

		FOR BHF USE					

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**2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2019)**

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

I. IDPH License ID Number: 0052415

Facility Name: Warren Barr Gold Coast

Address: 66 West Oak Street Chicago 60610
 Number City Zip Code

County: Cook

Telephone Number: (312) 705-5100 **Fax #** (312) 705-5041

HFS ID Number: _____

Date of Initial License for Current Owners: 8/1/2013

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/19 to 12/31/19 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	* Subject to the attached Accountants' Consulting Report	
	(Print Name and Title) _____	
	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Warren Barr Gold Coast

0052415 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	271	Skilled (SNF)	271	98,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	271	TOTALS	271	98,915	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	38,919	2,041	31,399	72,359	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,919	2,041	31,399	72,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.15%

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 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/1/2013 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 271 and days of care provided 22,352

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2019 Fiscal Year: 12/31/2019

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	742,522	53,551	564	796,637		796,637	4,001	800,638		1
2	Food Purchase		586,056		586,056		586,056	(8,201)	577,855		2
3	Housekeeping	395,323	81,816	7,200	484,339		484,339	3,051	487,390		3
4	Laundry	28,354	61,697	226,056	316,107		316,107		316,107		4
5	Heat and Other Utilities			390,434	390,434		390,434	(14,980)	375,454		5
6	Maintenance	248,763	38,012	393,271	680,046		680,046	7,742	687,788		6
7	Other (specify):*										7
8	TOTAL General Services	1,414,962	821,132	1,017,525	3,253,619		3,253,619	(8,386)	3,245,233		8
	B. Health Care and Programs										
9	Medical Director			95,429	95,429		95,429		95,429		9
10	Nursing and Medical Records	6,804,581	248,296	79,880	7,132,757		7,132,757	117,219	7,249,976		10
10a	Therapy	354,498			354,498		354,498		354,498		10a
11	Activities	138,539	11,128		149,667		149,667	47	149,714		11
12	Social Services	650,089	105,996	5,596	761,681		761,681	6,851	768,532		12
13	CNA Training										13
14	Program Transportation			326,189	326,189		326,189	98	326,287		14
15	Other (specify):* <u>Alloc Related Co Benefits</u>			45	45		45	19,934	19,979		15
16	TOTAL Health Care and Programs	7,947,707	365,420	507,139	8,820,266		8,820,266	144,150	8,964,416		16
	C. General Administration										
17	Administrative	389,309			389,309		389,309	140,778	530,087		17
18	Directors Fees										18
19	Professional Services			597,769	597,769	(5,046)	592,723	(36,858)	555,865		19
20	Dues, Fees, Subscriptions & Promotions			235,728	235,728		235,728	(137,427)	98,301		20
21	Clerical & General Office Expenses	254,807	9,020	1,107,233	1,371,060		1,371,060	(340,486)	1,030,574		21
22	Employee Benefits & Payroll Taxes			1,420,524	1,420,524		1,420,524		1,420,524		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,874	17,874		17,874	3,844	21,718		24
25	Other Admin. Staff Transportation			7,240	7,240		7,240	37,367	44,607		25
26	Insurance-Prop.Liab.Malpractice			309,696	309,696		309,696	24,455	334,151		26
27	Other (specify):*							109,911	109,911		27
28	TOTAL General Administration	644,116	9,020	3,696,064	4,349,200	(5,046)	4,344,154	(198,415)	4,145,739		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,006,785	1,195,572	5,220,728	16,423,085	(5,046)	16,418,039	(62,652)	16,355,387		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							1,464,097	1,464,097			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,611	164,611		164,611	1,521,123	1,685,734			32
33	Real Estate Taxes			912,000	912,000	5,046	917,046	6,690	923,736			33
34	Rent-Facility & Grounds			2,251,865	2,251,865		2,251,865	(2,251,696)	169			34
35	Rent-Equipment & Vehicles			31,159	31,159		31,159	(4,170)	26,989			35
36	Other (specify):*			607,000	607,000		607,000	(607,000)	0			36
37	TOTAL Ownership			3,966,635	3,966,635	5,046	3,971,681	129,045	4,100,726			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,350,197	3,424,939	4,775,136		4,775,136		4,775,136			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			446,775	446,775		446,775		446,775			42
43	Other (specify):*			1,355,349	1,355,349		1,355,349	(1,355,349)				43
44	TOTAL Special Cost Centers		1,350,197	5,227,063	6,577,260		6,577,260	(1,355,349)	5,221,911			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,006,785	2,545,769	14,414,426	26,966,980		26,966,980	(1,288,956)	25,678,024			45

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

Warren Barr Gold Coast

ID# 0052415

Report Period Beginning: 01/01/19

Ending: 12/31/19

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (2,054)	21	1
2	Sequestration Expense	(242,041)	21	2
3	Theft & Damage Loss	(506)	21	3
4	Pharmacy Discounts	(23,219)	10	4
5	Non-allowable - Management Fees	(1,355,349)	43	5
6	Non-allowable - Collections	(522)	21	6
7	Non-allowable - Other Professional Fees	(22,174)	19	7
8	Non-allowable - Legal Fees	(44,229)	19	8
9	PAC Dues	(23,470)	20	9
10	Non-allowable - Entertainment	(1,663)	20	10
11	Non-allowable - Seminar	(600)	24	11
12	Capitalized R&M	(14,850)	06	12
13	Amortization of Goodwill	(607,000)	36	13
14	Non-Allowable Auto Rental	(11,760)	35	14
15	Bldg Co - Accounting	(6,932)	19	15
16	Bldg Co - Replacement Tax	(105)	21	16
17	Bldg Co - Amortization	(35,833)	36	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	(2,392,306)		49

