

Facility Name & ID Number Warren Barr South Loop

0054353 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	207	Skilled (SNF)	207	75,762	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,098	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,860	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	37,199	1,113	12,405	50,717	8
9	SNF/PED					9
10	ICF	575	17	49	641	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,774	1,130	12,454	51,358	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.82%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 8/14/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/14/2014 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 207 and days of care provided 9,252

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 South Loop # 0054353 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	636,714	64,706		701,420		701,420	3,719	705,139		1
2	Food Purchase		403,012		403,012		403,012	6,985	409,997		2
3	Housekeeping	431,311	45,638	5,435	482,384		482,384	2,411	484,795		3
4	Laundry	42,332	53,632	169,098	265,062		265,062	164	265,226		4
5	Heat and Other Utilities			214,523	214,523		214,523	(11,845)	202,678		5
6	Maintenance	110,243	20,268	183,799	314,310		314,310	11,427	325,737		6
7	Other (specify):*										7
8	TOTAL General Services	1,220,600	587,256	572,855	2,380,711		2,380,711	12,861	2,393,572		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	5,882,569	712,184	72,344	6,667,097		6,667,097	77,383	6,744,480		10
10a	Therapy	110,361			110,361		110,361	(53,108)	57,253		10a
11	Activities	181,946	2,416	411	184,773		184,773	10	184,783		11
12	Social Services	502,968	46,016	7,248	556,232		556,232	6,459	562,691		12
13	CNA Training										13
14	Program Transportation			87,571	87,571		87,571		87,571		14
15	Other (specify):*							6,699	6,699		15
16	TOTAL Health Care and Programs	6,677,844	760,616	197,574	7,636,034		7,636,034	37,443	7,673,477		16
	C. General Administration										
17	Administrative	294,042			294,042		294,042	71,902	365,944		17
18	Directors Fees										18
19	Professional Services			794,627	794,627	(431)	794,196	(37,911)	756,285		19
20	Dues, Fees, Subscriptions & Promotions			137,160	137,160		137,160	(86,771)	50,389		20
21	Clerical & General Office Expenses	243,813	5,123	816,021	1,064,957		1,064,957	(314,604)	750,353		21
22	Employee Benefits & Payroll Taxes			1,186,929	1,186,929		1,186,929		1,186,929		22
23	Inservice Training & Education										23
24	Travel and Seminar			787	787		787	161	948		24
25	Other Admin. Staff Transportation			4,365	4,365		4,365	5,375	9,740		25
26	Insurance-Prop.Liab.Malpractice			820,316	820,316		820,316	458	820,774		26
27	Other (specify):*							28,819	28,819		27
28	TOTAL General Administration	537,855	5,123	3,760,205	4,303,183	(431)	4,302,752	(332,572)	3,970,180		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,436,299	1,352,995	4,530,634	14,319,928	(431)	14,319,497	(282,268)	14,037,229		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 South Loop

#0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							916,866	916,866			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,609	38,609		38,609	1,135,571	1,174,180			32
33	Real Estate Taxes			128,001	128,001	431	128,432	113,283	241,715			33
34	Rent-Facility & Grounds			2,599,702	2,599,702		2,599,702	(2,595,542)	4,160			34
35	Rent-Equipment & Vehicles			30,337	30,337		30,337	5,222	35,559			35
36	Other (specify):*							16,454	16,454			36
37	TOTAL Ownership			2,796,649	2,796,649	431	2,797,080	(408,147)	2,388,933			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	956,155	865,613	1,642,476	3,464,244		3,464,244	(30,349)	3,433,895			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			374,845	374,845		374,845		374,845			42
43	Other (specify):*			929,747	929,747		929,747	(929,747)				43
44	TOTAL Special Cost Centers	956,155	865,613	2,947,068	4,768,836		4,768,836	(960,096)	3,808,740			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,392,454	2,218,608	10,274,351	21,885,413		21,885,413	(1,650,511)	20,234,902			45

