		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: 0052787

Facility Name: Warren Barr North Shore

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

County: Lake

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

HFS ID Number:

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

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT
- [ ] Charitable Corp.
- [ ] Trust

IRS Exemption Code

[X] PROPRIETARY
- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [ ] "Sub-S" Corp.
- [X] Limited Liability Co.
- [ ] Trust
- [ ] Other

[ ] GOVERNMENTAL
- [ ] State
- [ ] County
- [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 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) ______ 04/29/2021 (Date)

** Subject to the attached Accountants' Consulting Report*

(Print Name and Title) Steven N. Lavenda, CPA / Partner

(Firm Name & Address) Marcum, LLP / 9 Parkway North, Suite 200 Deerfield, IL 60015

(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	215	Skilled (SNF)	215	78,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	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	30,118	2,994	10,333	43,445	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,118	2,994	10,333	43,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.21%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 215 and days of care provided 8,297

Medicare Intermediary CGS Administrators LLC

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	243	7,682	1,143,649	1,151,574		1,151,574	4,059	1,155,633			1
2	Food Purchase		5,165		5,165		5,165	7,720	12,885			2
3	Housekeeping		20,063	426,287	446,350		446,350	2,632	448,982			3
4	Laundry	37,129	23,913	100,550	161,592		161,592	179	161,771			4
5	Heat and Other Utilities			229,211	229,211		229,211	(11,622)	217,589			5
6	Maintenance	177,571	26,706	285,627	489,904		489,904	14,081	503,985			6
7	Other (specify):*											7
8	TOTAL General Services	214,943	83,529	2,185,324	2,483,796		2,483,796	17,049	2,500,845			8
	B. Health Care and Programs											
9	Medical Director			14,100	14,100		14,100		14,100			9
10	Nursing and Medical Records	4,532,485	562,013	176,846	5,271,344		5,271,344	102,130	5,373,474			10
10a	Therapy	162,017			162,017		162,017		162,017			10a
11	Activities	139,301	7,397	2,231	148,929		148,929	10	148,939			11
12	Social Services	441,101	8,992	3,218	453,311		453,311	7,049	460,360			12
13	CNA Training											13
14	Program Transportation			52,888	52,888		52,888		52,888			14
15	Other (specify):*							7,312	7,312			15
16	TOTAL Health Care and Programs	5,274,904	578,402	249,283	6,102,589		6,102,589	116,501	6,219,090			16
	C. General Administration											
17	Administrative	305,697			305,697		305,697	78,471	384,168			17
18	Directors Fees											18
19	Professional Services			294,436	294,436	(470)	293,966	(52,177)	241,788			19
20	Dues, Fees, Subscriptions & Promotions			133,493	133,493		133,493	(80,261)	53,232			20
21	Clerical & General Office Expenses	214,634	3,503	533,074	751,211		751,211	(31,087)	720,124			21
22	Employee Benefits & Payroll Taxes			857,129	857,129		857,129		857,129			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,133	1,133		1,133	175	1,308			24
25	Other Admin. Staff Transportation			992	992		992	5,866	6,858			25
26	Insurance-Prop.Liab.Malpractice			717,465	717,465		717,465	499	717,964			26
27	Other (specify):*							31,452	31,452			27
28	TOTAL General Administration	520,331	3,503	2,537,722	3,061,556	(470)	3,061,086	(47,061)	3,014,024			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,010,178	665,434	4,972,329	11,647,941	(470)	11,647,471	86,489	11,733,959			29

