FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0053587

Facility Name: Warren Barr Lincolnshire

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

County: Lake

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	RSM US LLP 20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173
	(Telephone)	(847) 517-7070 Fax # (847)517-7067

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

Facility Name & ID Number: Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	144	Skilled (SNF)	144	52,704	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			8,244	8,244	8
9	SNF/PED					9
10	ICF	27,283	5,112		32,395	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,283	5,112	8,244	40,639	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.11%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 05/01/2015

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 144 and days of care provided 5,724

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	661,325	69,313	19,844	750,482		750,482	(19,953)	730,529			1
2	Food Purchase		99,267		99,267		99,267	5,171	104,438			2
3	Housekeeping	-	(173)	351,949	351,776		351,776	1,763	353,539			3
4	Laundry	79,501	12,010	-	91,511		91,511	120	91,631			4
5	Heat and Other Utilities			174,249	174,249		174,249	919	175,168			5
6	Maintenance	207,535	98,395	232,241	538,171		538,171	19,010	557,181			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	948,361	278,812	778,283	2,005,456		2,005,456	7,030	2,012,486			8
	B. Health Care and Programs											
9	Medical Director	-	-	36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	4,887,250	258,979	58,078	5,204,307		5,204,307	90,383	5,294,690			10
10a	Therapy	113,921	-	-	113,921		113,921		113,921			10a
11	Activities	198,750	8,337	249	207,336		207,336	7	207,343			11
12	Social Services	164,050	-	2,362	166,412		166,412	4,722	171,134			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	28,929	28,929		28,929		28,929			14
15	Other (specify):* Alloc. Mgmt. Bene	-	-	-				4,897	4,897			15
16	TOTAL Health Care and Programs	5,363,971	267,316	125,618	5,756,905		5,756,905	100,009	5,856,914			16
	C. General Administration											
17	Administrative	136,477	-	617,393	753,870		753,870	(564,835)	189,035			17
18	Directors Fees			-								18
19	Professional Services			209,442	209,442		209,442	(75,641)	133,801			19
20	Dues, Fees, Subscriptions & Promotions			32,503	32,503		32,503	(8,298)	24,205			20
21	Clerical & General Office Expenses	466,633	-	277,141	743,774		743,774	227,737	971,511			21
22	Employee Benefits & Payroll Taxes			967,365	967,365		967,365		967,365			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			1,902	1,902		1,902	117	2,019			24
25	Other Admin. Staff Transportation		-	185	185		185	3,929	4,114			25
26	Insurance-Prop.Liab.Malpractice			247,834	247,834		247,834	85,334	333,168			26
27	Other (specify):* Alloc. Mgmt. Bene			-				21,065	21,065			27
28	TOTAL General Administration	603,110		2,353,765	2,956,875		2,956,875	(310,592)	2,646,283			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,915,442	546,128	3,257,666	10,719,236		10,719,236	(203,553)	10,515,683			29

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

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

Facility Name & ID Number: Warren Barr Lincolnshire #0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			327,592	327,592		327,592	(118,909)	208,683			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			23,755	23,755		23,755	(728)	23,027			32
33	Real Estate Taxes			162,000	162,000		162,000	2,895	164,895			33
34	Rent-Facility & Grounds			1,000,520	1,000,520		1,000,520	26,680	1,027,200			34
35	Rent-Equipment & Vehicles			65,521	65,521		65,521	1,126	66,647			35
36	Other (specify):*			-								36
37	TOTAL Ownership			1,579,388	1,579,388		1,579,388	(88,936)	1,490,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	441,941	844,993	1,286,934		1,286,934		1,286,934			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			300,793	300,793		300,793		300,793			42
43	Other (specify):* Non-Allowable Co:	61,234	-	356,983	418,217		418,217	(418,217)				43
44	TOTAL Special Cost Centers	61,234	441,941	1,502,769	2,005,944		2,005,944	(418,217)	1,587,727			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,976,676	988,069	6,339,823	14,304,568		14,304,568	(710,706)	13,593,862			45

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,655)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(129,008)	30		9
10	Interest and Other Investment Income	(3,914)	32		10
11	Discounts, Allowances, Rebates & Refunds	(22,671)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,701)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,882)	43		18
19	Entertainment	(893)	43		19
20	Contributions	(14,781)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(197,444)	43		24
25	Fund Raising, Advertising and Promotional	(14,448)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(189,994)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (588,391)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(122,315)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (122,315)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (710,706)		37

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

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

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

STATE OF ILLINOIS

Warren Barr Lincolnshire

ID# 0053587

Report Period Beginning: 1/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (17,643)	43	1
2	Labs - Part A	(38,207)	43	2
3	X-Rays - Part A	(20,589)	43	3
4	Consolidated Billing charges	(5,815)	43	4
5	Sequestration Expense	(31,339)	43	5
6	Theft and damage loss	(629)	43	6
7	Lobbying	(11,244)	20	7
8	Non-allowable legal	(646)	19	8
9	Admissions directors salary	(61,234)	43	9
10	Swag store expenses	43	43	10
11	Auto lease disallowed	(2,691)	35	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(189,994)		49