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

Warren Barr South Loop

ID# 0054353

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Expense	\$ (928,540)	43	1
2	Marketing - History	22	43	2
3	Patient Personal Items	(4,065)	10	3
4	Bank Charges	(6,963)	21	4
5	Sequestration Expense	(64,526)	21	5
6	Pharmacy Discounts	(3,344)	10	6
7	Therapy Discount	(53,108)	10A	7
8	Swage Store	(50)	21	8
9	PAC Dues	(21,253)	20	9
10	Non-Allowable Expense	(1,229)	43	10
11	Out of Period Dues	(519)	20	11
12	Non-Allowable Legal	(50,961)	19	12
13	Additional R&M	2,450	06	13
14	Capitalized R&M	(3,888)	06	14
15	Building Co. - Amortization	(27,667)	36	15
16	Building Co. - Professional Fees	(135,351)	19	16
17	Building Co. - Bank Fees	(39,779)	21	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	(1,338,772)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr South Loop# 0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			3,719									3,719	1
2	Food Purchase	(89)		7,074									6,985	2
3	Housekeeping			2,411									2,411	3
4	Laundry			164									164	4
5	Heat and Other Utilities	(13,103)				1,258							(11,845)	5
6	Maintenance	(1,438)		12,088		1,219	(441)						11,427	6
7	Other (specify):*													7
8	TOTAL General Services	(14,630)		25,456		2,476	(441)						12,861	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(43,552)		123,648				(2,713)					77,383	10
10a	Therapy	(53,108)											(53,108)	10a
11	Activities			10									10	11
12	Social Services			6,459									6,459	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,699								6,699	15
16	TOTAL Health Care and Programs	(96,660)		130,117	6,699			(2,713)					37,443	16
	C. General Administration													
17	Administrative			71,902									71,902	17
18	Directors Fees													18
19	Professional Services	(186,312)	135,351	23,605		529			(11,083)				(37,911)	19
20	Fees, Subscriptions & Promotions	(90,802)		4,030		1							(86,771)	20
21	Clerical & General Office Expenses	(665,939)	39,779	311,264		292							(314,604)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			161									161	24
25	Other Admin. Staff Transportation			5,375									5,375	25
26	Insurance-Prop.Liab.Malpractice			142		316							458	26
27	Other (specify):*			28,819									28,819	27
28	TOTAL General Administration	(943,053)	175,130	445,297		1,138			(11,083)				(332,572)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,054,344)	175,130	600,870	6,699	3,614	(441)	(2,713)	(11,083)				(282,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	909,109				7,757							916,866	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,314)	1,144,526			4,359							1,135,571	32
33	Real Estate Taxes		109,323			3,960							113,283	33
34	Rent-Facility & Grounds		(2,595,654)	36,500		(36,388)							(2,595,542)	34
35	Rent-Equipment & Vehicles				5,222								5,222	35
36	Other (specify):*	(27,667)	44,121										16,454	36
37	TOTAL Ownership	868,128	(1,297,684)	36,500	5,222	(20,312)							(408,147)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(30,349)		(30,349)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(929,747)											(929,747)	43
44	TOTAL Special Cost Centers	(929,747)									(30,349)		(960,096)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,115,963)	(1,122,554)	637,370	11,921	(16,699)	(441)	(2,713)	(11,083)		(30,349)		(1,650,511)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 2,595,654	FNR Chicago SL		\$	(2,595,654)	1
2	V	32 Interest	12	FNR Chicago SL		1,144,538	1,144,526	2
3	V	33 Real Estate Tax Expense		FNR Chicago SL		109,323	109,323	3
4	V	36 MIP Expense		FNR Chicago SL		16,454	16,454	4
5	V	36 Amortization		FNR Chicago SL		27,667	27,667	5
6	V	19 Professional Fees		FNR Chicago SL		135,351	135,351	6
7	V	21 Recording and Bank Fees		FNR Chicago SL		39,779	39,779	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,595,666			\$ 1,473,112	\$ * (1,122,554)	14