Warren Barr Gold Coast

ID# 0052415
 Report Period Beginning: 01/01/19
 Ending: 12/31/19

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Gold Coast# 0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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			4,001									4,001	1
2	Food Purchase	(13,178)		4,977									(8,201)	2
3	Housekeeping			3,051									3,051	3
4	Laundry													4
5	Heat and Other Utilities	(16,720)				1,740							(14,980)	5
6	Maintenance	(14,850)		21,548		1,787	(742)						7,742	6
7	Other (specify):*													7
8	TOTAL General Services	(44,748)		33,577		3,527	(742)						(8,386)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(29,446)		146,689				(24)					117,219	10
10a	Therapy													10a
11	Activities			47									47	11
12	Social Services			6,851									6,851	12
13	CNA Training													13
14	Program Transportation			98									98	14
15	Other (specify):*				19,934								19,934	15
16	TOTAL Health Care and Programs	(29,446)		153,685	19,934			(24)					144,150	16
	C. General Administration													
17	Administrative			140,778									140,778	17
18	Directors Fees													18
19	Professional Services	(73,334)	6,932	45,389		13			(15,857)				(36,858)	19
20	Fees, Subscriptions & Promotions	(139,031)		1,603		1							(137,427)	20
21	Clerical & General Office Expenses	(922,781)	105	581,916		274							(340,486)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(600)		4,444									3,844	24
25	Other Admin. Staff Transportation			37,367									37,367	25
26	Insurance-Prop.Liab.Malpractice			23,942		513							24,455	26
27	Other (specify):*			109,911									109,911	27
28	TOTAL General Administration	(1,135,746)	7,037	945,350		801			(15,857)				(198,415)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,209,940)	7,037	1,132,612	19,934	4,328	(742)	(24)	(15,857)				(62,652)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	1,464,097											1,464,097	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15,598)	1,529,381			7,340							1,521,123	32
33	Real Estate Taxes					6,690							6,690	33
34	Rent-Facility & Grounds		(2,251,865)	62,724		(62,555)							(2,251,696)	34
35	Rent-Equipment & Vehicles	(11,760)			7,590								(4,170)	35
36	Other (specify):*	(642,833)	35,833										(607,000)	36
37	TOTAL Ownership	793,906	(686,651)	62,724	7,590	(48,525)							129,045	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,355,349)											(1,355,349)	43
44	TOTAL Special Cost Centers	(1,355,349)											(1,355,349)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,771,383)	(679,614)	1,195,336	27,525	(44,196)	(742)	(24)	(15,857)				(1,288,956)	45

Facility Name & ID Number

Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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:	
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)	
1	V	34 Rent	\$ 2,251,865	FNR WB		\$	(2,251,865)	1
2	V	21 Replacement Tax Fee		FNR WB, LLC		105	105	2
3	V	19 Professional Fees - Accounting		FNR WB, LLC		6,932	6,932	3
4	V	32 Interest Expense - Mortgage A		FNR WB, LLC		1,529,381	1,529,381	4
5	V	36 Amortization Expense		FNR WB, LLC		35,833	35,833	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,251,865			\$ 1,572,251	\$ * (679,614)	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	Chaim Rajchenbach	34.77%	Astoria Place Skilled Nursing Facility LLC	Chicago	FNR WB, LLC		Building Company	1
2	Menachem Shabat	34.77%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	Ronald Shabat	10.38%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4	Yair Zuckerman	2.09%	Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5	Susan Friedman	5.00%	Avantara Billings	Billings, MT	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	Rajchenbach Family Trust	6.69%	Avantara Clark	Clark, SD	Propay HR	Evanston	Payroll Processing	6
7	Yoseph & Naomi Rajchenbach	0.44%	Avantara Elgin	Elgin	Ecobrite Linen	Skokie	Laundry Supplies	7
8	Avrohom & Chana Rajchenbach	0.44%	Avantara Evergreen Park	Evergreen Park	Aurora Supportive Living	Aurora	Supportive Living	8
9	Shlomo Zalmain Busel & Chava Busel	0.44%	Avantara Groton	Groton, SD	Terrace Gardens	Morton Grove	Assisted Living	9
10	Pinchas & Nahama Schwartz	0.44%	Avantara Huron	Huron, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11	Ross Bottner	2.61%	Avantara Ipswich	Ipswich, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12	Jack Rajchenbach	1.95%	Avantara Lake Norden	Lake Norden, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Long Grove	Long Grove				13
14			Avantara Milbank	Milbank, SD				14
15			Avantara Mountainview	Rapid City, SD				15
16			Avantara North	Rapid City, SD				16
17			Avantara Norton	Sioux Falls, SD				17
18			Avantara Park Ridge	Park Ridge				18
19			Avantara Pierre	Pierre, SD				19
20			Avantara Redfield	Redfield, SD				20
21			Avantara Salem	Salem, SD				21
22			Avantara St. Cloud	Rapid City, SD				22
23			Avantara Watertown	Watertown, SD				23
24			Bella Terra Streamwood	Streamwood				24
25			Bella Terra Wheeling	Wheeling				25
26			Bethany Terrace	Morton Grove				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				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		\$ 3,824	\$	3,824	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		177		177	16
17	V	02 Food		Legacy Healthcare Financial Services		4,977		4,977	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		3,051		3,051	18
19	V	06 Maintenance Salary		Legacy Healthcare Financial Services		19,290		19,290	19
20	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		2,257		2,257	20
21	V	10 Nursing Salary		Legacy Healthcare Financial Services		140,454		140,454	21
22	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		6,156		6,156	22
23	V	10 Medical Supplies		Legacy Healthcare Financial Services		79		79	23
24	V	12 Social Service Salary		Legacy Healthcare Financial Services		6,468		6,468	24
25	V	11 Activities Program		Legacy Healthcare Financial Services		47		47	25
26	V	12 Social Service Consultant		Legacy Healthcare Financial Services		384		384	26
27	V	14 Patient Transportation		Legacy Healthcare Financial Services		98		98	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		140,778		140,778	28
29	V	19 Professional Fees		Legacy Healthcare Financial Services		45,389		45,389	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		1,603		1,603	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		561,155		561,155	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		20,761		20,761	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		4,444		4,444	33
34	V	25 Travel		Legacy Healthcare Financial Services		37,367		37,367	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		23,942		23,942	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		109,911		109,911	36
37	V	34 Rent		Legacy Healthcare Financial Services		62,555		62,555	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		169		169	38
39	Total		\$			\$ 1,195,336	\$ *	1,195,336	39

