374		4,374	2,889	7,263			35
36	Other (specify):*							63,532	63,532			36
37	TOTAL Ownership			1,114,920	1,114,920	638	1,115,558	843,710	1,959,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		339,900	629,937	969,837		969,837	(9,385)	960,452			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,141	187,141		187,141		187,141			42
43	Other (specify):*			380,991	380,991		380,991	(380,991)				43
44	TOTAL Special Cost Centers		339,900	1,198,069	1,537,969		1,537,969	(390,376)	1,147,593			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,412,646	603,030	5,346,687	9,362,363		9,362,363	512,834	9,875,197			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(6,531)	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	621,596	30		9
10	Interest and Other Investment Income	(7,554)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(2,630)	21		18
19	Entertainment	(1,076)	21		19
20	Contributions	(14,093)	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	(193,522)	21		24
25	Fund Raising, Advertising and Promotional	(5,242)	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	(1,463,363)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,072,416)		\$	30

BHF USE ONLY							
48		49		50		51	

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	2	
		Amount	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)	1,585,250		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,585,250		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 512,834		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Warren Barr Lincoln Park

ID# 0053892

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Expense	\$ (380,991)	43	1
2	Rebates	(10,462)	21	2
3	Bank Charges	(6,991)	21	3
4	Sequestration	(26,748)	21	4
5	Capitalized R&M	(2,895)	06	5
6	Marketing License	(692)	20	6
7	PAC Dues	(11,091)	20	7
8	Prior Period Dues	(519)	20	8
9	Bldg Co - Filing Fees	(75)	20	9
10	Bldg Co - Accounting	(18,309)	19	10
11	Bldg Co - Legal Fees	(3,210)	19	11
12	Bldg Co - Amortization	(3,567)	36	12
13	Bldg Co - Prepayment Penalty	(990,100)	21	13
14	Non Allowable Legal	(7,712)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,463,363)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Lincoln Park# 0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			2,057									2,057	1
2	Food Purchase	(1)		3,914									3,913	2
3	Housekeeping			1,334									1,334	3
4	Laundry			91									91	4
5	Heat and Other Utilities	(6,531)				696							(5,835)	5
6	Maintenance	(2,895)		6,688		674		(647)					3,820	6
7	Other (specify):*													7
8	TOTAL General Services	(9,427)		14,084		1,370		(647)					5,380	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			68,414					(2,713)				65,701	10
10a	Therapy													10a
11	Activities			5									5	11
12	Social Services			3,574									3,574	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,707								3,707	15
16	TOTAL Health Care and Programs			71,993	3,707				(2,713)				72,987	16
	C. General Administration													
17	Administrative			39,783									39,783	17
18	Directors Fees													18
19	Professional Services	(29,231)	21,519	13,061		292	(4,435)						1,206	19
20	Fees, Subscriptions & Promotions	(31,712)	75	2,230		0							(29,407)	20
21	Clerical & General Office Expenses	(1,231,529)	990,100	172,222		162							(69,045)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			89									89	24
25	Other Admin. Staff Transportation			2,974									2,974	25
26	Insurance-Prop.Liab.Malpractice		19,335	78		175							19,588	26
27	Other (specify):*			15,945									15,945	27
28	TOTAL General Administration	(1,292,473)	1,031,029	246,383		629	(4,435)						(18,867)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,301,900)	1,031,029	332,460	3,707	1,999	(4,435)	(647)	(2,713)				59,501	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	621,596	557,784			4,292							1,183,672	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,554)	448,991			2,412							443,849	32
33	Real Estate Taxes		197,883			2,191							200,074	33
34	Rent-Facility & Grounds		(1,050,368)	20,195		(20,133)							(1,050,306)	34
35	Rent-Equipment & Vehicles				2,889								2,889	35
36	Other (specify):*	(3,567)	67,099										63,532	36
37	TOTAL Ownership	610,475	221,389	20,195	2,889	(11,238)							843,710	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(9,385)		(9,385)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(380,991)											(380,991)	43
44	TOTAL Special Cost Centers	(380,991)									(9,385)		(390,376)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,072,416)	1,252,418	352,655	6,596	(9,239)	(4,435)	(647)	(2,713)		(9,385)		512,834	45