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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 3,699	\$	3,699	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		20		20	16
17	V	02 Food		Legacy Healthcare Financial Services		7,074		7,074	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		2,411		2,411	18
19	V	04 Linen Replacement		Legacy Healthcare Financial Services		164		164	19
20	V	06 Maintenance Salary		Legacy Healthcare Financial Services		11,410		11,410	20
21	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		677		677	21
22	V	10 Nursing Salary		Legacy Healthcare Financial Services		94,444		94,444	22
23	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		8,914		8,914	23
24	V	10 Medical Supplies		Legacy Healthcare Financial Services		20,290		20,290	24
25	V	12 Social Service Salary		Legacy Healthcare Financial Services		6,434		6,434	25
26	V	11 Activities Program		Legacy Healthcare Financial Services		10		10	26
27	V	12 Social Service Consultant		Legacy Healthcare Financial Services		25		25	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		71,902		71,902	28
29	V	19 Professional Fees		Legacy Healthcare Financial Services		23,605		23,605	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,030		4,030	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		290,109		290,109	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		21,155		21,155	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		161		161	33
34	V	25 Travel		Legacy Healthcare Financial Services		5,375		5,375	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		142		142	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		28,819		28,819	36
37	V	34 Rent		Legacy Healthcare Financial Services		36,388		36,388	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		112		112	38
39	Total		\$			\$ 637,370	\$ *	637,370	39

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

Facility Name & ID Number Warren Barr South Loop

0054353

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	35 Equipment Rental		Legacy Healthcare Financial Services		486	\$	486	15
16	V	35 Auto Rental		Legacy Healthcare Financial Services		4,736		4,736	16
17	V	15 Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		6,699		6,699	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		\$			\$ 11,921	\$ *	11,921	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	CF St. Louis LLC		\$ 1,258	\$ 1,258
16	V	6 Repairs & Maintenance		CF St. Louis LLC		1,219	1,219
17	V	19 Property Valuation Fee		CF St. Louis LLC		431	431
18	V	19 Accounting Fees		CF St. Louis LLC		98	98
19	V	20 Dues & Subscriptions		CF St. Louis LLC		1	1
20	V	21 Office Expense		CF St. Louis LLC		292	292
21	V	26 Insurance		CF St. Louis LLC		316	316
22	V	30 Depreciation		CF St. Louis LLC		7,757	7,757
23	V	32 Interest Expense		CF St. Louis LLC		4,359	4,359
24	V	33 Real Estate Taxes		CF St. Louis LLC		3,960	3,960
25	V						
26	V	34 Rent	36,388	CF St. Louis LLC			(36,388)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 36,388			\$ 19,689	\$ * (16,699)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance	\$ 18,000	ML Group Design & Development		\$ 17,559	\$ (441)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 18,000			\$ 17,559	\$ * (441)

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

Facility Name & ID Number Warren Barr South Loop

0054353

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	10 Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,000			\$ 6,287	\$ * (2,713)

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

Facility Name & ID Number Warren Barr South Loop

0054353

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	19 Payroll Services	\$ 48,376	ProPay HR LLC		\$ 37,293	\$ (11,083)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 48,376			\$ 37,293	\$ * (11,083)

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

Facility Name & ID Number Warren Barr South Loop

0054353

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	04 Laundry Services	\$ 256,938	EcoBrite Linen		\$ 256,938	\$	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		\$ 256,938			\$ 256,938	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Laboratory	\$ 74,568	Lifescan Labs of Illinois		\$ 44,219	\$ (30,349)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 74,568			\$ 44,219	\$ * (30,349)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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 South Loop # 0054353 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietician Salary	Available Bed Days	2,540,133	53	\$ 130,303	\$ 130,303	72,102	\$ 3,699	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		72,102	20	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		72,102	7,074	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		72,102	2,411	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		72,102	164	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	72,102	11,410	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		72,102	677	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	72,102	94,444	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	2,540,133	53	314,035		72,102	8,914	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		72,102	20,290	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	72,102	6,434	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		72,102	10	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		72,102	25	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	72,102	71,902	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		72,102	23,605	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		72,102	4,030	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	72,102	290,109	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		72,102	21,155	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		72,102	161	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		72,102	5,375	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		72,102	142	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		72,102	28,819	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		72,102	36,388	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		72,102	112	24
25	TOTALS					\$ 22,454,338	\$ 16,839,706		\$ 637,370	25