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning: 01/01/19

Ending: 12/31/19

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		87	\$	87	15
16	V	35 Auto Rental		Legacy Healthcare Financial Services		7,503		7,503	16
17	V	15 Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		19,934		19,934	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		\$			27,525	\$ *	27,525	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		\$ 1,740	\$ 1,740
16	V	6 Repairs & Maintenance		CF St. Louis LLC		1,787	1,787
17	V	19 Professional Fees		CF St. Louis LLC		13	13
18	V	20 Dues & Subscriptions		CF St. Louis LLC		1	1
19	V	21 Office Expense		CF St. Louis LLC		274	274
20	V	26 Insurance		CF St. Louis LLC		513	513
21	V	32 Interest Expense		CF St. Louis LLC		7,340	7,340
22	V	33 Real Estate Taxes		CF St. Louis LLC		6,690	6,690
23	V						
24	V						
25	V	34 Rent	62,555	CF St. Louis LLC			(62,555)
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		\$ 62,555			\$ 18,359	\$ * (44,196)

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning: 01/01/19

Ending: 12/31/19

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	\$ 24,000	ML Group Design and Development		\$ 23,258	\$ (742)
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		\$ 24,000			\$ 23,258	\$ * (742)

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning: 01/01/19

Ending: 12/31/19

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 LLC		\$ 8,976	\$ (24)
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			\$ 8,976	\$ * (24)

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning: 01/01/19

Ending: 12/31/19

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	\$ 61,485	ProPay HR LLC		\$ 45,628	\$ (15,857)
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		\$ 61,485			\$ 45,628	\$ * (15,857)

* 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.

VII. RELATED PARTIES (continued)

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

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

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

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

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 Gold Coast

#

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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 Gold Coast

0052415 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending: 12/31/19

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	2,157,364	52	\$ 83,412	\$ 83,412	98,915	\$ 3,824	1
2	01	Dietary Supplies	Available Bed Days	2,157,364	52	3,862		98,915	177	2
3	02	Food	Available Bed Days	2,157,364	52	108,556		98,915	4,977	3
4	03	Housekeeping	Available Bed Days	2,157,364	52	66,543		98,915	3,051	4
5	06	Maintenance Salary	Available Bed Days	2,157,364	52	420,731	420,731	98,915	19,290	5
6	06	Repairs & Maintenance	Available Bed Days	2,157,364	52	49,227		98,915	2,257	6
7	10	Nursing Salary	Available Bed Days	2,157,364	52	3,063,332	3,063,332	98,915	140,454	7
8	10	Nurse/Medical Director Consultant	Available Bed Days	2,157,364	52	134,265		98,915	6,156	8
9	10	Medical Supplies	Available Bed Days	2,157,364	52	1,732		98,915	79	9
10	12	Social Service Salary	Available Bed Days	2,157,364	52	141,061	141,061	98,915	6,468	10
11	11	Activities Program	Available Bed Days	2,157,364	52	1,020		98,915	47	11
12	12	Social Service Consultant	Available Bed Days	2,157,364	52	8,366		98,915	384	12
13	14	Patient Transportation	Available Bed Days	2,157,364	52	2,147		98,915	98	13
14	17	COO / Administrative Salary	Available Bed Days	2,157,364	52	3,070,400	3,070,400	98,915	140,778	14
15	19	Professional Fees	Available Bed Days	2,157,364	52	989,949		98,915	45,389	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,157,364	52	34,952		98,915	1,603	16
17	21	Clerical & General Wages	Available Bed Days	2,157,364	52	12,238,949	12,238,949	98,915	561,155	17
18	21	Clerical & Office Expense	Available Bed Days	2,157,364	52	452,802		98,915	20,761	18
19	24	Education & Seminars	Available Bed Days	2,157,364	52	96,921		98,915	4,444	19
20	25	Travel	Available Bed Days	2,157,364	52	814,982		98,915	37,367	20
21	26	Insurance - General	Available Bed Days	2,157,364	52	522,189		98,915	23,942	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,157,364	52	2,397,200		98,915	109,911	22
23	34	Rent	Available Bed Days	2,157,364	52	1,364,347		98,915	62,555	23
24	34	Offsite Storage / Parking	Available Bed Days	2,157,364	52	3,689		98,915	169	24
25	TOTALS					\$ 26,070,633	\$ 19,017,885		\$ 1,195,336	25

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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	35	Equipment Rental	Available Bed Days	2,157,364	52	1,905	98,915	87	1
2	35	Auto Rental	Available Bed Days	2,157,364	52	163,643	98,915	7,503	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,157,364	52	434,774	98,915	19,934	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					\$ 600,322	\$	\$ 27,525	25

Facility Name & ID Number Warren Barr Gold Coast

0052415 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	2,157,364	52	\$ 37,960	\$ 98,915	\$ 1,740	1
2	6	Repairs & Maintenance	Available Bed Days	2,157,364	52	38,965	98,915	1,787	2
3	19	Professional Fees	Available Bed Days	2,157,364	52	281	98,915	13	3
4	20	Dues & Subscriptions	Available Bed Days	2,157,364	52	23	98,915	1	4
5	21	Office Expense	Available Bed Days	2,157,364	52	5,978	98,915	274	5
6	26	Insurance	Available Bed Days	2,157,364	52	11,190	98,915	513	6
7	32	Interest Expense	Available Bed Days	2,157,364	52	160,092	98,915	7,340	7
8	33	Real Estate Taxes	Available Bed Days	2,157,364	52	145,917	98,915	6,690	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					\$ 400,406	\$	\$ 18,359	25

Facility Name & ID Number Warren Barr Gold Coast

0052415 Report Period Beginning: 01/01/19

Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct		\$	\$		\$ 23,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 23,258	25

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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	10	Medical Supplies	Direct		\$	\$		\$ 8,976	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 8,976	25

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending: 12/31/19

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		\$	\$		\$ 45,628	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				\$	\$		\$ 45,628	25

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending: 12/31/19

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 Gold Coast

0052415 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending: 12/31/19

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 Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	CIBC		X	Mortgage			\$	\$ 41,197,193			\$	1,529,381						
2																		
3																		
4																		
5																		
Working Capital																		
6	CIBC		X	Note Payable				2,217,975				164,611						
7	Allocated from CF St. Louis		X									7,340						
8																		
9	TOTAL Facility Related						\$	\$ 43,415,168			\$	1,701,332						
B. Non-Facility Related*																		
10	Interest Income		X									(15,598)						
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(15,598)						
15	TOTALS (line 9+line14)						\$	\$ 43,415,168			\$	1,685,734						

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

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

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

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 2018 report.		\$	<u>497,241</u>	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.)		\$	<u>1,095,074</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>597,833</u>	3
4. Real Estate Tax accrual used for 2019 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>320,857</u>	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.)		\$	<u>5,046</u>	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.		\$	<u>923,736</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2014	<u>628,004</u>	8
	2015	<u>832,183</u>	9
	2016	<u>909,580</u>	10
	2017	<u>977,614</u>	11
	2018	<u>1,088,384</u>	12

2019 Accrual = \$1,088,384 x .29 = \$320,857

Allocated from CF St. Louis: \$6,690

Beginning Accrual Adjusted

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2018	\$	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.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Gold Coast COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052415

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2018 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 2018.

	(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>17-04-423-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>22,637.55</u>	\$ <u>22,637.55</u>
2.	<u>17-04-423-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,065,746.53</u>	\$ <u>1,065,746.53</u>
3.	<u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>480,588.35</u>	\$ <u>6,690.27</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>1,568,972.43</u></u>	\$ <u><u>1,095,074.35</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 a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

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: 2018 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 2018 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2018.

Please complete the Real Estate Tax Statement below and include it in the 2019 cost report along with a copy of your 2018 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.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Gold Coast COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0052415
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

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 Gold Coast

0052415 Report Period Beginning:

01/01/19 Ending:

12/31/19

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,152 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 9

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 4,000,000	1
2	Allocated from CF St. Louis, LLC			9,049	2
3	TOTALS			\$ 4,009,049	3

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	271	2013	1976	\$ 30,630,000	\$	39	\$ 785,385	\$ 785,385	\$ 4,400,668
5									
6									
7									
8									
Improvement Type**									
9	Various		2013	891,734		20	46,717	46,717	318,799
10	Various		2014	589,334		20	34,754	34,754	208,525
11	Various		2015	844,194		20	42,297	42,297	211,486
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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								67
68			422,250		20,068	20,068	70,341	68
69								69
70			\$ 33,377,512	\$	\$ 929,221	\$ 929,221	\$ 5,209,819	70

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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		\$ 33,377,512	\$		\$ 929,221	\$ 929,221	\$ 5,209,819	1
2	Installed Alarm System/Wanderguard System	2016	3,451		20	173	173	690	2
3	Installed Cables For Speakers/Phones	2016	36,172		20	1,809	1,809	7,234	3
4	Installed Outlets On 9Th Floor	2016	4,500		20	225	225	900	4
5	Lobby Area Office Dampers	2016	5,306		20	265	265	1,061	5
6	Pa Amplifier And Speakers	2016	5,897		20	295	295	1,179	6
7	Installed Pedestrian Door And Frame	2016	2,790		20	140	140	558	7
8	Corridor Sprinkler System	2016	7,187		20	359	359	1,437	8
9	Repaired Elevator	2016	15,059		20	753	753	3,012	9
10	Repaired Door Motor/Cables	2016	8,021		20	401	401	1,604	10
11	Kitchen - Replaced Walk In Cooler, New Coil Unit, Temperature	2016	6,944		20	347	347	1,389	11
12	Main Entrance - Installed Wander Guard System	2016	5,176		20	259	259	1,035	12
13	5Th Floor Drapery	2016	8,826		20	441	441	1,765	13
14	9Th Floor Shades	2016	2,975		20	149	149	595	14
15	Kitchen Millwork	2016	19,888		20	994	994	3,978	15
16	Repaired South Elevator Doors	2016	3,575		20	179	179	715	16
17	Roof Repair Over Glass Entrance	2016	8,700		20	435	435	1,740	17
18	Furnished And Installed Door Sensor For Elevators	2016	5,100		20	255	255	1,020	18
19	Installed New Springs/Air Switch For Doors	2016	2,592		20	130	130	518	19
20	Repaired 9Th Floor Nurse Call System	2016	4,350		20	218	218	870	20
21	Repaired Roof	2016	3,572		20	179	179	714	21
22	Repaired Motor/Valves/Pipes On Air Handlers	2016	3,730		20	187	187	746	22
23	7Th And 8Th Floor Bathrooms Sprinkler Repair	2016	9,667		20	483	483	1,933	23
24	5Th-8Th Floor Shower Rooms - Tiling/Paint/Flooring	2016	40,163		20	2,008	2,008	8,033	24
25	East/West Spa Room - Demo/Framing/Floor/Tiling/Millwork/Elec	2016	268,825		20	15,000	15,000	60,000	25
26	Kitchen - Stationary/Millwork	2016	22,819		20	1,141	1,141	4,564	26
27	Security System For 1St Floor And 9Th Floor Therapy Room	2016	18,914		20	946	946	3,783	27
28	8Th Flr Resid Rms/Lobby/Dining-Demo/Lighting/Framing/Floori	2016	39,370		20	1,969	1,969	7,874	28
29	5Th Floor Electric/Plumbing/Paint/Flooring/Sprinkler	2016	74,401		20	3,758	3,758	15,030	29
30	2Nd Flr Offices - Demo/Masonry/Carpentry/Millwork/Electrical/F	2016	228,132		20	11,407	11,407	45,626	30
31	9Th Flr Pt Room - Flooring/Roof Deck/Doors/Demo/Electrical/Pai	2016			20				31
32	Concrete/Sprinkler/Architectural And Engineering Fees	2016	1,184,223		20	59,211	59,211	236,845	32
33	1St Flr Lobby/Exterior-A/C System/Electrical/Plumbing/Demo/Til	2016			20				33
34	TOTAL (lines 1 thru 33)		\$ 35,427,838	\$		\$ 1,033,334	\$ 1,033,334	\$ 5,626,269	34

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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		\$ 35,427,838	\$		\$ 1,033,334	\$ 1,033,334	\$ 5,626,269	1
2	Doors/Sprinkler/Carpentry/Architectural And Engineering Fees/P	2016	1,479,480		20	73,974	73,974	295,896	2
3	Ice Block Glass Tile (21,902)	2016	20,273		20	1,014	1,014	2,027	3
4	Electrical Work For Corridor Door Operator	2017	4,350		20	218	218	653	4
5	Installed Glass Mirror Rooms 401 And 405	2017	3,070		20	154	154	461	5
6	Installed Two Keypads-3Rd Flr West Stairwell/Egress Locks 2Nd	2017	8,876		20	444	444	1,331	6
7	Installed New Drain In Kitchen/Cut Floor Tile/Pipes	2017	3,650		20	183	183	548	7
8	Repaired Pipes In Rooms 814 And 815	2017	3,870		20	194	194	581	8
9	Medical Curtains	2017	5,775		20	289	289	866	9
10	Fire Sprinkler System Repair	2017	3,473		20	174	174	521	10
11	Repaired Leaking Pipes	2017	3,245		20	162	162	487	11
12	Hvac Repair - Thermostat, Sensor, Wires, Relays, Filters, Belts	2017	3,682		20	184	184	552	12
13	Hvac-Air Handler Control System	2017	10,892		20	545	545	1,634	13
14	Parking Entrance Door Repair	2017	3,968		20	198	198	595	14
15	Hvac - Air Handler Control System	2017	11,308		20	565	565	1,696	15
16	Cubicle Curtain Tracks For 5Th And 6Th Floor	2017	6,224		20	311	311	934	16
17	Removal & Repair Of #1 Heating Pump	2017	4,250		20	213	213	638	17
18	Replace Broken Pipe In Dishwasher Area	2017	3,500		20	175	175	525	18
19	Elevator Flooring & 9Th Fl Outlets	2017	4,340		20	217	217	651	19
20	Repair Handrails On 5Th,6Th, 7Th Floors & 9Th Fl Hvac	2017	30,261		20	1,513	1,513	4,539	20
21	90 Cubicle Curtains	2017	18,749		20	937	937	2,812	21
22	Repair & Adjusted Elevator Roller Guide	2017	3,738		20	187	187	561	22
23	Damper Replacement (8,418)	2018	7,792		20	390	390	779	23
24	Replace Compressor & Leaking Pipe (6,605)	2018	6,114		20	306	306	611	24
25	Repair Air Handler Coil (4,176)	2018	3,866		20	193	193	387	25
26	Install Booster Pump For Domestic Water System (3,924)	2018	3,632		20	182	182	363	26
27	Repair Heat Circulating Pump (13,059)	2018	12,087		20	604	604	1,209	27
28	Repair Doors On 2, 5, 6-8 Floors (4,250)	2018	3,934		20	197	197	393	28
29	Install New Building Drain Pipe (5,700)	2018	5,276		20	264	264	528	29
30	21 Keypad Deadbolt With Auto Lock (2,705)	2018	2,504		20	125	125	250	30
31	Repair 2Nd Fl Air Handlers In Boiler Rm (5,100)	2018	4,721		20	236	236	472	31
32	Bathroom Wall & Fl Tiles, Wallpaper, Lobby Electrical (10,700)	2018	9,904		20	495	495	990	32
33	Illuminated Lobby Sign (2,699)	2018	2,498		20	125	125	250	33
34	TOTAL (lines 1 thru 33)		\$ 37,127,137	\$		\$ 1,118,299	\$ 1,118,299	\$ 5,951,008	34