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

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

Facility Name & ID Number Warren Barr North Shore #0052787 Report Period Beginning: 01/01/20 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							887,987	887,987			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,215	21,215		21,215	860,384	881,599			32
33	Real Estate Taxes			(18)	(18)	470	452	194,265	194,718			33
34	Rent-Facility & Grounds			1,666,570	1,666,570		1,666,570	(1,664,896)	1,674			34
35	Rent-Equipment & Vehicles			41,102	41,102		41,102	3,313	44,415			35
36	Other (specify):*							130,275	130,275			36
37	TOTAL Ownership			1,728,869	1,728,869	470	1,729,339	411,328	2,140,668			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	9,022	521,333	1,418,853	1,949,208		1,949,208	(37,553)	1,911,655			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,800	345,800		345,800		345,800			42
43	Other (specify):*			695,963	695,963		695,963	(694,531)	1,432			43
44	TOTAL Special Cost Centers	9,022	521,333	2,460,616	2,990,971		2,990,971	(732,084)	2,258,887			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,019,200	1,186,767	9,161,814	16,367,781		16,367,781	(234,267)	16,133,514			45

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	(12,994)	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	518,511	30		9
10	Interest and Other Investment Income	(4,578)	32		10
11	Discounts, Allowances, Rebates & Refunds	(24,873)	10		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	(30,308)	21		18
19	Entertainment	(10,169)	21		19
20	Contributions	(55,937)	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	(270,739)	21		24
25	Fund Raising, Advertising and Promotional	(6,321)	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	(1,187,807)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,085,216)		$	30

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)	850,949		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 850,949		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (234,267)		37

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

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

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

BHF USE ONLY

48		49		50		51		52	

Warren Barr North Shore

ID# 0052787
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (4,306)	10	1
2	Bank Charges	(10,278)	21	2
3	Sequestration Expense	(47,822)	21	3
4	Pharmacy Discounts	(924)	10	4
5	Miscellaneous Income	(1,767)	21	5
6	Therapy Discount	(21,810)	39	6
7	Swag Store	(28)	21	7
8	Non-allowable Expense	(694,092)	43	8
9	Non-allowable Auto Rental	(2,386)	35	9
10	Building Co. - Amortization	(290,636)	36	10
11	Building Co. - Accounting	(18,979)	19	11
12	Building Co. - Filing Fees	(102)	20	12
13	PAC Dues	(21,883)	20	13
14	Non-Allowable Expense	(439)	43	14
15	Non-Allowable Legal Fees	(71,836)	19	15
16	Out of Period Dues Expense	(519)	20	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,187,807)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Warren Barr North Shore

ID# 0052787

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr North Shore # 0052787 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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			4,059									4,059	1
2	Food Purchase	(1)		7,721									7,720	2
3	Housekeeping			2,632									2,632	3
4	Laundry			179									179	4
5	Heat and Other Utilities	(12,994)				1,372							(11,622)	5
6	Maintenance			13,192		1,330	(441)						14,081	6
7	Other (specify):*													7
8	**TOTAL General Services**	(12,995)		27,783		2,702	(441)						17,049	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(30,103)		134,946				(2,713)					102,130	10
10a	Therapy													10a
11	Activities			10									10	11
12	Social Services			7,049									7,049	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				7,312								7,312	15
16	**TOTAL Health Care and Programs**	(30,103)		142,005	7,312			(2,713)					116,501	16
	C. General Administration													
17	Administrative			78,471									78,471	17
18	Directors Fees													18
19	Professional Services	(90,815)	18,979	25,762		577			(6,680)				(52,177)	19
20	Fees, Subscriptions & Promotions	(84,762)	102	4,398		1							(80,261)	20
21	Clerical & General Office Expenses	(371,111)		339,704		319							(31,087)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			175									175	24
25	Other Admin. Staff Transportation			5,866									5,866	25
26	Insurance-Prop.Liab.Malpractice			155		345							499	26
27	Other (specify):*			31,452									31,452	27
28	**TOTAL General Administration**	(546,688)	19,081	485,984		1,242			(6,680)				(47,061)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(589,786)	19,081	655,772	7,312	3,944	(441)	(2,713)	(6,680)				86,489	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr North Shore # 0052787 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	518,511	361,011			8,465							887,987	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,578)	860,205			4,757							860,384	32
33	Real Estate Taxes		189,943			4,322							194,265	33
34	Rent-Facility & Grounds		(1,665,018)	39,835		(39,713)							(1,664,896)	34
35	Rent-Equipment & Vehicles	(2,386)			5,699								3,313	35
36	Other (specify):*	(290,636)	420,911										130,275	36
37	**TOTAL Ownership**	220,911	167,052	39,835	5,699	(22,168)							411,328	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(21,810)									(15,743)		(37,553)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(694,531)											(694,531)	43
44	**TOTAL Special Cost Centers**	(716,341)									(15,743)		(732,084)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,085,216)	186,133	695,608	13,010	(18,224)	(441)	(2,713)	(6,680)		(15,743)		(234,267)	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. [X] YES [ ] NO