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109	72,102	486	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843	72,102	4,736	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021	72,102	6,699	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	\$	\$ 11,921	25

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CF St. Louis LLC
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 676-5300
 Fax Number (847) 676-5348

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	\$ 44,301	\$ 72,102	\$ 1,258	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932	72,102	1,219	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181	72,102	431	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453	72,102	98	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23	72,102	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298	72,102	292	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124	72,102	316	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261	72,102	7,757	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558	72,102	4,359	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524	72,102	3,960	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	\$	\$ 19,689	25

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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 ()

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

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Barr South Loop

0054353

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 NO

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 37,293	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				\$	\$		\$ 37,293	25

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	04	Laundry Services	Direct		\$	\$		\$ 256,938	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				\$	\$		\$ 256,938	25

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization LIFESCAN LABS OF ILLINOIS, LLC
 Street Address 5255 GOLF RD
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 663 - 8300
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct		\$	\$		\$ 44,219	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				\$	\$		\$ 44,219	25

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	CIBC Bank		X	Mortgage			\$	\$ 33,368,744			\$	1,144,538						
2																		
3																		
4																		
5																		
Working Capital																		
6	Interest Only		X									38,609						
7	Allocated from CF St. Louis		X									4,359						
8																		
9	TOTAL Facility Related						\$	\$ 33,368,744			\$	1,187,506						
B. Non-Facility Related*																		
10	Interest Income		X									(13,314)						
11	Interest Income - Bldg Co.		X									(12)						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(13,326)						
15	TOTALS (line 9+line14)						\$	\$ 33,368,744			\$	1,174,180						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,454 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 South Loop**

0054353

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.

1. Real Estate Tax accrual used on 2019 report.	\$	244,584	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.)	\$	239,037	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(5,547)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	246,831	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.)	\$	431	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.	\$	241,715	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	381,836	8
	2016	354,328	9
	2017	448,563	10
	2018	231,123	11
	2019	235,077	12

2020 Accrual = \$235,077 x 1.05 = \$246,831

Allocated from CF St. Louis LLC: \$3,960

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr South Loop COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054353

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>17-22-300-045-0000</u>	<u>Long Term Care Facility</u>	\$ <u>13,127.79</u>	\$ <u>13,127.79</u>
2.	<u>17-22-300-047-0000</u>	<u>Long Term Care Facility</u>	\$ <u>13,600.17</u>	\$ <u>13,600.17</u>
3.	<u>17-22-300-049-0000</u>	<u>Long Term Care Facility</u>	\$ <u>14,071.72</u>	\$ <u>14,071.72</u>
4.	<u>17-22-300-074-0000</u>	<u>Long Term Care Facility</u>	\$ <u>31,379.33</u>	\$ <u>31,379.33</u>
5.	<u>17-22-301-014-0000</u>	<u>Long Term Care Facility</u>	\$ <u>18,250.71</u>	\$ <u>18,250.71</u>
6.	<u>17-22-301-015-0000</u>	<u>Long Term Care Facility</u>	\$ <u>23,589.91</u>	\$ <u>23,589.91</u>
7.	<u>17-22-301-016-0000</u>	<u>Long Term Care Facility</u>	\$ <u>63,231.32</u>	\$ <u>63,231.32</u>
8.	<u>17-22-301-017-0000</u>	<u>Long Term Care Facility</u>	\$ <u>36,186.56</u>	\$ <u>36,186.56</u>
9.	<u>17-22-301-050-0000</u>	<u>Long Term Care Facility</u>	\$ <u>21,639.29</u>	\$ <u>21,639.29</u>
10.	<u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>459,532.44</u>	\$ <u>3,960.40</u>
TOTALS			\$ <u><u>694,609.24</u></u>	\$ <u><u>239,037.20</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr South Loop COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054353

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Rows include Facility (1982, \$1,748,076), Allocated from CF St. Louis, LLC (5,602), and TOTALS (\$1,753,678).