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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 12C, Carried Forward		\$ 37,127,137	\$		\$ 1,118,299	\$ 1,118,299	\$ 5,951,008	1
2	2Nd Fl Mechanical Rm Chilled Water Pumps (6,000)	2018	5,554		20	278	278	555	2
3	Paint Resident Rms & Waiting Area Ceiling Repair (8,550)	2018	7,914		20	396	396	791	3
4	Repaired Drywalls In Resident Rms On Fl 5-8 (4,250)	2018	3,934		20	197	197	393	4
5	Install New Coil In Conference Rm A (3,560)	2018	3,295		20	165	165	330	5
6	Door Holder Installation (7,529)	2018	6,969		20	348	348	697	6
7	Repair Door On East Side Of Building (3,785)	2018	3,503		20	175	175	350	7
8	Refurbish Marley Cooling Tower (38,225)	2018	35,381		20	1,769	1,769	3,538	8
9	Lobby Chandelier & Carpet, Lobby Bathroom Tile (13,119)	2018	12,143		20	607	607	1,214	9
10	Paint Ceiling & Install Lighting Fixtures In Lobby (10,897)	2018	10,086		20	504	504	1,009	10
11	Lobby Carpet (2,521)	2018	2,333		20	117	117	233	11
12	9Th Fl Air Handler Controls Repair (12,780)	2018	11,829		20	591	591	1,183	12
13	Repair Water Supply Lines (8,955)	2018	8,289		20	414	414	829	13
14	Repair 9Th Fl Pt Walls (2,650)	2018	2,453		20	123	123	245	14
15	Hallway & Lobby Make-Up Air Controls Repair (18,000)	2018	16,661		20	833	833	1,666	15
16	Design Fee For Tiles (12,750)	2018	11,801		20	590	590	1,180	16
17	Piping Repairs On Dual Temp System (5,681)	2018	5,258		20	263	263	526	17
18	Repair Ducts On 3Rd & 4Th Fl Soc Serv Office (4,705)	2018	4,355		20	218	218	435	18
19	Repair Hot Water Valves On Upper Floors (5,120)	2018	4,739		20	237	237	474	19
20	Paint Third And Fourth Floor Hallways (\$36000)	2019	34,888		20	900	900	900	20
21	Kitchen Flooring (\$9850)	2019	9,546		20	410	410	410	21
22	Intall New Amplifier For Overhead Paging, Rewire Cables (\$5268)	2019	5,106		20	307	307	307	22
23	Wire Repair For Garage And Stairs Em Lights (\$2778)	2019	2,692		20	255	255	255	23
24	Install 2 New Circuit Breakers, Ptac Unit - 1St Floor, Exit Sign Ga	2019	3,458		20	327	327	327	24
25	Heating System Repair - Coils/Water Leaks - Hr Office, 2Nd/9Th	2019	18,598		20	1,759	1,759	1,759	25
26	Building Improvement (\$2519.79)	2019	2,442		20	147	147	147	26
27	Install 2 Plenum Rated Heaters In Attic (\$6200)	2019	6,008		20	664	664	664	27
28	Installation Of Arial Call Station Communication System (\$33267)	2019	32,240		20	2,376	2,376	2,376	28
29	Repaired Pavement/Asphalt (\$2800)	2019	2,713		20	70	70	70	29
30	Installed End Suction Pump (\$6000)	2019	5,815		20	150	150	150	30
31	Installed 8Th Floor Nurse Call System (\$35000)	2019	33,919		20	583	583	583	31
32	Common Area /Restrooms Signs (\$4598.78)	2019	4,457		20	102	102	102	32
33	Hvac Systems - Wiring, Junction Box (\$3125)	2019	3,028		20	151	151	151	33
34	TOTAL (lines 1 thru 33)		\$ 37,448,544	\$		\$ 1,134,327	\$ 1,134,327	\$ 5,974,861	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 37,448,544	\$		\$ 1,134,327	\$ 1,134,327	\$ 5,974,861	1
2	Repaired Doors (\$7378.51)	2019	7,151		20	358	358	358	2
3	Repaired And Replaced Parts For Hvac/Boiler System (\$10,937.47	2019	10,600		20	530	530	530	3
4	Repaired And Installed Condensate Pumps For Hvac/Boiler Syste	2019	3,792		20	190	190	190	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)		\$ 37,470,085	\$		\$ 1,135,404	\$ 1,135,404	\$ 5,975,938	34

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

Facility Name & ID Number **Warren Barr Gold Coast**

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	48,724		35	1,392	1,392	5,568	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	302,505		20	15,125	15,125	60,501	9
10	Allocated from CF St. Louis, LLC	2017	7,021		20	351	351	1,053	10
11	Allocated from CF St. Louis, LLC	2019	63,639		20	3,182	3,182	3,182	11
12									12
13	Allocated from Legacy HC	2018	361		20	18	18	36	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)		\$ 422,250	\$		\$ 20,068	\$ 20,068	\$ 70,341	34

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

Facility Name & ID Number **Warren Barr Gold Coast**

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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		\$ 422,250	\$		\$ 20,068	\$ 20,068	\$ 70,341	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)	\$ 422,250	\$		\$ 20,068	\$ 20,068	\$ 70,341	34

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

Facility Name & ID Number Warren Barr Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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	\$ 3,268,840	\$	\$ 322,523	\$ 322,523	10	\$ 1,854,711	71
72	Current Year Purchases	7,227		705	705	10	705	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,276,067	\$	\$ 323,228	\$ 323,228		\$ 1,855,417	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		Bus	2015	\$ 23,822	\$	\$ 4,764	\$ 4,764	5	\$ 23,822	76
77		Therapy Bus	2016	3,500		700	700	5	2,800	77
78										78
79										79
80	TOTALS			\$ 27,322	\$	\$ 5,464	\$ 5,464		\$ 26,622	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)	\$ 44,782,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,464,097	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,464,097	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,857,976	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	Construction in Progress	\$ 25,607	92
93			93
94			94
95		\$ 25,607	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	<u>Allocated from Legacy HC</u>				<u>169</u>			5
6								6
7	TOTAL				\$ 169			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2020 \$ _____

13. _____ /2021 \$ _____

14. _____ /2022 \$ _____

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: \$ 12,290 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	<u>Facility</u>	<u>2016 Cadillac</u>	\$ <u>599.70</u>	\$ <u>7,196</u>	17
18	<u>Allocated from Legacy HC</u>			<u>7,503</u>	18
19					19
20					20
21	TOTAL		\$ 599.70	\$ 14,699	21

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

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

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		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 1,304,226				\$ 1,304,226	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				320,411				320,411	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				1,427,919				1,427,919	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					960,051			960,051	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						372,383	390,146			762,529	13
14	TOTAL				\$		\$ 3,424,939	\$ 1,350,197			\$ 4,775,136	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 Gold Coast

0052415

Report Period Beginning: 01/01/19

Ending:

12/31/19

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/19

(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	\$ 729	\$ 33,659	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,900,860	3,900,860	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,189	47,189	6
7	Other Prepaid Expenses	217,305	253,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	1,482,269	1,482,269	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,649,352	\$ 5,718,957	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,562	4,325,933	13
14	Buildings, at Historical Cost	90,848	20,772,935	14
15	Leasehold Improvements, at Historical Cost	7,457,699	7,457,699	15
16	Equipment, at Historical Cost	2,924,082	7,612,624	16
17	Accumulated Depreciation (book methods)	(3,223,977)	(9,774,658)	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 Schedule</u>	7,159,268	8,845,421	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,431,482	\$ 39,239,954	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 20,080,834	\$ 44,958,911	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,497,780	\$ 2,497,779	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	701,959	701,959	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,735	35,735	31
32	Accrued Real Estate Taxes(Sch.IX-B)		320,857	32
33	Accrued Interest Payable	200,035	1,695,704	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	673,432	673,432	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,108,941	\$ 5,925,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,217,975	2,217,975	39
40	Mortgage Payable		41,197,193	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	9,003,947	3,761,984	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,221,922	\$ 47,177,152	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,330,863	\$ 53,102,618	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,749,971	\$ (8,143,707)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 20,080,834	\$ 44,958,911	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,495,398	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,495,401	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	254,586	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	(16)	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)	\$ 254,570	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)	\$ 4,749,971	24 *

* This must agree with page 17, line 47.

**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.**

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 27,109,623	1
2	Discounts and Allowances for all Levels	(15,194,826)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,914,797	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	14,062,853	6
7	Oxygen	260	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 14,063,113	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	936,629	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	137,509	19
20	Radiology and X-Ray	60	20
21	Other Medical Services	117,628	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,191,826	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,598	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,598	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	36,232	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,232	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 27,221,566	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,253,619	31
32	Health Care	8,820,266	32
33	General Administration	4,349,200	33
B. Capital Expense			
34	Ownership	3,966,635	34
C. Ancillary Expense			
35	Special Cost Centers	6,130,485	35
36	Provider Participation Fee	446,775	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 26,966,980	40
41	Income before Income Taxes (line 30 minus line 40)**	254,586	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 254,586	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,810,203	44
45	Private Pay - Net Inpatient Revenue	765,350	45
46	Medicare - Net Inpatient Revenue	2,690,457	46
47	Other-(specify) <u>Insurance</u>	648,787	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,914,797	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 Gold Coast

0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19

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	1,888	2,080	\$ 139,542	\$ 67.09	1
2	Assistant Director of Nursing	1,952	2,080	102,244	49.16	2
3	Registered Nurses	52,191	58,308	2,185,521	37.48	3
4	Licensed Practical Nurses	51,294	61,047	1,896,226	31.06	4
5	CNAs & Orderlies	135,198	163,149	2,366,258	14.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,593	15,175	354,498	23.36	8
9	Activity Director	1,976	2,112	50,030	23.69	9
10	Activity Assistants	6,639	6,915	88,509	12.80	10
11	Social Service Workers	13,200	14,208	370,880	26.10	11
12	Dietician	3,389	3,633	69,156	19.04	12
13	Food Service Supervisor	3,536	3,733	98,672	26.43	13
14	Head Cook	7,467	8,322	140,297	16.86	14
15	Cook Helpers/Assistants	29,578	31,995	434,397	13.58	15
16	Dishwashers					16
17	Maintenance Workers	11,287	12,071	248,763	20.61	17
18	Housekeepers	26,604	29,156	395,323	13.56	18
19	Laundry	1,787	2,018	28,354	14.05	19
20	Administrator	2,400	2,536	156,434	61.69	20
21	Assistant Administrator	3,680	3,768	139,036	36.90	21
22	Other Administrative	2,000	2,088	93,839	44.94	22
23	Office Manager	1,965	2,128	33,068	15.54	23
24	Clerical	11,321	12,133	221,739	18.28	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	3,890	4,163	74,748	17.96	31
32	Other Health Care(specify)					32
33	Other(specify)	19,779	20,891	319,252	15.28	33
34	TOTAL (lines 1 - 33)	406,613	463,709	\$ 10,006,786 *	\$ 21.58	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	Quarterly	\$ 564	01-03	35
36	Medical Director	Monthly	95,429	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	53,187	10-03	38
39	Pharmacist Consultant	Monthly	26,693	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				44
45	Social Service Consultant	Monthly	5,596	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 181,469		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount	
<u>Crystal Shelby</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 86,323</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 101,234</u>	<u>IDPH License Fee</u>	<u>\$ 426</u>		
<u>Staci Palmer</u>	<u>Administrator</u>	<u>0.00%</u>	<u>85,225</u>	<u>Unemployment Compensation Insurance</u>	<u>69,924</u>	<u>Advertising: Employee Recruitment</u>			
<u>Kate Gilday</u>	<u>Executive Director</u>	<u>0.00%</u>	<u>115,326</u>	<u>FICA Taxes</u>	<u>757,052</u>	<u>Health Care Worker Background Check</u>			
<u>Andrea Martinez</u>	<u>Assistant Admin</u>	<u>0.00%</u>	<u>42,269</u>	<u>Employee Health Insurance</u>	<u>314,617</u>	<u>(Indicate # of checks performed)</u>	<u>402</u>	<u>4,016</u>	
<u>Isaac Ninio</u>	<u>Assistant Admin</u>	<u>0.00%</u>	<u>60,166</u>	<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>1768</u>	<u>17,680</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>		<u>51,921</u>	
				<u>Union Pension</u>	<u>52,086</u>	<u>Licenses & Permits</u>		<u>22,653</u>	
TOTAL (agree to Schedule V, line 17, col. 1)				<u>401K Expense</u>	<u>28,934</u>				
(List each licensed administrator separately.)			\$ 389,309	<u>Voluntary Benefit Contributions</u>	<u>9,021</u>				
B. Administrative - Other				<u>Employee Physical Exams</u>	<u>29,349</u>	<u>See Supplemental Schedule</u>		<u>1,604</u>	
Description			Amount	<u>Other Employee Benefits</u>	<u>58,307</u>	<u>Less: Public Relations Expense</u>	(
			\$			<u>Non-allowable advertising</u>	(
						<u>Yellow page advertising</u>	(
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,420,524	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 98,300	
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services						\$	<u>Out-of-State Travel</u>	\$	
Vendor/Payee	Type		Amount						
<u>Marcum LLP</u>	<u>Accounting Services</u>		<u>\$ 24,000</u>				<u>In-State Travel</u>		
<u>Various - See Attached</u>	<u>Legal Fees</u>		<u>430,851</u>						
<u>ProPay HR LLC</u>	<u>Payroll Processing</u>		<u>61,485</u>				<u>Seminar Expense</u>	<u>17,274</u>	
<u>2401 Incorporated of Illinois</u>	<u>Architectural Consultant</u>		<u>2,780</u>						
<u>Achieve Accreditation LLC</u>	<u>Accreditation Services</u>		<u>7,897</u>				<u>See Supplemental Schedule</u>	<u>4,444</u>	
<u>Compliagent</u>	<u>Compliance</u>		<u>1,584</u>				<u>Entertainment Expense</u>	(
<u>Cortex Health Inc</u>	<u>Data Processing</u>		<u>20,350</u>				TOTAL (agree to Sch. V, line 24, col. 8)		
<u>IIT/Sourcetek</u>	<u>Data Processing</u>		<u>1,595</u>					\$ 21,718	
<u>Integra Scripts LLC</u>	<u>Pharmacy Purchasing Consultan</u>		<u>17,703</u>						
<u>MTS Consulting</u>	<u>Tax Consultant</u>		<u>10,475</u>						
<u>MVS LLC</u>	<u>Real Estate Appraiser</u>		<u>5,000</u>						
<u>See Supplemental Schedule</u>			<u>14,049</u>	TOTAL		\$			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 597,768						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr Gold Coast# 0052415

Report Period Beginning:

01/01/19

Ending:

12/31/19**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. IHCA - \$19,187 & HCCI - \$34,710
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69,797 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 446,775
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.