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,050,368	Lincoln Park PropCo		\$	(1,050,368)	1
2	V	32 Interest	269	Lincoln Park PropCo		449,260	448,991	2
3	V	33 RE Taxes		Lincoln Park PropCo		197,883	197,883	3
4	V	26 Property Insurance		Lincoln Park PropCo		19,335	19,335	4
5	V	36 MIP Expense		Lincoln Park PropCo		63,532	63,532	5
6	V	20 Filing Fees		Lincoln Park PropCo		75	75	6
7	V	19 Accounting		Lincoln Park PropCo		18,309	18,309	7
8	V	19 Legal Fees		Lincoln Park PropCo		3,210	3,210	8
9	V	30 Depreciation		Lincoln Park PropCo		557,784	557,784	9
10	V	36 Amortization		Lincoln Park PropCo		3,567	3,567	10
11	V	21 Prepayment Penalty		Lincoln Park PropCo		990,100	990,100	11
12	V							12
13	V							13
14	Total		\$ 1,050,637			\$ 2,303,055	\$ * 1,252,418	14

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

Facility Name & ID Number

Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Lincoln Park PropCo		Building Company	1
2	Doros Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

Facility Name & ID Number

Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

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			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Berwyn	Berwyn				4
5			Grove of Fox Valley	Aurora				5
6			Grove of St. Charles	St. Charles				6
7			Lagrange Skilled Nursing Facility LLC	Lagrange Park				7
8			Lakefront Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,046	\$ 2,046	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		11	11	16
17	V	02 Food		Legacy Healthcare Financial Services		3,914	3,914	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		1,334	1,334	18
19	V	04 Linen Replacement		Legacy Healthcare Financial Services		91	91	19
20	V	06 Maintenance Salary		Legacy Healthcare Financial Services		6,313	6,313	20
21	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		375	375	21
22	V	10 Nursing Salary		Legacy Healthcare Financial Services		52,256	52,256	22
23	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		4,932	4,932	23
24	V	10 Medical Supplies		Legacy Healthcare Financial Services		11,227	11,227	24
25	V	12 Social Service Salary		Legacy Healthcare Financial Services		3,560	3,560	25
26	V	11 Activities Program		Legacy Healthcare Financial Services		5	5	26
27	V	12 Social Service Consultant		Legacy Healthcare Financial Services		14	14	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		39,783	39,783	28
29	V	19 Professional Fees		Legacy Healthcare Financial Services		13,061	13,061	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,230	2,230	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		160,517	160,517	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		11,705	11,705	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		89	89	33
34	V	25 Travel		Legacy Healthcare Financial Services		2,974	2,974	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		78	78	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		15,945	15,945	36
37	V	34 Rent		Legacy Healthcare Financial Services		20,133	20,133	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		62	62	38
39	Total		\$			\$ 352,655	\$ * 352,655	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Equipment Rental		Legacy Healthcare Financial Services		269	\$	269	15
16	V	35 Auto Rental		Legacy Healthcare Financial Services		2,620		2,620	16
17	V	15 Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		3,707		3,707	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 6,596	\$ *	6,596	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	CF St. Louis LLC		\$ 696	\$ 696	15
16	V	6 Repairs & Maintenance		CF St. Louis LLC		674	674	16
17	V	19 Property Valuation Fee		CF St. Louis LLC		238	238	17
18	V	19 Accounting Fees		CF St. Louis LLC		54	54	18
19	V	20 Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21 Office Expense		CF St. Louis LLC		162	162	20
21	V	26 Insurance		CF St. Louis LLC		175	175	21
22	V	30 Depreciation		CF St. Louis LLC		4,292	4,292	22
23	V	32 Interest Expense		CF St. Louis LLC		2,412	2,412	23
24	V	33 Real Estate Taxes		CF St. Louis LLC		2,191	2,191	24
25	V							25
26	V	34 Rent	20,133	CF St. Louis LLC			(20,133)	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		\$ 20,133			\$ 10,894	\$ * (9,239)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 19,358	ProPay HR LLC		\$ 14,923	\$ (4,435)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 19,358			\$ 14,923	\$ * (4,435)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance	\$ 26,400	ML Group Design & Development		\$ 25,753	\$ (647)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 26,400			\$ 25,753	\$ * (647)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,000			\$ 6,287	\$ * (2,713)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04 Laundry Services	\$ 76,583	EcoBrite Linen		\$ 76,583	\$	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		\$ 76,583			\$ 76,583	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Laboratory	\$ 23,058	Lifescan Labs of Illinois		\$ 13,673	\$ (9,385)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 23,058			\$ 13,673	\$ * (9,385)

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietician Salary	Available Bed Days	2,540,133	53	\$ 130,303	\$ 130,303	39,894	\$ 2,046	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		39,894	11	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		39,894	3,914	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		39,894	1,334	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		39,894	91	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	39,894	6,313	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		39,894	375	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	39,894	52,256	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	2,540,133	53	314,035		39,894	4,932	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		39,894	11,227	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	39,894	3,560	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		39,894	5	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		39,894	14	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	39,894	39,783	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		39,894	13,061	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		39,894	2,230	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	39,894	160,517	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		39,894	11,705	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		39,894	89	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		39,894	2,974	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		39,894	78	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		39,894	15,945	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		39,894	20,133	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		39,894	62	24
25	TOTALS					\$ 22,454,338	\$ 16,839,706		\$ 352,655	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109	39,894	269	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843	39,894	2,620	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021	39,894	3,707	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					\$ 419,973	\$	\$ 6,596	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	\$ 44,301	\$ 39,894	\$ 696	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932	39,894	674	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181	39,894	238	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453	39,894	54	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23	39,894	0	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298	39,894	162	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124	39,894	175	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261	39,894	4,292	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558	39,894	2,412	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524	39,894	2,191	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					\$ 693,655	\$ 39,894	\$ 10,894	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 St.
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 3268
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 14,923	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				\$	\$		\$ 14,923	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 ML Group Design and Development
 Street Address 3424 Oakton St
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 676-5300
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct		\$	\$		\$ 25,753	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 25,753	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 ReMED Services LLC
 Street Address 3424 Oakton Street, Suite 102
 City / State / Zip Code Skokie, IL
 Phone Number (847) 440-2600
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct		\$	\$		\$ 6,287	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 6,287	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 EcoBrite Linen
 Street Address 3712 Jarvis Avenue
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 582-4000
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	04	Laundry Services	Direct		\$	\$		\$ 76,583	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				\$	\$		\$ 76,583	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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 Lifescan Labs of Illinois, LLC
 Street Address 5255 Golf Road
 City / State / Zip Code Skokie, IL 60077
 Phone Number ()
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct		\$	\$		\$ 13,673	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 13,673	25

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending: 12/31/20

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

Facility Name & ID Number Warren Barr Lincoln Park # 0053892 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	CIBC		X	Mortgage			\$	\$ 10,879,196			\$	449,260	1					
2													2					
3													3					
4													4					
5													5					
Working Capital																		
6	CIBC		X	Note Payable				2,140,257				28,120	6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$ 13,019,453			\$	477,380	9					
B. Non-Facility Related*																		
10	Interest Income		X									(7,554)	10					
11	Interest Income - Bldg Co		X									(269)	11					
12	Allocated from CF St. Louis	X										2,412	12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(5,411)	14					
15	TOTALS (line 9+line14)						\$	\$ 13,019,453			\$	471,969	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,532 Line # 36

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.	\$	210,510	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	206,106	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(4,404)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	214,110	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.)	\$	638	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.	\$	210,344	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	173,085	8
	2016	189,183	9
	2017	203,333	10
	2018	200,485	11
	2019	203,915	12

2020 Accrual = \$203,915 x 1.05 = \$214,110

Allocated from CF St. Louis \$2,191

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincoln Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053892

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>14-28-308-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>203,914.65</u>	\$ <u>203,914.65</u>
2. <u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>459,532.44</u>	\$ <u>2,191.29</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>663,447.09</u></u>	\$ <u><u>206,105.94</u></u>

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Lincoln Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053892

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Rows include Facility (690,000), Allocated from CF St. Louis, LLC (3,100), and TOTALS (693,100).

Facility Name & ID Number **Warren Barr Lincoln Park**

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	109	2015	1969	\$ 19,193,193	\$ 557,784	35	\$ 548,377	\$ (9,407)	\$ 3,290,262	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2008	34,490		20	1,725	1,725	22,419	9
10	Various		2009	579,416		20	32,715	32,715	317,700	10
11	Various		2010	36,209		20	1,810	1,810	19,915	11
12	Various		2011	116,529		20	5,826	5,826	58,265	12
13	Various		2012	71,395		20	3,570	3,570	32,128	13
14	Various		2013	80,916		20	4,046	4,046	32,366	14
15	Various		2014	241,336		20	12,067	12,067	72,401	15
16	Various		2015	968,330		20	48,680	48,680	285,961	16
17	Various		2016	623,474		20	31,174	31,174	124,695	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Lincoln Park

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)		145,878	3,957		6,936	2,980	31,031	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 22,091,166	\$ 561,741		\$ 696,925	\$ 135,185	\$ 4,287,141	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 22,091,166	\$ 561,741		\$ 696,925	\$ 135,185	\$ 4,287,141	1
2	Elevator-Furnish And Install New Oil Line	2017	8,591		20	430	430	1,431	2
3	Cubicle Curtains	2017	4,135		20	207	207	966	3
4	Furnish & Replace 3 Boiler Circulator Pumps	2017	4,274		20	214	214	997	4
5	Sewer Plumbing For Commercial Water Heater	2017	8,200		20	410	410	1,640	5
6	Masonry Work On Outside Of The Building	2017	3,050		20	153	153	610	6
7	Masonry Work On Outside Of The Building	2017	18,000		20	900	900	3,600	7
8	New Lights, Doors, Tiles-Office,Therapy Room, Front Desk	2017	33,995		20	1,700	1,700	6,799	8
9	Remove Defective Air Handler Heating Coil	2017	4,047		20	202	202	809	9
10	Door Handles, Hardware, And Sink Insulation (3,450)	2018	3,193		20	160	160	607	10
11	Faucet And Shut Off Valves (3,900)	2018	3,610		20	180	180	621	11
12	Mirrors (2,754)	2018	2,549		20	127	127	714	12
13	New Heater Installation (7,985)	2018	7,391		20	370	370	1,109	13
14	Generator Installation	2018	144,732		20	7,237	7,237	20,981	14
15	Install Push Button For Back Door (\$2,978)	2019	2,886		20	144	144	293	15
16	Window Frames (5,282)	2020	5,153		20	258	258	258	16
17	Install New A/C In Rm 403 (2,822)	2020	2,753		20	138	138	138	17
18	Install New Elevator Valve (5,072)	2020	4,948		20	247	247	247	18
19	New Hot Water Boiler (9,650)	2020	9,414		20	471	471	471	19
20	Remove, Replace, Restripe Lot (9,500)	2020	9,267		20	463	463	463	20
21	New Pump & Unit Blower Motor (3,607)	2020	3,518		20	176	176	176	21
22	Repair Hot Water Pump, Kitchenpipe, 3Rd Fl Door (2,895)	2020	2,824		20	141	141	141	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)		\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	34

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

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		\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 22,377,695	\$ 561,741		\$ 711,252	\$ 149,511	\$ 4,330,212	34

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number **Warren Barr Lincoln Park**

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
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.

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	16,690	775	35	477	(298)	2,384	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	103,620	2,556	20	5,181	2,625	25,905	9
10	Allocated from CF St. Louis, LLC	2017	2,405	59	20	120	61	481	10
11	Allocated from CF St. Louis, LLC	2019	21,799	538	20	1,090	552	2,180	11
12	Allocated from CF St. Louis, LLC	2019	1,147	28	20	57	29	57	12
13									13
14	Allocated from Legacy HC	2018	124		20	6	6	19	14
15	Allocated from Legacy HC	2020	93		20	5	5	5	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)		\$ 145,878	\$ 3,957		\$ 6,936	\$ 2,980	\$ 31,031	34

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 145,878	\$ 3,957		\$ 6,936	\$ 2,980	\$ 31,031	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 145,878	\$ 3,957		\$ 6,936	\$ 2,980	\$ 31,031	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 4,724,180	\$ 334	\$ 472,418	\$ 472,084	10	\$ 2,895,236	71
72	Current Year Purchases	22	1	2	1	10	2	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,724,202	\$ 335	\$ 472,420	\$ 472,085		\$ 2,895,238	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 27,794,997	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 562,076	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,183,672	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 621,596	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,225,450	85

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

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

G. Construction-in-Progress

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

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

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

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				22,426			5
6	Allocated from Legacy Healthcare				62			6
7	TOTAL				\$ 22,488			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: _____ *

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: \$ 4,643 Description: See Attached

(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	Allocated from Legacy Healthcare		\$	\$ 2,620	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,620	21

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.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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	\$		\$ 212,435	\$		\$ 212,435	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			100,734			100,734	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			259,648			259,648	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				258,963		258,963	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached</u>					57,120	80,937		138,057	13
14	TOTAL			\$		\$ 629,937	\$ 339,900		\$ 969,837	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/20**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 83,073	\$ 633,786	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,481,639	1,481,639	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	266,067	300,781	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	240,219	241,121	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,070,998	\$ 2,657,327	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		638,434	13
14	Buildings, at Historical Cost		6,879,534	14
15	Leasehold Improvements, at Historical Cost	628,252	996,285	15
16	Equipment, at Historical Cost	438,235	2,634,670	16
17	Accumulated Depreciation (book methods)	(442,679)	(3,838,733)	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): <u>See Attached</u>	1,346,868	4,318,615	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,970,676	\$ 11,628,805	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,041,674	\$ 14,286,132	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 628,847	\$ 635,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,140,257	2,355,798	29
30	Accrued Salaries Payable	139,805	139,805	30
31	Accrued Taxes Payable (excluding real estate taxes)	150,226	150,226	31
32	Accrued Real Estate Taxes(Sch.IX-B)		214,110	32
33	Accrued Interest Payable		35,357	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	1,637,845	2,111,345	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,696,980	\$ 5,642,023	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,663,655	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	1,507,799	2,638,009	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,507,799	\$ 13,301,664	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,204,779	\$ 18,943,687	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,163,105)	\$ (4,657,555)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,041,674	\$ 14,286,132	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (789,415)	1
2	Restatements (describe):		2
3	Bad Debts	57,210	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (732,205)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(928,926)	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	(501,974)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,430,900)	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)	\$ (2,163,105)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning: 01/01/20

Ending: 12/31/20

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,688,305	1
2	Discounts and Allowances for all Levels	(3,437,660)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,250,645	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,057,938	6
7	Oxygen	22	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,057,960	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	242,868	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	56,989	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,174	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 315,031	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,554	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,554	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	802,247	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 802,247	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,433,437	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,540,106	31
32	Health Care	3,407,157	32
33	General Administration	1,762,211	33
B. Capital Expense			
34	Ownership	1,114,920	34
C. Ancillary Expense			
35	Special Cost Centers	1,350,828	35
36	Provider Participation Fee	187,141	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,362,363	40
41	Income before Income Taxes (line 30 minus line 40)**	(928,926)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (928,926)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,393,127	44
45	Private Pay - Net Inpatient Revenue	370,934	45
46	Medicare - Net Inpatient Revenue	1,211,797	46
47	Other-(specify) <u>Insurance</u>	274,787	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,250,645	49

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

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

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

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

Facility Name & ID Number Warren Barr Lincoln Park

0053892

Report Period Beginning: 01/01/20

Ending: 12/31/20

12/31/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,112	2,345	\$ 162,430	\$ 69.27	1
2	Assistant Director of Nursing	1,648	1,820	73,874	40.59	2
3	Registered Nurses	11,286	13,924	472,974	33.97	3
4	Licensed Practical Nurses	20,916	25,785	804,223	31.19	4
5	CNAs & Orderlies	51,547	61,917	1,026,199	16.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,759	6,700	147,143	21.96	8
9	Activity Director	1,947	2,160	39,240	18.17	9
10	Activity Assistants	5,208	5,728	78,029	13.62	10
11	Social Service Workers	6,240	6,599	145,130	21.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,896	2,160	50,451	23.36	17
18	Housekeepers	1,916	2,161	33,516	15.51	18
19	Laundry					19
20	Administrator	2,112	2,200	105,228	47.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,368	8,165	141,029	17.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,320	1,360	42,314	31.11	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	5,306	5,967	90,867	15.23	33
34	TOTAL (lines 1 - 33)	126,582	148,990	\$ 3,412,647 *	\$ 22.91	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 829,052	01-03	35
36	Medical Director	Monthly	27,050	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	39,986	10-03	38
39	Pharmacist Consultant	Monthly	3,009	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	773	11-03	44
45	Social Service Consultant	Monthly	2,288	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 902,158		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Warren Barr Lincoln Park**

0053892

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount	
Kate M. Gilday	Administrator	0	\$ 27,457	Workers' Compensation Insurance		\$ 36,371		IDPH License Fee		\$ 166	
Jennifer A. LaBella	Administrator	0	77,771	Unemployment Compensation Insurance		16,442		Advertising: Employee Recruitment		468	
				FICA Taxes		261,068		Health Care Worker Background Check (Indicate # of checks performed 55)		557	
				Employee Health Insurance		155,070		Patient Background Checks		213	2,130
				Employee Meals				Dues & Subscriptions		27,139	
				Illinois Municipal Retirement Fund (IMRF)*				Licenses & Fees		1,083	
				Union Pension		19,251					
				Employee Benefits		20,218					
				401K Expense		10,857					
				Voluntary Benefit Contributions		8,517		See Supplemental Schedule		2,230	
				Employee Physical Exams		4,455		Less: Public Relations Expense	(
								Non-allowable advertising	(
								Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)				TOTAL (agree to Sch. V, line 20, col. 8)			
(List each licensed administrator separately.)			\$ 105,228				\$ 532,249				\$ 33,773
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
			\$				\$			\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL		\$	
(Attach a copy of any management service agreement)								(agree to Sch. V, line 24, col. 8)			
C. Professional Services											
Vendor/Payee	Type		Amount								
Marcum LLP	Accounting		\$ 24,000								
ProPay HR	Payroll Processing		19,358								
Onyx Procurement Solutions	Procurement Services		6,870								
Achieve Accreditation	Accreditation		7,715								
Compliagent	Compliance		3,843								
Cortex Health	Health Care Software		10,885								
Hygieneering	Hygiene & Safety Consulting		1,965								
Language Line Services	Translation Services		563								
MTS Consulting	Tax Consultant		557								
Patient Ping	Patient Care Coordination		18,000								
See Attached	Legal		228,323								
See Supplemental Schedule			8,968								
TOTAL (agree to Schedule V, line 19, column 3)											
(For legal fee disclosure, see page 39 of instructions)			\$ 331,047								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr Lincoln Park# 0053892Report Period Beginning: 01/01/20Ending: 12/31/20**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI \$16,982 ; IHCA \$9,461
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 28,266 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. \$ 187,141
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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