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207		2014	1983	\$ 14,080,962	\$	35	\$ 402,313	\$ 402,313	\$ 2,575,769	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2014		172,636		20	8,632	8,632	73,327	9
10	Various		2015		1,039,558		20	51,978	51,978	345,795	10
11	Various		2016		342,294		20	17,115	17,115	85,573	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 South Loop**

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		3,336,767			166,838	166,838	834,191	67
68		263,651	7,151		12,536	5,385	56,083	68
69								69
70		\$ 19,235,866	\$ 7,151		\$ 659,412	\$ 652,261	\$ 3,970,740	70

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

Facility Name & ID Number Warren Barr South Loop# 0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,235,866	\$ 7,151		\$ 659,412	\$ 652,261	\$ 3,970,740	1
2	Repaired Elevator Cab 2 Core Cars	2017	3,300		20	165	165	660	2
3	Elevator Cab - Demo/Installed Panels/Flooring/Railings	2017	26,320		20	1,316	1,316	5,264	3
4	1St Floor North Bathrooms Tiling	2017	3,200		20	160	160	640	4
5	Installed Four Nurse Call Stations On 1St Floor	2017	16,101		20	805	805	3,220	5
6	Signage - 1St-3Rd Floors Resident Rooms/Janitorial/Office	2017	3,320		20	166	166	664	6
7	Guestrm/Bath - Demo/Tile Base/Flooring/Doors/Drywall/Paint	2017	85,852		20	4,293	4,293	17,170	7
8	Repaired Air Handlers In Kitchen	2017	9,354		20	468	468	1,871	8
9	Installed/Repaired Duct Work/Vents/Controllers In Lobby	2017	12,065		20	603	603	2,413	9
10	Guestroom - Headboard/Closet Millwork/Lamination	2017	32,195		20	1,610	1,610	6,439	10
11	1St Floor North Patient Rms-New Flloing/Tiling/Electrical	2017	35,300		20	1,765	1,765	7,060	11
12	Cubicle Curtains	2017	4,982		20	249	249	996	12
13	Installed Light Receptacles/Switches For 11 1St Floor Rooms	2017	11,495		20	575	575	2,299	13
14	Kitchen Exhaust Fan Repair	2017	3,891		20	195	195	778	14
15	A/C-Convactor Filters And Liner	2017	3,962		20	198	198	792	15
16	Repair Of Brick On The Façade West Side Of Building	2017	8,500		20	425	425	1,700	16
17	1St-3Rd Floor - Shower/Bathroom/Closet Repair	2017	107,586		20	5,379	5,379	21,517	17
18	Installation Of Intercom Delivery Door To Ring At Front Desk	2017	2,511		20	126	126	502	18
19	Door Operators For Elevators 1 & 3	2017	3,500		20	175	175	700	19
20	Fire Alarm System - Relocate Existing Smoke Detectors	2017	5,581		20	279	279	1,116	20
21	16 Cubicle Curtains	2017	2,566		20	128	128	513	21
22	Lobby - Prime And Paint All New Drywall And Existing Wall	2017	4,655		20	233	233	931	22
23	Paint Stairway From Lobby Area To 1St Floor	2017	3,845		20	192	192	769	23
24	Electrical Work - Lower Level Electrical Room, Generator Dtribu	2017	26,500		20	1,325	1,325	5,300	24
25	Roofing - Install Metal Scupper/Coping With Downspout On Nort	2017	3,500		20	175	175	700	25