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary	$	Legacy Healthcare Financial Services	100%	$ 2,704	$ 2,704	15
16	V	1	Dietary Supplies		Legacy Healthcare Financial Services	100%	14	14	16
17	V	2	Food		Legacy Healthcare Financial Services	100%	5,171	5,171	17
18	V	3	Housekeeping		Legacy Healthcare Financial Services	100%	1,763	1,763	18
19	V	4	Linen Replacement		Legacy Healthcare Financial Services	100%	120	120	19
20	V	6	Maintenance Salary		Legacy Healthcare Financial Services	100%	8,341	8,341	20
21	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services	100%	495	495	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services	100%	69,035	69,035	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services	100%	6,516	6,516	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services	100%	14,832	14,832	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services	100%	4,703	4,703	25
26	V	11	Activities Program		Legacy Healthcare Financial Services	100%	7	7	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services	100%	19	19	27
28	V	17	COO / Administrative Salary	617,393	Legacy Healthcare Financial Services	100%	16,537	(600,856)	28
29	V	17	Administrative (Non-Owner)		Legacy Healthcare Financial Services	100%	36,021	36,021	29
30	V	19	Propay Fees		Legacy Healthcare Financial Services	100%	643	643	30
31	V	19	Accounting Fees		Legacy Healthcare Financial Services	100%	732	732	31
32	V	19	Legal / Other Professional Fees		Legacy Healthcare Financial Services	100%	15,879	15,879	32
33	V	20	License / Dues / Permits		Legacy Healthcare Financial Services	100%	2,946	2,946	33
34	V	21	A&G Wages		Legacy Healthcare Financial Services	100%	212,059	212,059	34
35	V	21	Office Expenses		Legacy Healthcare Financial Services	100%	15,464	15,464	35
36	V	24	Education & Seminars		Legacy Healthcare Financial Services	100%	117	117	36
37	V	25	Travel		Legacy Healthcare Financial Services	100%	3,929	3,929	37
38	V	26	Insurance - General		Legacy Healthcare Financial Services	100%	104	104	38
39	Total			$ 617,393			$ 418,151	$ * (199,242)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Non-Nursing Payroll Taxes / Benefits	$	Legacy Healthcare Financial Services	100%	$ 21,065	$ 21,065	15
16	V	34	Rent Expense		Legacy Healthcare Financial Services	100%	26,598	26,598	16
17	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services	100%	82	82	17
18	V	35	Equipment Rental		Legacy Healthcare Financial Services	100%	355	355	18
19	V	35	Auto Rental		Legacy Healthcare Financial Services	100%	3,462	3,462	19
20	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services	100%	4,897	4,897	20
21	V	30	Depreciation Expense		Legacy Healthcare Financial Services	100%	675	675	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			$			$ 57,134	$ * 57,134	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	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	100%	$ 919	$ 919	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100%	891	891	16
17	V	19	PROPERTY VALUATION FEES		CF ST. LOUIS, LLC	100%	315	315	17
18	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100%	72	72	18
19	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100%			19
20	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100%	214	214	20
21	V	26	INSURANCE		CF ST. LOUIS, LLC	100%	231	231	21
22	V	30	DEPRECIATION		CF ST. LOUIS, LLC	100%	5,670	5,670	22
23	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100%	3,186	3,186	23
24	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100%	2,895	2,895	24
25	V	30	DEPRECIATION		CF ST. LOUIS, LLC	100%	3,754	3,754	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 18,147	$ * 18,147	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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	6	Repairs and Maintenance	$ 9,000	ReMed Services, LLC		$ 18,283	$ 9,283	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 18,283	$ * 9,283	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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	$ 33,333	ProPay HR LLC		$ 25,696	$ (7,637)	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			$ 33,333			$ 25,696	$ * (7,637)	39

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	YAIR ZUCKERMAN	10%	Astoria Place	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	MENACHEM SHABAT	3.1%	Aurora, Avantara	Aurora	Financial Srvcs, LLC			2
3	MENACHEM & AHUVA SHABAT DES(	27.95%	Berwyn, The Grove of	Berwyn				3
4	CHAIM RAJCHENBACH	7.76%	Bethany Terrace	Morton Grove	Legacy Real	Skokie	Real Estate	4
5	GPN FAMILY TRUST	23.29%	Carlton at the Lake	Chicaog	Properties, LLC			5
6	DAVID M. FRIEDMAN	4.9%	Chalet Living & Rehab	Chicago				6
7	RONALD SHABAT	10%	Clark Skilled Nursing Facility	Chicago	Grove Healthcare	Skokie	Real Estate	7
8	THE RAJCHENBACH 2015 FAMILY TI	10%	Elmhurst, The Grove of	Elmhurst	Properties, LLC			8
9	ROSS BOTTNER	3%	Elgin, Avantara	Elgin				9
10			Evanston, The Grove of	Evanston	ReMED Services,	Skokie	Medical	10
11			Evergreen Park, Avantara	Evergreen Park	LLC		Equipment Sales	11
12			Fox Valley, The Grove of	Aurora				12
13			LaGrange, The Grove of	LaGrange Park	Progressive	Skokie	Consulting	13
14			Lake, The Grove at	Zion	Healthcare			14
15			Lakefront	Chicago	Consulting			15
16			Lincoln Park, Warren Barr	Chicago				16
17			Lincolnshire, Warren Barr	Lincolnshire	MG Property	Morton Grove	Real Estate	17
18			Long Grove, Avantara	Long Grove	Holdings, LLC			18
19			Northbrook, The Grove of	Northbrook				19
20			North Shore, Warren Barr	Highland Park	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21			Park Ridge, Avantara	Park Ridge				21
22			Peterson Park	Chicago	ProPay	Evanston	Payroll Services	22
23			Skokie, The Grove of	Skokie				23
24			South Loop, Warren Barr	Chicago	ML Group Design	Skokie	Asset Mgmt Fees	24
25			St. Charles, The Grove of	St. Charles				25
26			Streamwood, Bella Terra	Streamwood	ML Enterprise	Skokie	Asset Mgmt Fees	26
27			Terrace Gardens	Chicago				27
28			Vistas Fox Valley	Aurora	CF St.Louis Inc	Skokie	Management Co.	28
29			Warren Barr	Chicago				29
30			Wellshire	Lincolnshire				30

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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			Wheeling, Bella Terra	Wheeling				1
2								2
3			Arlington, Avantara (South Dakota)	South Dakota				3
4			Armour, Avantara (South Dakota)	South Dakota				4
5			Arrowhead, Avantara (South Dakota)	South Dakota				5
6			Billings, Avantara (Montana)	Montana				6
7			Clark, Avantara (South Dakota)	South Dakota				7
8			Groton, Avantara (South Dakota)	South Dakota				8
9			Huron, Avantara (South Dakota)	South Dakota				9
10			Huron-Wellshire (South Dakota)	South Dakota				10
11			Ipswich, Avantara (South Dakota)	South Dakota				11
12			Lake Norden, Avantara (South Dakota)	South Dakota				12
13			Milbank, Avantara (South Dakota)	South Dakota				13
14			Mountainview, Avantara (South Dakota)	South Dakota				14
15			North, Avantara (South Dakota)	South Dakota				15
16			Norton, Avantara (South Dakota)	South Dakota				16
17			Park Place, Wellshire (South Dakota)	South Dakota				17
18			Pierre, Avantara (South Dakota)	South Dakota				18
19			Redfield, Avantara (South Dakota)	South Dakota				19
20			Salem, Avantara (South Dakota)	South Dakota				20
21			St. Cloud, Avantara (South Dakota)	South Dakota				21
22			St. George, Bella Terra (Utah)	Utah				22
23			Valley SNF, Bella Terra (Montana)	Montana				23
24			Watertown, Avantara (South Dakota)	South Dakota				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3	No owners from this facility received any compensation.										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary	AVAIL. BED DAYS	2,540,133	53	$ 130,303	$ 130,303	52,704	$ 2,704	1
2	1	Dietary Supplies	AVAIL. BED DAYS	2,540,133	53	697		52,704	14	2
3	2	Food	AVAIL. BED DAYS	2,540,133	53	249,220		52,704	5,171	3
4	3	Housekeeping	AVAIL. BED DAYS	2,540,133	53	84,952		52,704	1,763	4
5	4	Linen Replacement	AVAIL. BED DAYS	2,540,133	53	5,771		52,704	120	5
6	6	Maintenance Salary	AVAIL. BED DAYS	2,540,133	53	401,986	401,986	52,704	8,341	6
7	6	Repairs & Maintenance	AVAIL. BED DAYS	2,540,133	53	23,857		52,704	495	7
8	10	Nursing Salary	AVAIL. BED DAYS	2,540,133	53	3,327,223	3,327,223	52,704	69,035	8
9	10	Nurse/Medical Director Consulta	AVAIL. BED DAYS	2,540,133	53	314,035		52,704	6,516	9
10	10	Medical Supplies	AVAIL. BED DAYS	2,540,133	53	714,824		52,704	14,832	10
11	12	Social Service Salary	AVAIL. BED DAYS	2,540,133	53	226,662	226,662	52,704	4,703	11
12	11	Activities Program	AVAIL. BED DAYS	2,540,133	53	335		52,704	7	12
13	12	Social Service Consultant	AVAIL. BED DAYS	2,540,133	53	893		52,704	19	13
14	17	COO / Administrative Salary	AVAIL. BED DAYS	2,540,133	53	797,017	797,017	52,704	16,537	14
15	17	Administrative (Non-Owner)	AVAIL. BED DAYS	2,540,133	53	1,736,060		52,704	36,021	15
16	19	Propay Fees	AVAIL. BED DAYS	2,540,133	53	31,002		52,704	643	16
17	19	Accounting Fees	AVAIL. BED DAYS	2,540,133	53	35,278		52,704	732	17
18	19	Legal / Other Professional Fees	AVAIL. BED DAYS	2,540,133	53	765,313		52,704	15,879	18
19	20	License / Dues / Permits	AVAIL. BED DAYS	2,540,133	53	141,983		52,704	2,946	19
20	21	A&G Wages	AVAIL. BED DAYS	2,540,133	53	10,220,453	10,220,453	52,704	212,059	20
21	21	Office Expenses	AVAIL. BED DAYS	2,540,133	53	745,293		52,704	15,464	21
22	24	Education & Seminars	AVAIL. BED DAYS	2,540,133	53	5,655		52,704	117	22
23	25	Travel	AVAIL. BED DAYS	2,540,133	53	189,364		52,704	3,929	23
24	26	Insurance - General	AVAIL. BED DAYS	2,540,133	53	4,997		52,704	104	24
25	TOTALS					$ 20,153,173	$ 15,103,644		$ 418,151	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Non-Nursing Payroll Taxes / Bene	AVAIL. BED DAYS	2,540,133	53	$ 1,015,274	$	52,704	$ 21,065	1
2	34	Rent Expense	AVAIL. BED DAYS	2,540,133	53	1,281,940		52,704	26,598	2
3	34	Offsite Storage / Parking	AVAIL. BED DAYS	2,540,133	53	3,949		52,704	82	3
4	35	Equipment Rental	AVAIL. BED DAYS	2,540,133	53	17,109		52,704	355	4
5	35	Auto Rental	AVAIL. BED DAYS	2,540,133	53	166,843		52,704	3,462	5
6	15	Nursing Payroll Taxes / Benefits	AVAIL. BED DAYS	2,540,133	53	236,021		52,704	4,897	6
7	30	Depreciation Expense	Direct Allocation						675	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					$ 2,721,136	$		$ 57,134	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	2,540,133	34	$ 44,301	$	52,704	$ 919	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	2,540,133	34	42,932		52,704	891	2
3	19	PROPERTY VALUATION FEES	AVAIL. BED DAYS	2,540,133	34	15,181		52,704	315	3
4	19	PROFESSIONAL FEES	AVAIL. BED DAYS	2,540,133	34	3,453		52,704	72	4
5	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	2,540,133	34	23		52,704		5
6	21	OFFICE EXPENSE	AVAIL. BED DAYS	2,540,133	34	10,298		52,704	214	6
7	26	INSURANCE	AVAIL. BED DAYS	2,540,133	34	11,124		52,704	231	7
8	30	DEPRECIATION	AVAIL. BED DAYS	2,540,133	34	273,261		52,704	5,670	8
9	32	INTEREST EXPENSE	AVAIL. BED DAYS	2,540,133	34	153,558		52,704	3,186	9
10	33	REAL ESTATE TAXES	AVAIL. BED DAYS	2,540,133	34	139,524		52,704	2,895	10
11	30	DEPRECIATION	DIRECT						3,754	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	$		$ 18,147	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	ReMed Services, LLC
Street Address	3450 Oakton Street
City / State / Zip Code	Skokie, IL 60076
Phone Number	(847) 679-9797
Fax Number	(847) 683-2900

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & Maintenance	Direct Allocation			$	$		$ 18,283	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					$	$		$ 18,283	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 X NO

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: ( )
Fax Number: ( )

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 25,696	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					$	$		$ 25,696	25

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	TCF Equipment Finance		X	Auto	896.99	4/10/2017	$ 51,864	$ 23,581	4/10/2023	0.0751	$ 2,082	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	CapEx		8/9/2017	2,500,000	-	1/1/2020	Libor + 4.75%	21,673	6
7	NGS		X	MCR Advance Pmt		4/30/2020	805,241	805,241	4/30/2022		-	7
8												8
9	TOTAL Facility Related				$896.99		$ 3,357,105	$ 828,822			$ 23,755	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(3,914)	12
13								Allocated from Mgmt Co.			3,186	13
14	TOTAL Non-Facility Related						$	$			$ (728)	14
15	TOTALS (line 9+line14)						$ 3,357,105	$ 828,822			$ 23,027	15

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

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

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

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.

Line			Amount	
1. Real Estate Tax accrual used on 2019 report.		$	10,204	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.)	2019	$	172,204	2
3. Under or (over) accrual (line 2 minus line 1).		$	162,000	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$		5
	Alloc. Fr. Mgmt. Co.		2,895	
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.		$	164,895	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	166,492	8
	2016	169,516	9
	2017	176,352	10
	2018	181,335	11
	2019	172,204	12

Beginning Accrual Adjusted

Allocated from CF St. Louis LLC: $2,895

FOR BHF USE ONLY

Line				Line
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 CALCULATIOI	$		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 Lincolnshire COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053587

CONTACT PERSON REGARDING THIS REPORT Moti Ninio

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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 nursin 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)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	15-15-200-062	LTCF	$ 172,204.08	$ 172,204.08
2.			$	$
3.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 2,895.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 631,736.52	$ 175,099.08

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.

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

Lincolnshire Assisted Living

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from CF St. Louis	-		$ 4,095	1
2					2
3	TOTALS			$ 4,095	3

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation C.F St. Louis, LLC			2016	22,049		35	630	630	3,150	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 22,049	$		$ 630	$ 630	$ 3,150	70

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 12A, Carried Forward		$ 22,049	$		$ 630	$ 630	$ 3,150	1
2	Kitchen - Millwork/Countertop/Cabinet	2015	25,783		20	752	752	5,049	2
3	Resident Rm/Dining/Hallways - Wall Sconces/Light Fixtures	2015	20,930		20	610	610	3,924	3
4	Resident Rooms - Power Outlets/Cables/Plates	2015	4,200		20	123	123	770	4
5	Resident Rooms - Carpet/Flooring	2015	4,300		20	125	125	788	5
6	Tile In Riviera Wing	2015	6,400		20	187	187	1,173	6
7	Resident Room Carpet	2015	31,058		20	906	906	5,694	7
8	Wood/Fire Rated Door & Hinges For Corridor	2015	10,953		20	319	319	2,008	8
9	Glass Door	2015	7,730		20	225	225	1,417	9
10	Resident Room Flooring	2015	14,057		20	410	410	2,577	10
11	Cape Cod Unit Tile	2015	7,715		20	225	225	1,414	11
12	Double Egress Fire Doors	2015	2,992		20	87	87	549	12
13	Corridors Carpet/Flooring	2015	9,096		20	265	265	1,630	13
14	Cape Cod Unit Drapery/Curtains	2015	12,109		20	353	353	2,119	14
15	Cape Cod Unit Wallcovering	2015	3,102		20	90	90	543	15
16	Cape Cod Unit Glass Mount Bracket	2015	4,052		20	118	118	709	16
17	Cape Cod Unit Double Doors	2015	7,730		20	225	225	1,353	17
18	Corridor Signage	2015	3,855		20	112	112	755	18
19	Cape Cod Unit - New Frames/Doors	2015	3,647		20	106	106	623	19
20	New Compressor For Chiller	2015	8,897		20	259	259	1,594	20
21	Install Door Controls	2015	20,150		20	588	588	3,694	21
22	Drapery - Coventry/Palm Beach Wings	2015	6,000		20	175	175	1,025	22
23	Dining Area/Guest Room - Valance/Rods/Divider Panels	2015	33,300		20	971	971	6,521	23
24	Bathroom/Resident Rooms - Dividers/Doors	2015	17,820		20	520	520	3,490	24
25	Resident Rooms/Corridors - Painting	2015	16,900		20	493	493	3,169	25
26	Cape Cod Unit Wallcovering	2015	5,603		20	163	163	1,004	26
27	East Wing - Primer/Tile	2015	30,947		20	903	903	6,060	27
28	Dining Room, Hallway, Gym & Library - Painted Ceiling/Walls	2016	9,850		20	493	493	2,463	28
29	Hallways - Tiles & Carpet	2016	6,392		20	320	320	1,598	29
30	Cape Cod -Installed Roller Shades	2016	5,580		20	279	279	1,395	30
31	Wireless Access Point	2016	58,169		20	2,908	2,908	14,542	31
32	Security Cameras	2016	25,993		20	1,300	1,300	6,498	32
33	Hallways - Vinyl Tiles, Carpet	2016	4,100		20	205	205	1,025	33
34	TOTAL (lines 1 thru 33)		$ 451,459	$		$ 15,448	$ 15,448	$ 90,324	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 12B, Carried Forward		$ 451,459	$		$ 15,448	$ 15,448	$ 90,324	1
2	Repaired Boiler	2016	2,732		20	137	137	683	2
3	Painted Resident Rooms/Bathrooms/Kitchen/Lounge/Office	2016	9,160		20	458	458	2,290	3
4	Installed Nurse Stations, Counters, Cabinets	2016	23,460		20	1,173	1,173	5,865	4
5	Tuscany Wing - Drywall & Nurses Station Repair	2016	2,633		20	132	132	658	5
6	Painted Dining Room And Hallways	2016	25,200		20	1,260	1,260	6,300	6
7	Architectural Fees - Wing Conversion	2016	12,000		20	600	600	3,000	7
8	Exterior Signage	2016	14,135		20	707	707	3,534	8
9	Tuscany/Barcelona Wing - Carpeting	2016	19,655		20	983	983	4,914	9
10	Unit Melbourne - Carpeting	2016	3,995		20	200	200	999	10
11	Painted 8 Regular And 4 Double Rooms	2016	11,957		20	598	598	2,989	11
12	Chiller Hook Up	2016	2,590		20	130	130	648	12
13	Repair Leaks In 4-Rtu Hydronic Coils	2016	6,646		20	332	332	1,662	13
14	Landscaping Including Shrubs & Ground Cover	2016	8,749		20	437	437	2,187	14
15	Installation Of Wiring For Kiosk, Nurse Station, And Speaker Loca	2016	4,496		20	524	524	2,922	15
16	Replaced Garbage Disposal	2016	3,250		20	379	379	1,896	16
17	Repaired Generator	2016	2,934		20	342	342	1,761	17
18	Repaired Pump	2016	4,902		20	327	327	1,634	18
19	Installed Light Fixtures For Melbourne, Tuscany & Sydney Wings	2016	3,853		20	502	502	2,868	19
20	Demolition Of 9 Fixtures & Can Lights For Nurse Stations	2016	3,610		20	182	182	961	20
21	Insulated Chilled Water Pipes/Mechanical Room Pipes	2016	10,875		20	544	544	2,719	21
22	Repaired Pump	2016	4,902		20	245	245	1,225	22
23	Removed And Replaced Garbage Disposal	2016	2,650		20	133	133	663	23
24	Repaired Fire Alarm System	2016	3,124		20	156	156	781	24
25	Repaired Valves On Boiler	2016	3,033		20	152	152	758	25
26	Cape Cod Unit - Demo/Carpentry/Drywall/Electical/Tiling.Painting	2016	334,638		20	16,732	16,732	83,660	26
27	West Wing - Installed Nurse Station/Work Hub	2016	28,688		20	1,434	1,434	7,172	27
28	Installed New Chiller	2016	168,000		20	8,400	8,400	42,000	28
29	Repair cracks in curb, storm drain & wooden fence	2017	4,250		20	212	212	742	29
30	Cut down 47 trees, hauled away and ground stumps	2017	9,800		20	490	490	1,715	30
31									31
32	Replace high low pressure switch, fix compressor	2017	2,540		20	127	127	445	32
33	East boiler replaced and leaking water lines fixed	2017	7,907		20	395	395	1,383	33
34	TOTAL (lines 1 thru 33)		$ 1,197,822	$		$ 53,869	$ 53,869	$ 281,356	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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		$ 1,197,822	$		$ 53,869	$ 53,869	$ 281,356	1
2	Knock down frames or doors, preped hinges, install								2
3	hinges and double engress frames and doors	2017	7,761		20	388	388	1,358	3
4									4
5	Maintenance on 4 large slope roofs, cleaned gutters, fixed								5
6	damaged fascia and shingles	2017	6,300		20	315	315	1,103	6
7									7
8	Brick wall at the rear of the facility, wall need to be reinforced								8
9	bricks were cut out and put back in without gaps.	2018	2,650		20	133	133	332	9
10	Repair underground passage that connects Lincolnshire								10
11	to the Wellshire building. Water proof, crack sealer,								11
12	repair pipes.	2018	4,500		20	225	225	563	12
13	Spriklers in grass area, replace nozzles and rotaries	2018	5,565		20	278	278	695	13
14	Install glycol in 2 Aaon rooftop units, first floor Carrier								14
15	air handler coil, and 2 chillers	2018	3,445		20	172	172	430	15
16									16
17	Metroflor Commonwealth vinyl Tile-Coventry unit resident rooms	2019	10,612		20	530	530	795	17
18									18
19	Carport reapir-sofits, plywood, shingles, fascia, gutter	2019	12,000		20	600	600	900	19
20									20
21	New flooring room, 201-212	2019	20,400		20	1,020	1,020	1,530	21
22									22
23	Concrete raising	2019	2,864		20	144	144	216	23
24	New 6 steps, railing, and fix blacktop	2019	12,520		20	626	626	939	24
25	Plumbing, piping to PVC new ball and check valves	2019	7,975		20	398	398	597	25
26	Hydromatic pump	2019	8,825		20	442	442	663	26
27	Replace condenser coil on Trane roof top unit	2019	8,498		20	424	424	636	27
28	Glycol in 4 Aaon rooftop units first floor carrier air chillers	2019	4,740		20	238	238	357	28
29	Replace 6 parking lot lights on light poles	2020	13,400		20	335	335	335	29
30	Boiler, 1.950.000 BTU, Dominator , Series DB	2020	22,300		20	558	558	558	30
31	Installed new motor, pully, and belts HVAC - 2nd Floor Lobby	2020	3,310		20	83	83	83	31
32	Replace water circulation pump - Entire Building	2020	11,350		5	1,135	1,135	1,135	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,366,837	$		$ 61,913	$ 61,913	$ 294,580	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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 12D, Carried Forward		$ 1,366,837	$		$ 61,913	$ 61,913	$ 294,580	1
2									2
3	Allocated from CF St. Louis LLC	2019							3
4									4
5	Allocated from Legacy	2018	164			8	8	25	5
6	Allocated from Legacy	2020	123			6	6	6	6
7									7
8	Allocated from CF St. Louis LLC	2016	136,893		20	6,845	6,845	34,223	8
9	Allocated from CF St. Louis LLC	2017	3,177		20	159	159	635	9
10	Allocated from CF St. Louis LLC	2019	28,798		20	1,440	1,440	2,880	10
11	Allocated from CF St. Louis LLC	2020	1,515		20	76	76	76	11
12									12
13									13
14									14
15	Reconcile book depreciation			190,290			(190,290)		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,537,507	$ 190,290		$ 70,447	$ (119,843)	$ 332,425	34

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

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	$ 808,169	$ 126,586	$ 126,586	$	5-10	$ 665,767	71
72	Current Year Purchases	3,427	343	343	(0)	5	343	72
73	Fully Depreciated Assets							73
74	From Sch 13A	9,349		935	935	10	4,735	74
75	TOTALS	$ 820,945	$ 126,929	$ 127,864	$ 935		$ 670,845	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	Facility Use	Ford Truck E350, 2013	01/01/19	$ 51,864	$ 10,373	$ 10,373	$	5	$ 20,746	76
77										77
78										78
79										79
80	TOTALS			$ 51,864	$ 10,373	$ 10,373	$		$ 20,746	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,414,411	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 327,592	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,683	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (118,909)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,024,016	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living Addition - 2016	$ 53,025	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 53,025	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/20

Schedule 13A

XI. Ownership Costs
Line 74 - Equipment

Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6
Allocated from Legacy HC Fin Svc	$ 6,604	$	$ 661	$ 661	10	$ 3,374
Allocated from CF St. Louis	2,745		274	274	10	1,361
				0		
TOTALS	$ 9,349	$ 0	$ 935	$ 935		$ 4,735

Facility Name & ID Number: Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		144		$ 1,000,520			3
4	Additions							4
5								5
6	Alloc fr Mgmt				26,680			6
7	TOTAL		144		$ 1,027,200 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2021	$ 1,880,814
13.	12/31/2022	$ 1,894,240
14.	12/31/2023	$ 1,907,762

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: $ 63,185 Description: See Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	Alloc fr Mgmt			3,462	20
21	TOTAL		$	$ 3,462	21

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

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

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/20

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Durable Medical Equipment Rental	49,334
Oxygen Equipment Rental	2,420
Dietary Equipment Rental	4,725
Office Equipment Rental-Postage	6,351
allocated from Legacy HC Fin Svc	355
Total - Line 16	**63,185**
	-

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	4,879	$ 351,296	$	4,879	$ 351,296	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,049	75,541		1,049	75,541	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,808	418,156		5,808	418,156	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				405,931		405,931	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					36,010		36,010	12
13	Other (specify):									13
14	TOTAL			$	11,736	$ 844,993	$ 441,941	11,736	$ 1,286,934	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.

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,244	$ 1,244	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,025,414))	2,089,354	2,089,354	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	33,716	33,716	6
7	Other Prepaid Expenses	79,647	79,647	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Sch 17A	328,823	328,823	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,532,784	$ 2,532,784	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	4,095	13
14	Buildings, at Historical Cost	-	22,049	14
15	Leasehold Improvements, at Historical Cost	1,134,082	1,515,458	15
16	Equipment, at Historical Cost	1,287,600	872,809	16
17	Accumulated Depreciation (book methods)	(1,575,742)	(1,024,016)	17
18	Deferred Charges	-	-	18
19	Organization & Pre-Operating Costs	-	-	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	-	-	20
21	Restricted Funds	-	-	21
22	Other Long-Term Assets (specify):	-	-	22
23	Other(specify): See Sch 17A	3,896,282	3,896,282	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,742,222	$ 5,286,677	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,275,006	$ 7,819,461	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 885,877	$ 885,877	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	367,062	367,062	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,464	15,464	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	-	32
33	Accrued Interest Payable	-	-	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Sch 17A	10,352,529	10,352,529	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 11,620,932	$ 11,620,932	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	828,822	828,822	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43		-	-	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 828,822	$ 828,822	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,449,754	$ 12,449,754	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,174,748)	$ (4,630,293)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,275,006	$ 7,819,461	48

*(See instructions.)

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/2020

Schedule 17A

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

Description	Operating	After Consolidation
Refund	130,779	130,779
Insurance Refund Exchange	3,549	3,549
Escrow - R&R	322,753	322,753
Payroll Clearing	4,821	4,821
Security Deposit	6,258	6,258
Due To/From - Warren Barr Lincolnshire & Avantara	(139,337)	(139,337)
Total - Line 9	**328,823**	**328,823**
	-	-

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

Description	Operating	After Consolidation
Resident Fund	272	272
Refund - Transfer	62,171	62,171
Due To/From - Warren Barr South Loop & Management	41	41
Due To/From - Warren Barr Lincolnshire & Alf	2,923,433	2,923,433
Due To/From - Warren Barr Lincolnshire & Avantara	(180,000)	(180,000)
Due To/From - South Loop & Warren Barr Lincolnshir	-	-
Due To/From - Warren Barr Lincolnshire & Bella Ter	196,632	196,632
Due To/From Prior Owner	162,089	162,089
Option Deposit On Lincolnshire Property	432,000	432,000
Due To/From Medicare	(728)	(728)
Note Payable - Capex	287,189	287,189
Bad Debt Part A - Mmai	13,183	13,183
Total - Line 23	**3,896,282**	**3,896,282**
	-	-

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

Description	Operating	After Consolidation
Exchange	(18,170)	(18,170)
Prepaid Insurance - Workmans Comp	44,132	44,132
Payroll Exchange	31,092	31,092
Rent Security Deposit	8,810	8,810
Due To/From - Warren Barr Lincolnshire & Managemen	2,393,425	2,393,425
Due To/From - Warren Barr Lincolnshire & Astoria P	249,967	249,967
Due To/From - Warren Barr South Loop & Warren Barr	693,996	693,996
Due To/From - Warren Barr Lincolnshire & Avantara	-	-
Due To/From - Northbrook & Warren Barr Lincolnshir	142,527	142,527
Due To/From - Lakefront & Warren Barr Lincolnshire	42,673	42,673
Due To/From - Grove Of Fox Valley & Warren Barr Li	-	-
Due To/From - Warren Barr Lincolnshire & Elmbrook	-	-
Due To/From Others	1,030,500	1,030,500
Due To/From Members - Entities	96,636	96,636
Accrued Expense	193,831	193,831
Accrued Accounting Fees	(28,902)	(28,902)
Accrued Quarterly Bed License Fee	1,098	1,098
Accrued Monthly Assessment Fee	1,766	1,766
Accrued Management Fees Entities	3,849,882	3,849,882
Accrued Bcbs Ee Insurance	33,824	33,824
Due To/From Medicaid	181,258	181,258
Deferred Soc Sec Tax	262,766	262,766
Due To Bcbs - Upp	141,418	141,418
Bcbs Accelerated Payment	-	-
Officer Loans	1,000,000	1,000,000
Total - Line 36	**10,352,529**	**10,352,529**
	-	-

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Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,395,029)	1
2	Restatements (describe):		2
3	Prior period adjustment	24,749	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,370,280)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(804,468)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (804,468)	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)**	$ (5,174,748)	24 *

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

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,867,088	1
2	Discounts and Allowances for all Levels	(7,693,444)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,173,644	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	3,670,725	6
7	Oxygen	888	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,671,613	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,163,109	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	319,367	17
18	Sale of Supplies to Non-Patients	15,464	18
19	Laboratory	122,757	19
20	Radiology and X-Ray	(215)	20
21	Other Medical Services	6,135	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,626,617	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	3,914	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,914	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Sch 19A	24,312	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,312	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,500,100	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,005,456	31
32	Health Care	5,756,905	32
33	General Administration	2,956,875	33
	B. Capital Expense		
34	Ownership	1,579,388	34
	C. Ancillary Expense		
35	Special Cost Centers	1,705,151	35
36	Provider Participation Fee	300,793	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,304,568	40
41	**Income before Income Taxes (line 30 minus line 40)****	(804,468)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (804,468)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,856,066	44
45	Private Pay - Net Inpatient Revenue	1,267,266	45
46	Medicare - Net Inpatient Revenue	1,389,891	46
47	Other-(specify) Insurance	192,768	47
48	Other-(specify) Part B	(532,347)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,173,644	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

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

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

^Entity is a cash basis taxpayer.

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 53587
Fiscal Year End: 12/31/2020

Schedule 19A

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

Description	Amount
#NAME?	#NAME?
#NAME?	#NAME?
Total - Line 28	**#NAME?**

#NAME?

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 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	1,954	2,177	$ 152,939	$ 70.26	1
2	Assistant Director of Nursing	1,804	2,010	90,531	45.04	2
3	Registered Nurses	42,120	46,733	1,710,070	36.59	3
4	Licensed Practical Nurses	27,011	29,827	934,403	31.33	4
5	CNAs & Orderlies	87,794	96,135	1,789,408	18.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,575	4,991	113,921	22.82	8
9	Activity Director	2,500	2,686	88,875	33.09	9
10	Activity Assistants	7,214	7,972	109,875	13.78	10
11	Social Service Workers	5,920	6,242	164,050	26.28	11
12	Dietician					12
13	Food Service Supervisor	3,789	4,061	114,710	28.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,141	36,334	546,615	15.04	15
16	Dishwashers					16
17	Maintenance Workers	7,313	8,156	207,535	25.44	17
18	Housekeepers					18
19	Laundry	4,969	5,306	79,501	14.98	19
20	Administrator	1,916	2,080	136,477	65.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,384	22,045	466,633	21.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,001	2,080	48,350	23.25	31
32	Other Health Ca See Sch 20A	3,853	4,160	161,548	38.83	32
33	Other(specify) See Sch 20A	2,207	2,316	61,234	26.44	33
34	TOTAL (lines 1 - 33)	260,465	285,311	$ 6,976,676 *	$ 24.45	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	$ 19,844	1(3)	35
36	Medical Director	Monthly	36,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	15,774	10(3)	38
39	Pharmacist Consultant	Monthly	7,203	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	249	11(3)	44
45	Social Service Consultant	Monthly	2,381	12(3)	45
46	Other(specify) MDS Consultant	Monthly	35,294	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 116,745		49

C. CONTRACT NURSES

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

Facility Name: **Warren Barr Lincolnshire**
IDPH License ID Number: **0053587**
Fiscal Year End: **12/31/20**

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS/Care Plan Coordinator LPN	1,923	2,080	82,227	$ 42.76
MDS/Care Plan Coordinator RN	1,930	2,080	79,321	$ 41.10
Total - Line 32 Other Health Care (specify):	**3,853**	**4,160**	**161,548**	
	-	-	0	

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Director	1,161	1,235	36,319	$ 29.41
Guest Services Director	1,046	1,081	24,915	$ 23.05
Total - Line 33 Other (specify):	**2,207**	**2,316**	**61,234**	
	-	-	-	

Facility Name & ID Number Warren Barr Lincolnshire # 0053587 Report Period Beginning: 1/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Florczak, Michael	Administrator	0.00%	$ 136,477
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 136,477

B. Administrative - Other

Description	Amount
Management Fees(elminated in column 7)	$ 617,393
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 617,393

C. Professional Services

Vendor/Payee	Type	Amount
See schedule 21C	Various	$ 209,442
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 209,442

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,218
Unemployment Compensation Insurance	45,392
FICA Taxes	493,480
Employee Health Insurance	222,212
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	61,605
Employee Physical Exams	7,400
Other Employee Benefits	36,058
TOTAL (agree to Schedule V, line 22, col.8)	$ 967,365

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 271
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 28)	280
Patient Background Checks 19	185
Miscellaneous Licenses & Fees	2,738
Miscellaneous Dues & Subscriptions	6,203
Allocated fr Mgmt	2,946
HCCI & IHCA Dues	22,826
Less: Disallow lobbying	(11,244)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,205

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,902
Allocated fr Mgmt	117
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,019

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Warren Barr Lincolnshire
IDPH License ID Number: 0053587
Fiscal Year End: 12/31/20

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ACCOUNTING FEES	RSM McGladrey Inc	24,000
LEGAL FEES	Sb2 Inc	77
LEGAL FEES	Mayer Brown LLP	252
LEGAL FEES	Corporation Service Company	412
LEGAL FEES	Stone Pogrund & Korey LLC	6,308
LEGAL FEES	BNF Reed Smith	18,750
LEGAL FEES	Prepaid Legal	6,250
LEGAL FEES	Baker, Donelson, Bearman, Caldwell & Berko	126
LEGAL FEES	Passen & Powell	33,333
LEGAL FEES	Meyer Magence	1,575
LEGAL FEES	Skidelsky & Associates	4,580
LEGAL FEES	Polsinelli PC	529
LEGAL FEES	Schwartz Wolf & Bernstein LLP	1,045
LEGAL FEES	Renewal Rehab LLC	2,340
LEGAL FEES	Passen & Powel	26,667
LEGAL FEES	Jamie Gowin	236
LEGAL FEES	Sarah Kahn Wool	1,275
LEGAL FEES	Johnson & Bell Ltd.	5,290
OTHER PROFESSIONAL FEE	Compliagent	3,843
OTHER PROFESSIONAL FEE	Personnel Planners	1,542
OTHER PROFESSIONAL FEE	Cortex Health Inc	12,250
OTHER PROFESSIONAL FEE	PatientPing, Inc.	6,000
OTHER PROFESSIONAL FEE	Achieve Accreditation LLC	8,483
OTHER PROFESSIONAL FEE	Prepaid Expense - Telemedicine	7,408
OTHER PROFESSIONAL FEE	MTS Consulting	867
OTHER PROFESSIONAL FEE	Language Line Services, Inc.	19
OTHER PROFESSIONAL FEE	Prepaid Expenses Apploi Corp	68
OTHER PROFESSIONAL FEE	Apploi Corp	400
OTHER PROFESSIONAL FEE	Hygieneering, Inc.	1,099
OTHER PROFESSIONAL FEE	Lighthouse Services, Inc	159
OTHER PROFESSIONAL FEE	Matrixcare	926
PAYCOR FEES	Paycor Fee	33,333
	Total (agree to Schedule V, line 19, column 3)	209,442
Allocated from Management Company	Accounting Fees	804
Allocated from Management Company	Legal & Professional Services	9,200
Less : Reclass Insurance Settlements		(84,999)
Less: Non-Allowable Legal Fees		(646)
	Total (agree to Schedule V, line 19, column 8)	133,801

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI Dues - $22,608 & IHCA Dues -$218**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **77,555** 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. $ **300,793**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln**

d. Have vehicle usage logs been maintained? **Adequate records have been maintained**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**

g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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