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,665,018	Half Day Property Holdings LLC		$	$ (1,665,018)	1
2	V	32	Interest	49	Half Day Property Holdings LLC		860,254	860,205	2
3	V	30	Depreciation		Half Day Property Holdings LLC		361,011	361,011	3
4	V	36	Amortization		Half Day Property Holdings LLC		290,636	290,636	4
5	V	19	Accounting		Half Day Property Holdings LLC		18,979	18,979	5
6	V	20	Filing Fees		Half Day Property Holdings LLC		102	102	6
7	V	36	Mortgage Insurance Premium		Half Day Property Holdings LLC		130,275	130,275	7
8	V	33	Real Estate Taxes		Half Day Property Holdings LLC		189,943	189,943	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,665,067			$ 1,851,200	$ * 186,133	14

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	Chaim Rajchenbach	41.65%	Astoria Place Skilled Nursing Facility LLC	Chicago	Half Day Property Holdings LLC		Building Company	1
2	Menachem Shabat	41.65%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	Jack Rajchenbach 2015 Family Trust	11.65%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4	Ronald Shabat	5.05%	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 North Shore # 0052787 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			Lincoln Park Skilled Nursing Facility LLC	Chicago				9
10			Lincolnshire Living & Rehab Center LLC	Lincolnshire				10
11			Northbrook Skilled Nursing Facility LLC	Northbrook				11
12			Peterson Park Associates Limited Partnership	Chicago				12
13			Skokie Skilled Nursing Facility LLC	Skokie				13
14			Valley Skilled Nursing Facility	Billings, MT				14
15			Warren Barr Living And Rehab	Chicago				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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 4,037	$ 4,037	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		22	22	16
17	V	02	Food		Legacy Healthcare Financial Services		7,721	7,721	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,632	2,632	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		179	179	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		12,453	12,453	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		739	739	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		103,073	103,073	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		9,728	9,728	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		22,144	22,144	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		7,022	7,022	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		10	10	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		28	28	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		78,471	78,471	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		25,762	25,762	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,398	4,398	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		316,616	316,616	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		23,088	23,088	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		175	175	33
34	V	25	Travel		Legacy Healthcare Financial Services		5,866	5,866	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		155	155	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		31,452	31,452	36
37	V	34	Rent		Legacy Healthcare Financial Services		39,713	39,713	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		122	122	38
39	Total			$			$ 695,608	$ * 695,608	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	35	Equipment Rental		Legacy Healthcare Financial Services		530	$ 530	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		5,169	5,169	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		7,312	7,312	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			$			$ 13,010	$ * 13,010	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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		$ 1,372	$ 1,372	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,330	1,330	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		470	470	17
18	V	19	Accounting Fees		CF St. Louis LLC		107	107	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		319	319	20
21	V	26	Insurance		CF St. Louis LLC		345	345	21
22	V	30	Depreciation		CF St. Louis LLC		8,465	8,465	22
23	V	32	Interest Expense		CF St. Louis LLC		4,757	4,757	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		4,322	4,322	24
25	V								25
26	V	34	Rent	39,713	CF St. Louis LLC			(39,713)	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			$ 39,713			$ 21,489	$ * (18,224)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	06	Maintenance	$ 18,000	ML Group Design & Development		$ 17,559	$ (441)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,000			$ 17,559	$ * (441)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	10	Medical Supplies	$ 9,000	ReMED Services		$ 6,287	$ (2,713)	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			$ 6,287	$ * (2,713)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	$ 29,156	ProPay HR LLC		$ 22,476	$ (6,680)	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			$ 29,156			$ 22,476	$ * (6,680)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	04	Laundry Service	$ 138,323	EcoBrite Linen		$ 138,323	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 138,323			$ 138,323	$ *	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	39	Laboratory	$ 38,681	Lifescan Labs of Illinois		$ 22,938	$ (15,743)	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			$ 38,681			$ 22,938	$ * (15,743)	39

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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. [ ] 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 North Shore # 0052787 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	2	3	4	5	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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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 [X]

Name of Related Organization
Street Address
City / State / Zip Code
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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	78,690	$ 4,037	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		78,690	22	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		78,690	7,721	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		78,690	2,632	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		78,690	179	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	78,690	12,453	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		78,690	739	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	78,690	103,073	8
9	10	Nurse/Medical Director Consulta	Available Bed Days	2,540,133	53	314,035		78,690	9,728	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		78,690	22,144	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	78,690	7,022	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		78,690	10	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		78,690	28	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	78,690	78,471	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		78,690	25,762	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		78,690	4,398	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	78,690	316,616	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		78,690	23,088	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		78,690	175	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		78,690	5,866	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		78,690	155	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		78,690	31,452	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		78,690	39,713	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		78,690	122	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 695,608	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 [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	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		78,690	530	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		78,690	5,169	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		78,690	7,312	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	$		$ 13,010	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 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	Available Bed Days	2,540,133	53	$ 44,301	$	78,690	$ 1,372	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		78,690	1,330	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		78,690	470	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		78,690	107	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		78,690	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		78,690	319	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		78,690	345	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		78,690	8,465	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		78,690	4,757	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		78,690	4,322	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	$		$ 21,489	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct						17,559	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 17,559	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 6,287	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 North Shore # 0052787 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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: ( )

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	19	Payroll Services	Direct			$	$		$ 22,476	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					$	$		$ 22,476	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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: (   )

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	4	Laundry Service	Direct			$	$		$ 138,323	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					$	$		$ 138,323	25

Facility Name & ID Number Warren Barr North Shore # 0052787 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 [X] 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: (847) 663 - 8300
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	39	Laboratory	Direct			$	$		$ 22,938	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					$	$		$ 22,938	25

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	First American Capital Group		X	Mortgage Payable			$	$ 21,769,392			$ 860,254	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Financial		X	Revolving Line of Credit				90,359			21,215	6
7	Allocated from CF St. Louis		X								4,757	7
8												8
9	TOTAL Facility Related						$	$ 21,859,751			$ 886,226	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,578)	10
11	Interest Income - Bldg Co.		X								(49)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,627)	14
15	TOTALS (line 9+line14)						$	$ 21,859,751			$ 881,599	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 130,275 Line # 36

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	Description		Amount	Line
1	Real Estate Tax accrual used on 2019 report.	$	173,613	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.)	$	181,650	2
3	Under or (over) accrual (line 2 minus line 1).	$	8,037	3
4	Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	186,211	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.)**	$	470	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.	$	194,718	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2015	153,877	8
2016	156,742	9
2017	160,689	10
2018	165,329	11
2019	177,327	12

2020 Accrual = $177,327 x 1.05 = $186,211

Allocated from CF St. Louis LLC: $4,322

FOR BHF USE ONLY

Line	Description			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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-401-005	Long Term Care Property	$ 177,327.24	$ 177,327.24
2.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 4,322.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 636,859.68	$ 181,649.50

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 North Shore COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052787

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES ________ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			$ 1,508,714	1
2	Allocated from CF St. Louis, LLC			6,114	2
3	TOTALS			$ 1,514,828	3

Facility Name & ID Number Warren Barr North Shore # 0052787 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		2014	1997	$ 16,827,972	$ 361,011	35	$ 480,799	$ 119,788	$ 3,202,736	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	34,469		20	1,723	1,723	9,871	9
10	Various			2015	2,381,072		20	119,054	119,054	729,829	10
11	Various			2016	227,247		20	11,362	11,362	56,812	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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
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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)		287,741	7,804		13,682	5,877	61,208	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 19,758,500	$ 368,815		$ 626,620	$ 257,805	$ 4,060,456	70

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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		$ 19,758,500	$ 368,815		$ 626,620	$ 257,805	$ 4,060,456	1
2	Provided And Installed New Copper Piping And Fittings On The F	2017	3,870		20	194	194	645	2
3	Installed Of Parking And Building Lights	2017	3,125		20	156	156	599	3
4	Repaired Sprinkler Heads In Dialysis Unit	2017	8,725		20	436	436	1,381	4
5	Repaired Carpet - 2Nd And 3Rd Floor	2017	17,680		20	884	884	2,062	5
6	Repaired Fuel Pump	2017	3,437		20	172	172	402	6
7	Install Customer Millwork/Electrical - Resident Rooms	2017	11,988		20	599	599	1,299	7
8	Permit Fee For Dialysis Unit	2017	8,946		20	447	447	969	8
9	Repaired Heat Exchanger And Gas Valve	2017	8,250		20	413	413	893	9
10	Installed Vinyl Plank For Dialysis Unit	2017	7,524		20	376	376	814	10
11	Repaired Valves For Water Box-Dialysis Unit	2017	5,640		20	282	282	1,128	11
12	Installed 61 Fire Retardant Troffer Boxes-Therapy Rooms	2017	5,490		20	275	275	595	12
13	Installed Handrail For Dialysis Unit	2017	5,092		20	255	255	551	13
14	Installed Mixing Valves And Water Lines	2017	4,725		20	236	236	513	14
15	Site Design Fees For Dialysis Unit	2017	3,660		20	183	183	396	15
16	Installed 2Nd Floor Countertops	2017	3,360		20	168	168	448	16
17	Kitchen Equipment	2017	3,239		20	162	162	432	17
18	Installed Wiring For Dialysis Unit	2017	3,200		20	160	160	426	18
19	Carpeting For Common Areas	2017	5,748		20	287	287	1,150	19
20	Repaired Dialysis Unit/Carpet/Vinyl Wall Base/Pipe Lines	2017	270,677		20	13,534	13,534	54,135	20
21	Removal And Replacment By S & H Paving Inc. (25,000)	2018	23,140		20	1,157	1,157	3,101	21
22	Installation Of A Mine Split 3 Ton In Dialysis Room In Basement (5	2018	4,628		20	231	231	647	22
23	Remove Tower Pump & Rebuild Seal Assy (4,271)	2018	3,953		20	198	198	554	23
24	Ceiling Tile, Ada Compliant Bathroom Fixtures (4,250)	2018	3,934		20	197	197	551	24
25	Kitchen Drop Ceiling (4,000)	2018	3,702		20	185	185	519	25
26	Installation Of Single Packing (2,850)	2018	2,638		20	132	132	322	26
27	Security Cameras Installation (6,003)	2018	5,556		20	278	278	628	27
28	Installation Of Fan And Motor Dolleys (3,152)	2018	2,917		20	146	146	356	28
29	Installation Of Digital Controlled Mixing Valve (3,250)	2018	3,008		20	150	150	908	29
30	Carpet And Lighting For Dialysis Room Conversion (6,252)	2018	5,787		20	289	289	2,373	30
31	Blinds For 2 Residents' Rooms (3,196)	2018	2,958		20	148	148	1,000	31
32	Dialysis Rm Painting, Flooring, New Electrical, Ceiling (18,370)	2018	17,003		20	850	850	4,218	32
33	Repair Water Main Break In Parking Lot (25,951)	2018	24,020		20	1,201	1,201	4,661	33
34	TOTAL (lines 1 thru 33)		$ 20,246,122	$ 368,815		$ 651,001	$ 282,186	$ 4,149,130	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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		$ 20,246,122	$ 368,815		$ 651,001	$ 282,186	$ 4,149,130	1
2	Repair Main Water Pipe In Parking Lot (10,818)	2018	10,013		20	501	501	1,943	2
3	Repair Of Bolts In Water Pipe (2,795)	2018	2,587		20	129	129	501	3
4	Replacing The Floors In All The First Floor Hallways (9,782)	2018	9,054		20	453	453	617	4
5	Seal Kit Replacement (6,405)	2018	5,928		20	296	296	1,150	5
6	Switch And Add Phone Extensions (3,595)	2018	3,328		20	166	166	766	6
7	Fire Pump System Modifications ($20965)	2019	20,317		20	1,016	1,016	2,181	7
8	Installed 2 480 V Heaters ($7200)	2019	6,978		20	349	349	669	8
9	Heater Installation ($6785.81)	2019	6,576		20	329	329	743	9
10	Door & Flooring Installation - Basement, 1St Flr Room, 2Nd Floor	2019	15,166		20	758	758	1,193	10
11	Flooring - Hallway, Dining Room, Receptionist Area ($19645)	2019	19,038		20	952	952	2,262	11
12	Cable Installation & Repair - 3 Resident Rm Floors ($19178.33)	2019	18,586		20	929	929	1,462	12
13	Diesel Storage Tank Piping ($3696)	2019	3,582		20	179	179	467	13
14	Cable Installation - Intercom At Front Desk Entrance ($3334.48)	2019	3,231		20	162	162	400	14
15	Domestic Hot Water Heater Replacement ($12535)	2019	12,148		20	607	607	2,100	15
16	Carpeting For Walkways ($3209)	2019	3,109		20	155	155	289	16
17	Installed Heating/Conditioning Unit ($5637.8)	2019	5,464		20	273	273	351	17
18	Flooring/Cove Base For Basement ($5450)	2019	5,282		20	264	264	355	18
19	Dialysis Room - Design Fees ($31202)	2019	30,238		20	1,512	1,512	3,024	19
20	Cooling Tower Pump Repair And Install New 7J Inserts ($5,920)	2019	5,737		20	287	287	574	20
21	Install New Key Card Entry System ($2,591.15)	2019	2,511		20	126	126	251	21
22	Vinyl Tile And Cove Base ($2,963.90)	2020	2,891		20	145	145	145	22
23	Replace Underground Broken Drain Pipe In Kitchen ($20,000)	2020	19,510		20	976	976	976	23
24	New Tiles In Hallway And Kitchen ($4,100)	2020	4,000		20	200	200	200	24
25	Replace Damaged Insulation From Exposed Pipe-Boiler & Electric:	2020	3,120		20	156	156	156	25
26	Fire Alarm Repair ($5,775.48)	2020	5,634		20	282	282	282	26
27	Booster Pump # 2 Repair ($3,642.33)	2020	3,553		20	178	178	178	27
28	Boiler-Repair Ignition,Repair 9 Roof Top Exhausts,Ejector Pumps	2020	3,380		20	169	169	169	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,477,082	$ 368,815		$ 662,549	$ 293,734	$ 4,172,532	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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		$ 20,477,082	$ 368,815		$ 662,549	$ 293,734	$ 4,172,532	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)		$ 20,477,082	$ 368,815		$ 662,549	$ 293,734	$ 4,172,532	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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		$ 20,477,082	$ 368,815		$ 662,549	$ 293,734	$ 4,172,532	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
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,477,082	$ 368,815		$ 662,549	$ 293,734	$ 4,172,532	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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 North Shore # 0052787 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 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	32,920	1,528	35	941	(588)	4,703	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	204,389	5,042	20	10,219	5,177	51,097	9
10	Allocated from CF St. Louis, LLC	2017	4,744	117	20	237	120	949	10
11	Allocated from CF St. Louis, LLC	2019	42,998	1,061	20	2,150	1,089	4,300	11
12	Allocated from CF St. Louis, LLC	2019	2,261	56	20	113	57	113	12
13									13
14	Allocated from Legacy HC	2018	244		20	12	12	37	14
15	Allocated from Legacy HC	2020	184		20	9	9	9	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)		$ 287,741	$ 7,804		$ 13,682	$ 5,877	$ 61,208	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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 12H, Carried Forward		$ 287,741	$ 7,804		$ 13,682	$ 5,877	$ 61,208	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 287,741	$ 7,804		$ 13,682	$ 5,877	$ 61,208	34

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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	$ 2,188,953	$ 659	$ 218,895	$ 218,236	10	$ 1,426,440	71
72	Current Year Purchases	69,178	2	6,543	6,540	10	6,543	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,258,130	$ 661	$ 225,438	$ 224,777		$ 1,432,983	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)	$ 24,250,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 369,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 887,987	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 518,511	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,605,515	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				1,552			5
6	Allocated from Legacy Financial				122			6
7	TOTAL				$ 1,674 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 27,664 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	Facility	Nissan Infiniti	$ 965	$ 11,582	17
18	Allocated from Legacy Financial			5,169	18
19					19
20					20
21	TOTAL		$ 965	$ 16,751	21

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

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

Facility Name & ID Number Warren Barr North Shore # 0052787 Report Period Beginning: 01/01/20 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

   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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 494,059	$		$ 494,059	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			156,683			156,683	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			646,843			646,843	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				310,439		310,439	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			9,022		121,268	210,894		341,184	13
14	TOTAL			$ 9,022		$ 1,418,853	$ 521,333		$ 1,949,208	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 North Shore # 0052787 Report Period Beginning: 01/01/20 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	$ 129,779	$ 626,585	1
2	Cash-Patient Deposits	6,064	6,064	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(71,557)	(71,557)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,518	11,518	6
7	Other Prepaid Expenses	517,540	517,540	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	8,808	8,808	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 602,152	$ 1,098,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	73,524	1,582,238	13
14	Buildings, at Historical Cost		13,977,972	14
15	Leasehold Improvements, at Historical Cost	3,422,464	3,461,482	15
16	Equipment, at Historical Cost	1,890,773	2,515,069	16
17	Accumulated Depreciation (book methods)	(2,518,185)	(5,624,539)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	4,445,904	6,052,144	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,314,480	$ 21,964,366	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,916,632	$ 23,063,324	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,067,851	$ 1,067,922	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	90,359	90,359	29
30	Accrued Salaries Payable	259,370	259,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	261,809	261,809	31
32	Accrued Real Estate Taxes(Sch.IX-B)		186,211	32
33	Accrued Interest Payable		59,866	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	5,106,994	5,106,994	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,786,383	$ 7,032,531	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,769,392	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,379,108	248,094	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,379,108	$ 22,017,486	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,165,491	$ 29,050,017	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (248,859)	$ (5,986,693)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,916,632	$ 23,063,324	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,093,450)	1
2	Restatements (describe):		2
3	Sequestration Expense	(4,192)	3
4	Bad Debt Expense	(608,058)	4
5	Equity Restatement	(347,706)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,053,406)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(905,453)	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	2,710,000	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)**	$ 1,804,547	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)**	$ (248,859)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,952,637	1
2	Discounts and Allowances for all Levels	(5,853,412)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,099,225	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,424,087	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,424,087	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	286,199	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	74,402	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,518	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 369,119	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,578	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,578	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,565,319	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,565,319	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,462,328	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,483,796	31
32	Health Care	6,102,589	32
33	General Administration	3,061,556	33
	B. Capital Expense		
34	Ownership	1,728,869	34
	C. Ancillary Expense		
35	Special Cost Centers	2,645,171	35
36	Provider Participation Fee	345,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,367,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	(905,453)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (905,453)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,462,668	44
45	Private Pay - Net Inpatient Revenue	146,371	45
46	Medicare - Net Inpatient Revenue	2,198,803	46
47	Other-(specify) Insurance	291,383	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,099,225	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,118	2,279	$ 151,577	$ 66.51	1
2	Assistant Director of Nursing	2,079	2,179	105,057	48.21	2
3	Registered Nurses	27,998	31,149	1,243,638	39.93	3
4	Licensed Practical Nurses	35,249	40,454	1,404,617	34.72	4
5	CNAs & Orderlies	69,949	82,599	1,549,416	18.76	5
6	CNA Trainees					6
7	Licensed Therapist	231	247	9,022	36.53	7
8	Rehab/Therapy Aides	6,932	8,329	162,017	19.45	8
9	Activity Director	1,672	1,859	38,208	20.55	9
10	Activity Assistants	7,009	7,492	101,093	13.49	10
11	Social Service Workers	9,264	10,082	285,636	28.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20	20	243	12.15	15
16	Dishwashers					16
17	Maintenance Workers	5,655	5,994	177,571	29.62	17
18	Housekeepers					18
19	Laundry	1,973	2,128	37,129	17.45	19
20	Administrator	1,992	2,474	183,677	74.24	20
21	Assistant Administrator	1,168	1,216	41,028	33.74	21
22	Other Administrative	1,560	1,640	80,992	49.39	22
23	Office Manager					23
24	Clerical	8,472	9,770	214,634	21.97	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	1,893	2,080	43,694	21.01	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	12,037	12,939	189,950	14.68	33
34	TOTAL (lines 1 - 33)	197,271	224,930	$ 6,019,199 *	$ 26.76	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	$ 1,143,649	01-03	35
36	Medical Director	Monthly	14,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	40,523	10-03	38
39	Pharmacist Consultant	Monthly	14,401	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,231	11-03	44
45	Social Service Consultant	59	3,218	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	59	$ 1,218,122		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	212	$ 10,587	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	4,453	111,335	10-03	52
53	TOTAL (lines 50 - 52)	4,665	$ 121,922		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator	0	$ 150,911
Katherine Simpson	Administrator	0	32,766
Sydney Garver	Asst Administrator	0	38,093
Christian Pineda	Executive Director	0	83,927
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 305,697

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 24,000
ProPay HR LLC	Payroll Processing	29,156
Onyx Procurement Solutions	Procurement Services	11,370
Achieve Accreditation	Accreditation	8,436
Compliagent	Compliance	3,843
MTS Consulting	Tax Consulting	824
Personnel Planners	Unemployment Tax Consultant	1,350
Prospect Resources	Energy Procurement	1,000
Cortex Health Care	Data Processing	11,810
Language Line Services	Interpreter	405
Telemedicine Solutions	Risk Prevention Software	7,408
See Supplemental Schedule		194,833
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 294,436

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,790
Unemployment Compensation Insurance	33,838
FICA Taxes	460,469
Employee Health Insurance	177,114
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	18,008
Employee Physical Exams	11,918
Other Employee Benefits	31,654
Voluntary Benefits	12,337
TOTAL (agree to Schedule V, line 22, col.8)	$ 857,127

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	400
Health Care Worker Background Check (Indicate # of checks performed 127)	1,273
Patient Background Checks 498	4,975
Dues & Subscriptions	39,087
Licenses & Fees	1,108
See Supplemental Schedule	4,399
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,233

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,133
See Supplemental Schedule	175
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,309

**See instructions.

Facility Name & ID Number **Warren Barr North Shore** # **0052787** Report Period Beginning: **01/01/20** Ending: **12/31/20**

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. **IHCA - $18,512, HCCI - $33,592**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,516** 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. $ **345,800**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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