26	Elevator Door Operators (\$7,560)	2018	6,998		20	350	350	1,144	26
27	Main Entrance - Repair Magnetic Breakout Switch For Door (\$2,6	2018	2,425		20	121	121	374	27
28	Repaired Water Pumps And Walves (\$10,000)	2018	9,256		20	463	463	1,388	28
29	Window Perforation Lamination (\$3,349)	2018	3,100		20	155	155	465	29
30	Installed Shower Head In Bathroom (\$3,178)	2018	2,942		20	147	147	441	30
31	Repaired Water Lines/Chilled Water System/Boiler/Piping (\$47,50	2018	43,966		20	2,198	2,198	6,595	31
32	Installed 2 New Elevator Door Operators (\$7,560)	2018	6,998		20	350	350	1,050	32
33	Repaired Radiator (\$10,957)	2018	10,142		20	507	507	1,521	33
34	TOTAL (lines 1 thru 33)		\$ 19,741,773	\$ 7,151		\$ 684,707	\$ 677,556	\$ 4,067,733	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 19,741,773	\$ 7,151		\$ 684,707	\$ 677,556	\$ 4,067,733	1
2	Installed Showerhead (\$3,178)	2018	2,942		20	147	147	441	2
3	Repaired Fire Alarm Egress/Magnetic Locks (\$2,859)	2018	2,646		20	132	132	397	3
4	Stainless Steel Door Levers, E-Z Pipe Wrap (\$8676.68)	2019	8,409		20	420	420	1,288	4
5	Painting - 2Nd/3Rd Floor Resident Rooms (\$28500)	2019	27,619		20	1,381	1,381	2,173	5
6	Masonry - New Foundation, Staircase, Metal Railings (\$16900)	2019	16,378		20	819	819	2,227	6
7	Painting - 2Nd/3Rd Floor Resident Rooms (\$12350)	2019	11,968		20	598	598	1,525	7
8	Replace Door Locks, Fit Bathroom Sinks, Wall Repair (\$5380)	2019	5,214		20	261	261	619	8
9	Ceiling Mounted Heater With Thermostat In Foyer (\$3775)	2019	3,658		20	183	183	875	9
10	Installed Showerhead/Valve Adapter (\$4743.38)	2019	4,597		20	230	230	1,020	10
11	Furnish And Install Tags On Elevator (\$10856)	2019	10,521		20	526	526	888	11
12	Installed Wall Mount Bracket (\$4031.25)	2019	3,907		20	195	195	263	12
13	Mirrors/Design Fees (\$20082)	2019	19,461		20	973	973	1,946	13
14	Install Upgraded Selector And Tape For Elevator # 1 (\$3,450)	2019	3,343		20	167	167	334	14
15	Elevator Repair (\$27,800)	2019	27,119		20	1,356	1,356	1,356	15
16	Milliken Carpet Tile Installation - 2Nd Flr Hallway (\$19,150)	2020	18,680		20	934	934	934	16
17	Mannington Walkway Plank Vinyl Tile Installation - 3Rd Flr Hal	2020	23,955		20	1,198	1,198	1,198	17
18	Install New Hot Water Heater Tank (\$7,521)	2020	7,337		20	367	367	376	18
19	Fix Basement Mechanical Room Hot Water Line Leak (\$3,888)	2020	3,793		20	190	190	194	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)		\$ 19,943,320	\$ 7,151		\$ 694,785	\$ 687,634	\$ 4,085,788	34

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

Facility Name & ID Number **Warren Barr South Loop**

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,943,320	\$ 7,151		\$ 694,785	\$ 687,634	\$ 4,085,788	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		\$ 19,943,320	\$ 7,151		\$ 694,785	\$ 687,634	\$ 4,085,788	34

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

Facility Name & ID Number **Warren Barr South Loop**

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,943,320	\$ 7,151		\$ 694,785	\$ 687,634	\$ 4,085,788	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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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		\$ 19,943,320	\$ 7,151		\$ 694,785	\$ 687,634	\$ 4,085,788	34

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

Facility Name & ID Number **Warren Barr South Loop**

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Therapy/Office/Gym - Demo/Masonry/Framing/Flooring/Electrical	2016	3,336,767		20	166,838	166,838	834,191	9
10	Related Architect/Design/IDPH Fees								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)		\$ 3,336,767	\$		\$ 166,838	\$ 166,838	\$ 834,191	34

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

Facility Name & ID Number **Warren Barr South Loop**

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,336,767	\$		\$ 166,838	\$ 166,838	\$ 834,191	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		\$ 3,336,767	\$		\$ 166,838	\$ 166,838	\$ 834,191	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	30,164	1,401	35	862	(539)	4,309	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	187,277	4,620	20	9,364	4,744	46,819	9
10	Allocated from CF St. Louis, LLC	2017	4,347	107	20	217	110	869	10
11	Allocated from CF St. Louis, LLC	2019	39,398	972	20	1,970	998	3,940	11
12	Allocated from CF St. Louis, LLC	2019	2,072	51	20	104	52	104	12
13									13
14	Allocated from Legacy HC	2018	224		20	11	11	34	14
15	Allocated from Legacy HC	2020	169		20	8	8	8	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)		\$ 263,651	\$ 7,151		\$ 12,536	\$ 5,385	\$ 56,083	34

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

Facility Name & ID Number **Warren Barr South Loop**

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 263,651	\$ 7,151		\$ 12,536	\$ 5,385	\$ 56,083	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)	\$ 263,651	\$ 7,151		\$ 12,536	\$ 5,385	\$ 56,083	34

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

Facility Name & ID Number Warren Barr South Loop

0054353

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	\$ 2,194,969	\$ 604	\$ 219,497	\$ 218,893	10	\$ 1,287,305	71
72	Current Year Purchases	25,840	2	2,584	2,582	10	2,584	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,220,809	\$ 606	\$ 222,081	\$ 221,475		\$ 1,289,889	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 23,917,806	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,757	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 916,866	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 909,109	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,375,677	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	CIP	\$ 114,010	92
93			93
94			94
95		\$ 114,010	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				4,048			5
6	Allocated from Legacy HC				112			6
7	TOTAL				\$ 4,160			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 18,714 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	2018 Dodge Caravan	\$ 1,009	\$ 12,109	17
18	Allocated from Legacy HC			4,736	18
19					19
20					20
21	TOTAL		\$ 1,009	\$ 16,845	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	585,110	\$		\$	585,110	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				179,005				179,005	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39 - 03	hrs				643,468				643,468	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 prescripts					511,469			511,469	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): _____											12	
13	Other (specify): <u>See Attached</u>				956,155		234,893	354,144			1,545,192	13	
14	TOTAL			\$	956,155		\$	1,642,476	\$	865,613	\$	3,464,244	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 South Loop**# **0054353**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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 527,442	\$ 1,027,625	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,727,828	4,727,828	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,088	20,088	6
7	Other Prepaid Expenses	731,698	1,090,461	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	823,504	2,680,900	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,830,560	\$ 9,546,902	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,748,076	13
14	Buildings, at Historical Cost		9,873,577	14
15	Leasehold Improvements, at Historical Cost	1,433,609	4,505,017	15
16	Equipment, at Historical Cost	552,791	1,497,630	16
17	Accumulated Depreciation (book methods)	1,000	(3,235,846)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	3,386,358	5,242,211	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,373,758	\$ 19,630,665	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,204,318	\$ 29,177,567	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,572,007	\$ 1,572,008	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,314	280,314	30
31	Accrued Taxes Payable (excluding real estate taxes)	406,975	406,975	31
32	Accrued Real Estate Taxes(Sch.IX-B)		246,831	32
33	Accrued Interest Payable		77,860	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	3,798,719	3,798,719	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,058,015	\$ 6,382,707	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		33,368,744	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	3,900,566	670,971	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,900,566	\$ 34,039,715	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,958,581	\$ 40,422,422	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,245,737	\$ (11,244,855)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,204,318	\$ 29,177,567	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,771,358	1
2	Restatements (describe):		2
3	Bad Debts/Sequestration	399,852	3
4	Real Estate Tax Expense	455,896	4
5	Depreciation	241,077	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,868,183	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,622,446)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,622,446)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,245,737	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning: 01/01/20

Ending:

12/31/20

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 18,640,281	1
2	Discounts and Allowances for all Levels	(5,287,891)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,352,390	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,652,817	6
7	Oxygen	2,417	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,655,234	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	386,474	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	128,505	19
20	Radiology and X-Ray	2,275	20
21	Other Medical Services	48,054	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 565,308	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,314	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,314	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	1,676,721	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,676,721	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,262,967	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,380,711	31
32	Health Care	7,636,034	32
33	General Administration	4,303,183	33
B. Capital Expense			
34	Ownership	2,796,649	34
C. Ancillary Expense			
35	Special Cost Centers	4,393,991	35
36	Provider Participation Fee	374,845	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,885,413	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,622,446)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,622,446)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 9,747,833	44
45	Private Pay - Net Inpatient Revenue	379,514	45
46	Medicare - Net Inpatient Revenue	2,519,051	46
47	Other-(specify) <u>Insurance</u>	705,992	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,352,390	49

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

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

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

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

Facility Name & ID Number Warren Barr South Loop

0054353

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,225	\$ 146,432	\$ 65.81	1
2	Assistant Director of Nursing	2,045	2,234	101,315	45.35	2
3	Registered Nurses	23,537	27,988	1,041,012	37.19	3
4	Licensed Practical Nurses	64,011	84,040	3,179,748	37.84	4
5	CNAs & Orderlies	65,030	82,470	1,372,114	16.64	5
6	CNA Trainees					6
7	Licensed Therapist	27,129	31,034	956,155	30.81	7
8	Rehab/Therapy Aides	6,636	7,298	110,361	15.12	8
9	Activity Director	1,896	2,153	40,149	18.65	9
10	Activity Assistants	9,274	10,219	141,797	13.88	10
11	Social Service Workers	11,836	12,997	305,223	23.48	11
12	Dietician	2,979	3,251	83,069	25.55	12
13	Food Service Supervisor	1,624	1,815	57,085	31.45	13
14	Head Cook	4,825	5,476	83,564	15.26	14
15	Cook Helpers/Assistants	26,452	28,869	412,996	14.31	15
16	Dishwashers					16
17	Maintenance Workers	5,347	5,734	110,243	19.23	17
18	Housekeepers	26,308	29,030	431,311	14.86	18
19	Laundry	2,615	2,871	42,332	14.74	19
20	Administrator	1,832	2,080	142,895	68.70	20
21	Assistant Administrator	2,320	2,448	79,441	32.45	21
22	Other Administrative	1,632	1,881	71,706	38.13	22
23	Office Manager	149	149	3,936	26.42	23
24	Clerical	13,069	13,893	239,877	17.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2	2	80	40.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	14,400	15,265	239,611	15.70	33
34	TOTAL (lines 1 - 33)	316,908	375,422	\$ 9,392,452 *	\$ 25.02	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	\$		35
36	Medical Director	Monthly 30,000	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly 56,681	10-03	38
39	Pharmacist Consultant	Monthly 15,663	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 411	11-03	44
45	Social Service Consultant	Monthly 7,248	12-03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 110,003		49

C. CONTRACT NURSES

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

Facility Name & ID Number Warren Barr South Loop# 0054353Report Period Beginning: 01/01/20Ending: 12/31/20**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$32,970, IHCA - \$17,352
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,631 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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Warren Barr South Loop, IDPH #0052902
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 374,845
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees