FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0052415

Facility Name: Warren Barr Gold Coast

Address: 66 West Oak Street (Number) Chicago (City) 60610 (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:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) 04/29/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	271	Skilled (SNF)	271	99,186	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	99,186	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,974	1,893	24,719	63,586	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,974	1,893	24,719	63,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.11%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 8/1/2013

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 271 and days of care provided 18,489

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	798,207	82,838		881,045		881,045	5,115	886,160			1
2	Food Purchase		500,379		500,379		500,379	9,582	509,961			2
3	Housekeeping	440,071	66,154	7,664	513,889		513,889	3,317	517,206			3
4	Laundry	12,888	71,758	188,086	272,732		272,732	225	272,957			4
5	Heat and Other Utilities			354,809	354,809		354,809	(15,632)	339,177			5
6	Maintenance	269,463	20,123	330,404	619,990		619,990	6,413	626,403			6
7	Other (specify):*											7
8	TOTAL General Services	1,520,629	741,252	880,963	3,142,844		3,142,844	9,020	3,151,864			8
	B. Health Care and Programs											
9	Medical Director			61,168	61,168		61,168		61,168			9
10	Nursing and Medical Records	7,209,123	599,991	107,571	7,916,685		7,916,685	77,257	7,993,942			10
10a	Therapy	301,005			301,005		301,005		301,005			10a
11	Activities	146,672	4,776		151,448		151,448	13	151,461			11
12	Social Services	631,591	79,776	8,815	720,182		720,182	8,885	729,067			12
13	CNA Training											13
14	Program Transportation			332,293	332,293		332,293		332,293			14
15	Other (specify):*							9,216	9,216			15
16	TOTAL Health Care and Programs	8,288,391	684,543	509,847	9,482,781		9,482,781	95,372	9,578,153			16
	C. General Administration											
17	Administrative	275,842			275,842		275,842	98,911	374,753			17
18	Directors Fees											18
19	Professional Services			592,508	592,508	(593)	591,915	1,426	593,341			19
20	Dues, Fees, Subscriptions & Promotions			127,240	127,240		127,240	(54,595)	72,645			20
21	Clerical & General Office Expenses	321,792	7,057	983,997	1,312,846		1,312,846	(352,859)	959,987			21
22	Employee Benefits & Payroll Taxes			1,675,486	1,675,486		1,675,486		1,675,486			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,471	1,471		1,471	221	1,692			24
25	Other Admin. Staff Transportation			8,788	8,788		8,788	7,394	16,182			25
26	Insurance-Prop.Liab.Malpractice			669,839	669,839		669,839	629	670,468			26
27	Other (specify):*							39,644	39,644			27
28	TOTAL General Administration	597,634	7,057	4,059,329	4,664,020	(593)	4,663,427	(259,230)	4,404,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,406,654	1,432,852	5,450,139	17,289,645	(593)	17,289,052	(154,838)	17,134,214			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Warren Barr Gold Coast #0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							1,351,463	1,351,463			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,236	33,236		33,236	1,409,029	1,442,265			32
33	Real Estate Taxes			23,180	23,180	593	23,773	917,448	941,221			33
34	Rent-Facility & Grounds			3,412,250	3,412,250		3,412,250	(3,412,096)	154			34
35	Rent-Equipment & Vehicles			30,843	30,843		30,843	6,283	37,126			35
36	Other (specify):*			607,700	607,700		607,700	(607,700)				36
37	**TOTAL Ownership**			4,107,209	4,107,209	593	4,107,802	(335,572)	3,772,229			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,215,161	2,642,824	3,857,985		3,857,985	(38,200)	3,819,785			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			435,666	435,666		435,666		435,666			42
43	Other (specify):*			1,219,801	1,219,801		1,219,801	(1,219,801)	(0)			43
44	**TOTAL Special Cost Centers**		1,215,161	4,298,291	5,513,452		5,513,452	(1,258,001)	4,255,451			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,406,654	2,648,013	13,855,639	26,910,306		26,910,306	(1,748,412)	25,161,894			45

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,362)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	790,325	30		9
10	Interest and Other Investment Income	(14,969)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,450)	21		18
19	Entertainment	(1,292)	21		19
20	Contributions	(15,200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(603,041)	21		24
25	Fund Raising, Advertising and Promotional	(16,054)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,220,641)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,100,833)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	352,421		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 352,421		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,748,412)		37

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

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

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

Warren Barr Gold Coast

ID# 0052415

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (9,305)	10	1
2	Bank Charges	(8,900)	21	2
3	Sequestration Expense	(160,082)	21	3
4	Pharmacy Discounts	(12,089)	10	4
5	Rebates	(68,730)	10	5
6	Misc Income	(4,682)	21	6
7	State Income Tax	(1,000)	21	7
8	Non-Allowable Expense	(1,218,109)	43	8
9	Capitalized R&M	(11,304)	06	9
10	Non-Allowable Expense	(1,692)	43	10
11	PAC Dues	(28,367)	20	11
12	Non-Allowable Legal	(19,199)	19	12
13	Building Co. - Bank Fees	(6,347)	21	13
14	Building Co. - Accounting Fees	(25,883)	19	14
15	Building Co. - Amortization	(35,833)	36	15
16	Amortization	(607,700)	36	16
17	Prior Year Dues	(519)	20	17
18	Non-Allowable Auto Lease	(900)	35	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**	(2,220,641)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			5,115									5,115	1
2	Food Purchase	(149)		9,731									9,582	2
3	Housekeeping			3,317									3,317	3
4	Laundry			225									225	4
5	Heat and Other Utilities	(17,362)				1,730							(15,632)	5
6	Maintenance	(11,304)		16,628		1,676	(588)						6,413	6
7	Other (specify):*													7
8	**TOTAL General Services**	(28,815)		35,017		3,406	(588)						9,020	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(90,124)		170,094				(2,713)					77,257	10
10a	Therapy													10a
11	Activities			13									13	11
12	Social Services			8,885									8,885	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				9,216								9,216	15
16	**TOTAL Health Care and Programs**	(90,124)		178,993	9,216			(2,713)					95,372	16
	C. General Administration													
17	Administrative			98,911									98,911	17
18	Directors Fees													18
19	Professional Services	(45,082)	25,883	32,472		728			(12,575)				1,426	19
20	Fees, Subscriptions & Promotions	(60,140)		5,544		1							(54,595)	20
21	Clerical & General Office Expenses	(787,794)	6,347	428,186		402							(352,859)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			221									221	24
25	Other Admin. Staff Transportation			7,394									7,394	25
26	Insurance-Prop.Liab.Malpractice			195		434							629	26
27	Other (specify):*			39,644									39,644	27
28	**TOTAL General Administration**	(893,016)	32,230	612,566		1,565			(12,575)				(259,230)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,011,955)	32,230	826,576	9,216	4,971	(588)	(2,713)	(12,575)				(154,838)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Gold Coast # 0052415 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	790,325	550,468			10,670							1,351,463	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,969)	1,418,002			5,996							1,409,029	32
33	Real Estate Taxes		912,000			5,448							917,448	33
34	Rent-Facility & Grounds		(3,412,250)	50,211		(50,057)							(3,412,096)	34
35	Rent-Equipment & Vehicles	(900)			7,183								6,283	35
36	Other (specify):*	(643,533)	35,833										(607,700)	36
37	TOTAL Ownership	130,923	(495,947)	50,211	7,183	(27,943)							(335,572)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(38,200)		(38,200)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,219,801)											(1,219,801)	43
44	TOTAL Special Cost Centers	(1,219,801)									(38,200)		(1,258,001)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,100,833)	(463,717)	876,787	16,399	(22,971)	(588)	(2,713)	(12,575)		(38,200)		(1,748,412)	45

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 3,412,250	FNR WB, LLC		$	$ (3,412,250)	1
2	V	32	Interest		FNR WB, LLC		1,418,002	1,418,002	2
3	V	33	Real Estate		FNR WB, LLC		912,000	912,000	3
4	V	30	Depreciation		FNR WB, LLC		550,468	550,468	4
5	V	21	Bank Fees		FNR WB, LLC		6,347	6,347	5
6	V	19	Accounting Fees		FNR WB, LLC		25,883	25,883	6
7	V	36	Amortization				35,833	35,833	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,412,250			$ 2,948,533	$ * (463,717)	14

* 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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Chaim Rajchenbach	37.12%	Astoria Place Skilled Nursing Facility LLC	Chicago	FNR WB, LLC		Building Company	1
2	Menachem Shabat	37.12%	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	Susan Friedman	5.00%	Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5	Jack Rajchenbach	6.69%	Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	Yoseph & Naomi Rajchenbach	0.44%	Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7	Avrohom & Chana Rajchenbach	0.44%	Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8	Shlomo Zalmain Busel & Chava Busel	0.44%	Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9	Pinchas & Nahama Schwartz	0.44%	Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10	Jack Rajchenbach	1.95%	Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Berwyn	Berwyn				4
5			Grove of Fox Valley	Aurora				5
6			Grove of St. Charles	St. Charles				6
7			Lagrange Skilled Nursing Facility LLC	Lagrange Park				7
8			Lakefront Skilled Nursing Facility LLC	Chicago				8
9			Lincoln Park Skilled Nursing Facility LLC	Chicago				9
10			Lincolnshire Living & Rehab Center LLC	Lincolnshire				10
11			Northbrook Skilled Nursing Facility LLC	Northbrook				11
12			Peterson Park Associates Limited Partnership	Chicago				12
13			Skokie Skilled Nursing Facility LLC	Skokie				13
14			Valley Skilled Nursing Facility	Billings, MT				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 5,088	$ 5,088	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		27	27	16
17	V	02	Food		Legacy Healthcare Financial Services		9,731	9,731	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		3,317	3,317	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		225	225	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		15,697	15,697	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		932	932	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		129,920	129,920	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		12,262	12,262	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		27,912	27,912	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		8,851	8,851	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		13	13	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		35	35	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		98,911	98,911	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		32,472	32,472	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		5,544	5,544	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		399,084	399,084	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		29,102	29,102	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		221	221	33
34	V	25	Travel		Legacy Healthcare Financial Services		7,394	7,394	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		195	195	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		39,644	39,644	36
37	V	34	Rent		Legacy Healthcare Financial Services		50,057	50,057	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		154	154	38
39	Total			$			$ 876,787	$ * 876,787	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		668	$ 668	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		6,515	6,515	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		9,216	9,216	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			$			$ 16,399	$ * 16,399	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 1,730	$ 1,730	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,676	1,676	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		593	593	17
18	V	19	Accounting Fees		CF St. Louis LLC		135	135	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		402	402	20
21	V	26	Insurance		CF St. Louis LLC		434	434	21
22	V	30	Depreciation		CF St. Louis LLC		10,670	10,670	22
23	V	32	Interest Expense		CF St. Louis LLC		5,996	5,996	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		5,448	5,448	24
25	V								25
26	V	34	Rent	50,057	CF St. Louis LLC			(50,057)	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			$ 50,057			$ 27,086	$ * (22,971)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 24,000	ML Group Design & Development		$ 23,412	$ (588)	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			$ 24,000			$ 23,412	$ * (588)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 54,890	ProPay HR LLC		$ 42,315	$ (12,575)	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			$ 54,890			$ 42,315	$ * (12,575)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 297,409	EcoBrite Linen		$ 297,409	$	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			$ 297,409			$ 297,409	$ *	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 93,858	Lifescan Labs of Illinois		$ 55,658	$ (38,200)	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			$ 93,858			$ 55,658	$ * (38,200)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	99,186	$ 5,088	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		99,186	27	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		99,186	9,731	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		99,186	3,317	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		99,186	225	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	99,186	15,697	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		99,186	932	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	99,186	129,920	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		99,186	12,262	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		99,186	27,912	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	99,186	8,851	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		99,186	13	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		99,186	35	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	99,186	98,911	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		99,186	32,472	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		99,186	5,544	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	99,186	399,084	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		99,186	29,102	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		99,186	221	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		99,186	7,394	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		99,186	195	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		99,186	39,644	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		99,186	50,057	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		99,186	154	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 876,787	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		99,186	668	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		99,186	6,515	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		99,186	9,216	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 419,973	$		$ 16,399	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	$ 44,301	$	99,186	$ 1,730	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		99,186	1,676	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		99,186	593	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		99,186	135	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		99,186	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		99,186	402	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		99,186	434	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		99,186	10,670	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		99,186	5,996	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		99,186	5,448	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 693,655	$		$ 27,086	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 23,412	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					$	$		$ 23,412	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St.
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: ((847) 905 3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 42,315	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					$	$		$ 42,315	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Service	Direct			$	$		$ 297,409	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					$	$		$ 297,409	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifescan Labs of Illinois, LLC
Street Address: 5255 Golf Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663 - 8300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 55,658	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					$	$		$ 55,658	25

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC		X	Mortgage			$	$ 39,695,654			$ 1,418,002	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Only		X								33,236	6
7	Allocated from CF St. Louis		X								5,996	7
8												8
9	TOTAL Facility Related						$	$ 39,695,654			$ 1,457,234	9
	B. Non-Facility Related*											
10	Interest Income		X								(14,969)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,969)	14
15	TOTALS (line 9+line14)						$	$ 39,695,654			$ 1,442,265	15

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.)

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 320,857	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.)		$ 1,143,000	2
3. Under or (over) accrual (line 2 minus line 1).		$ 822,143	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 118,485	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.)		$ 593	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.		$ 941,221	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	832,183	8
	2016	909,580	9
	2017	977,614	10
	2018	1,088,384	11
	2019	1,137,552	12

2020 Accrual = $1,137,552, x .104 = $118,485 (Rounded)

Allocated from CF St. Louis: $5,448

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Gold Coast COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052415

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-04-423-006-0000	Long Term Care Property	$ 23,071.17	$ 23,071.17
2.	17-04-423-019-0000	Long Term Care Property	$ 1,114,480.79	$ 1,114,480.79
3.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 5,448.06
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,597,084.40	$ 1,143,000.02

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Gold Coast COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052415

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 4,000,000	1
2	Allocated from CF St. Louis, LLC			7,706	2
3	TOTALS			$ 4,007,706	3

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	271		2013	1976	$ 30,630,000	$ 550,468	39	$ 785,385	$ 234,917	$ 5,186,053	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2013	891,734		20	44,587	44,587	363,386	9
10	Various			2014	589,334		20	29,467	29,467	237,992	10
11	Various			2015	844,194		20	42,210	42,210	253,696	11
12	Various			2016	3,550,079		20	177,504	177,504	891,877	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		362,687	9,837		17,245	7,408	77,150	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 36,868,028	$ 560,305		$ 1,096,397	$ 536,092	$ 7,010,154	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 36,868,028	$ 560,305		$ 1,096,397	$ 536,092	$ 7,010,154	1
2	Electrical Work For Corridor Door Operator	2017	4,350		20	218	218	870	2
3	Installed Glass Mirror Rooms 401 And 405	2017	3,070		20	154	154	614	3
4	Installed Two Keypads-3Rd Flr West Stairwell/Egress Locks 2Nd	2017	8,876		20	444	444	1,775	4
5	Installed New Drain In Kitchen/Cut Floor Tile/Pipes	2017	3,650		20	183	183	730	5
6	Repaired Pipes In Rooms 814 And 815	2017	3,870		20	194	194	774	6
7	Medical Curtains	2017	5,775		20	289	289	1,155	7
8	Fire Sprinkler System Repair	2017	3,473		20	174	174	695	8
9	Repaired Leaking Pipes	2017	3,245		20	162	162	649	9
10	Hvac Repair - Thermostat, Sensor, Wires, Relays, Filters, Belts	2017	3,682		20	184	184	736	10
11	Hvac-Air Handler Control System	2017	10,892		20	545	545	2,178	11
12	Parking Entrance Door Repair	2017	3,968		20	198	198	794	12
13	Hvac - Air Handler Control System	2017	11,308		20	565	565	2,262	13
14	Cubicle Curtain Tracks For 5Th And 6Th Floor	2017	6,224		20	311	311	1,245	14
15	Removal & Repair Of #1 Heating Pump	2017	4,250		20	213	213	850	15
16	Replace Broken Pipe In Dishwasher Area	2017	3,500		20	175	175	700	16
17	Elevator Flooring & 9Th Fl Outlets	2017	4,340		20	217	217	868	17
18	Repair Handrails On 5Th,6Th, 7Th Floors & 9Th Fl Hvac	2017	30,261		20	1,513	1,513	6,052	18
19	90 Cubicle Curtains	2017	18,749		20	937	937	3,750	19
20	Repair & Adjusted Elevator Roller Guide	2017	3,738		20	187	187	748	20
21	Damper Replacement (8,418)	2018	7,792		20	390	390	1,169	21
22	Replace Compressor & Leaking Pipe (6,605)	2018	6,114		20	306	306	917	22
23	Repair Air Handler Coil (4,176)	2018	3,866		20	193	193	580	23
24	Install Booster Pump For Domestic Water System (3,924)	2018	3,632		20	182	182	545	24
25	Repair Heat Circulating Pump (13,059)	2018	12,087		20	604	604	1,813	25
26	Repair Doors On 2, 5, 6-8 Floors (4,250)	2018	3,934		20	197	197	590	26
27	Install New Building Drain Pipe (5,700)	2018	5,276		20	264	264	791	27
28	21 Keypad Deadbolt With Auto Lock (2,705)	2018	2,504		20	125	125	376	28
29	Repair 2Nd Fl Air Handlers In Boiler Rm (5,100)	2018	4,721		20	236	236	708	29
30	Bathroom Wall & Fl Tiles, Wallpaper, Lobby Electrical (10,700)	2018	9,904		20	495	495	1,486	30
31	Illuminated Lobby Sign (2,699)	2018	2,498		20	125	125	375	31
32	2Nd Fl Mechanical Rm Chilled Water Pumps (6,000)	2018	5,554		20	278	278	833	32
33	Paint Resident Rms & Waiting Area Ceiling Repair (8,550)	2018	7,914		20	396	396	1,187	33
34	TOTAL (lines 1 thru 33)		$ 37,081,042	$ 560,305		$ 1,107,048	$ 546,743	$ 7,048,967	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 37,081,042	$ 560,305		$ 1,107,048	$ 546,743	$ 7,048,967	1
2	Repaired Drywalls In Resident Rms On Fl 5-8 (4,250)	2018	3,934		20	197	197	590	2
3	Install New Coil In Conference Rm A (3,560)	2018	3,295		20	165	165	494	3
4	Door Holder Installation (7,529)	2018	6,969		20	348	348	1,045	4
5	Repair Door On East Side Of Building (3,785)	2018	3,503		20	175	175	525	5
6	Refurbish Marley Cooling Tower (38,225)	2018	35,381		20	1,769	1,769	5,307	6
7	Lobby Chandelier & Carpet, Lobby Bathroom Tile (13,119)	2018	12,143		20	607	607	1,821	7
8	Paint Ceiling & Install Lighting Fixtures In Lobby (10,897)	2018	10,086		20	504	504	1,513	8
9	Lobby Carpet (2,521)	2018	2,333		20	117	117	350	9
10	9Th Fl Air Handler Controls Repair (12,780)	2018	11,829		20	591	591	1,774	10
11	Repair Water Supply Lines (8,955)	2018	8,289		20	414	414	1,243	11
12	Repair 9Th Fl Pt Walls (2,650)	2018	2,453		20	123	123	368	12
13	Hallway & Lobby Make-Up Air Controls Repair (18,000)	2018	16,661		20	833	833	2,499	13
14	Design Fee For Tiles (12,750)	2018	11,801		20	590	590	1,770	14
15	Piping Repairs On Dual Temp System (5,681)	2018	5,258		20	263	263	789	15
16	Repair Ducts On 3Rd & 4Th Fl Soc Serv Office (4,705)	2018	4,355		20	218	218	653	16
17	Repair Hot Water Valves On Upper Floors (5,120)	2018	4,739		20	237	237	711	17
18	Paint Third And Fourth Floor Hallways ($36000)	2019	34,888		20	1,744	1,744	2,644	18
19	Kitchen Flooring ($9850)	2019	9,546		20	477	477	888	19
20	Intall New Amplifier For Overhead Paging, Rewire Cables ($5268.	2019	5,106		20	255	255	563	20
21	Wire Repair For Garage And Stairs Em Lights ($2778)	2019	2,692		20	135	135	389	21
22	Install 2 New Circuit Breakers, Ptac Unit - 1St Floor, Exit Sign Ga	2019	3,458		20	173	173	500	22
23	Heating System Repair - Coils/Water Leaks - Hr Office, 2Nd/9Th	2019	18,598		20	930	930	2,689	23
24	Building Improvement ($2519.79)	2019	2,442		20	122	122	269	24
25	Install 2 Plenum Rated Heaters In Attic ($6200)	2019	6,008		20	300	300	965	25
26	Installation Of Arial Call Station Communication System ($33267	2019	10,746		20	537	537	2,914	26
27	Repaired Pavement/Asphalt ($2800)	2019	2,713		20	136	136	206	27
28	Installed End Suction Pump ($6000)	2019	5,815		20	291	291	441	28
29	Installed 8Th Floor Nurse Call System ($35000)	2019	33,919		20	1,696	1,696	2,279	29
30	Common Area /Restrooms Signs ($4598.78)	2019	4,457		20	223	223	325	30
31	Hvac Systems - Wiring, Junction Box ($3125)	2019	3,028		20	151	151	303	31
32	Repaired Doors ($7378.51)	2019	7,151		20	358	358	715	32
33	Repaired And Replaced Parts For Hvac/Boiler System ($10,937.47	2019	10,600		20	530	530	1,060	33
34	TOTAL (lines 1 thru 33)		$ 37,385,237	$ 560,305		$ 1,122,257	$ 561,952	$ 7,087,570	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 37,385,237	$ 560,305		$ 1,122,257	$ 561,952	$ 7,087,570	1
2	Repaired And Installed Condensate Pumps For Hvac/Boiler Syste	2019	3,792		20	190	190	379	2
3	Repaired Leaking Heating Pipe In Laundry Room ($14,755)	2020	14,394		20	720	720	720	3
4	Install New Ddc Controls For Boiler System ($22,578)	2020	22,025		20	1,101	1,101	1,101	4
5	Cooling Tower-Installed Drain Plug, New Ring-O Gasket ($3,964.9	2020	3,868		20	193	193	198	5
6	Chiller Repair - Rebuild 4 Contactors ($4,407.84)	2020	4,300		20	215	215	220	6
7	Exhaust Fan Repair ($3,622.84)	2020	3,534		20	177	177	177	7
8	Boiler Repair - Replace Ruptured Freeze Plugs ($7,416.26)	2020	7,235		20	362	362	362	8
9	Repair Broken Chilled Water Line-2Nd Flr Ahu Kitchen Unit ($15	2020	15,374		20	769	769	788	9
10	Ramp Gate Repair-Replace Loops With Sensors ($3,921.19)	2020	3,825		20	191	191	196	10
11	Heating/Cooling Piping Repair ($17,865)	2020	17,427		20	871	871	871	11
12	Install Drives On 2Nd Flr Mua And Penthouse Mua ($14,555.25)	2020	14,199		20	710	710	728	12
13	Repair Roof Cracks & Seams, Electrical Contractor Repair-2Nd F	2020	2,911		20	146	146	149	13
14	Replace Reader Interface Board For Garage Door ($2,688)	2020	2,622		20	131	131	134	14
15	Repair Door Operator On Elevator ($5,632)	2020	5,494		20	275	275	282	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)		$ 37,506,235	$ 560,305		$ 1,128,307	$ 568,002	$ 7,093,875	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 37,506,235	$ 560,305		$ 1,128,307	$ 568,002	$ 7,093,875	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)		$ 37,506,235	$ 560,305		$ 1,128,307	$ 568,002	$ 7,093,875	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	41,495	1,927	35	1,186	(741)	5,928	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	257,625	6,356	20	12,881	6,526	64,406	9
10	Allocated from CF St. Louis, LLC	2017	5,980	148	20	299	151	1,196	10
11	Allocated from CF St. Louis, LLC	2019	54,197	1,337	20	2,710	1,373	5,420	11
12	Allocated from CF St. Louis, LLC	2019	2,851	70	20	143	72	143	12
13									13
14	Allocated from Legacy HC	2018	308		20	15	15	46	14
15	Allocated from Legacy HC	2020	232		20	12	12	12	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)		$ 362,687	$ 9,837		$ 17,245	$ 7,408	$ 77,150	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 362,687	$ 9,837		$ 17,245	$ 7,408	$ 77,150	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 362,687	$ 9,837		$ 17,245	$ 7,408	$ 77,150	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,147,827	$ 830	$ 215,797	$ 214,966	10	$ 1,400,193	71
72	Current Year Purchases	18,953	3	1,895	1,893	10	1,896	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,166,779	$ 833	$ 217,692	$ 216,859		$ 1,402,089	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	3,500	77
78										78
79										79
80	TOTALS			$ 27,322	$	$ 5,464	$ 5,464		$ 27,322	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)	$ 43,708,043	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 561,138	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,351,463	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 790,325	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,523,286	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 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.

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy HC				154			5
6								6
7	TOTAL				$ 154 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 19,729 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	2019 Dodge Caravan		$ 989.28	$ 10,882	17
18	Allocated from Legacy HC			6,515	18
19					19
20					20
21	TOTAL		$ 989	$ 17,397	21

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

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 990,351	$		$ 990,351	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			294,777			294,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,075,175			1,075,175	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				840,881		840,881	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					282,521	374,280		656,801	13
14	TOTAL			$		$ 2,642,824	$ 1,215,161		$ 3,857,985	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.

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,136,089	$ 1,884,439	1
2	Cash-Patient Deposits	4,671	4,671	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,098,789	3,098,789	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,349	22,349	6
7	Other Prepaid Expenses	698,030	734,705	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	285,403	285,403	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,245,331	$ 6,030,356	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	7,475,564	7,475,564	15
16	Equipment, at Historical Cost	3,011,782	7,700,324	16
17	Accumulated Depreciation (book methods)	(5,492,071)	(14,241,153)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	7,312,995	8,792,298	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,422,680	$ 34,825,901	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,668,011	$ 40,856,257	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,607,498	$ 1,607,498	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	394,006	394,006	30
31	Accrued Taxes Payable (excluding real estate taxes)	449,531	449,531	31
32	Accrued Real Estate Taxes(Sch.IX-B)		118,485	32
33	Accrued Interest Payable	238,664	2,924,787	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	5,000,183	5,012,969	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,689,882	$ 10,507,276	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		39,695,654	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	9,327,141	4,332,647	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,327,141	$ 44,028,301	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,017,023	$ 54,535,577	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 650,988	$ (13,679,320)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,668,011	$ 40,856,257	48

*(See instructions.)

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,749,971	1
2	Restatements (describe):		2
3	**Depreciation**	(2,268,094)	3
4	**Bad Debts**	(800,000)	4
5	**Amortization, Legal Fees, Interest, Rounding**	(803,797)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 878,080	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(227,076)	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)**	$ (227,092)	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)**	$ 650,988	24 *

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

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 25,585,403	1
2	Discounts and Allowances for all Levels	(12,340,018)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,245,385	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,985,477	6
7	Oxygen	136	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,985,613	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	813,671	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	223,118	19
20	Radiology and X-Ray	360	20
21	Other Medical Services	106,196	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,143,345	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,969	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,969	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	2,293,918	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,293,918	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 26,683,230	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,142,844	31
32	Health Care	9,482,781	32
33	General Administration	4,664,020	33
	B. Capital Expense		
34	Ownership	4,107,209	34
	C. Ancillary Expense		
35	Special Cost Centers	5,077,786	35
36	Provider Participation Fee	435,666	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 26,910,306	40
41	**Income before Income Taxes (line 30 minus line 40)****	(227,076)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (227,076)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,247,985	44
45	Private Pay - Net Inpatient Revenue	544,830	45
46	Medicare - Net Inpatient Revenue	4,491,191	46
47	Other-(specify) Insurance	961,379	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,245,385	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: 01/01/20 Ending: 12/31/20

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,208	2,435	$ 170,540	$ 70.04	1
2	Assistant Director of Nursing	1,910	2,138	108,999	50.98	2
3	Registered Nurses	45,830	52,690	2,083,388	39.54	3
4	Licensed Practical Nurses	47,989	58,468	1,917,622	32.80	4
5	CNAs & Orderlies	120,002	150,578	2,815,896	18.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,519	12,489	301,005	24.10	8
9	Activity Director	2,072	2,192	52,917	24.14	9
10	Activity Assistants	6,230	6,914	93,755	13.56	10
11	Social Service Workers	12,579	13,634	327,975	24.06	11
12	Dietician	6,458	6,995	139,875	20.00	12
13	Food Service Supervisor	3,402	3,691	92,615	25.09	13
14	Head Cook	6,849	7,638	130,626	17.10	14
15	Cook Helpers/Assistants	27,113	30,214	435,091	14.40	15
16	Dishwashers					16
17	Maintenance Workers	11,550	12,512	269,463	21.54	17
18	Housekeepers	27,316	30,127	440,071	14.61	18
19	Laundry	659	853	12,888	15.11	19
20	Administrator	2,064	2,180	122,118	56.02	20
21	Assistant Administrator	1,914	2,112	54,687	25.89	21
22	Other Administrative	2,104	2,200	99,037	45.02	22
23	Office Manager	1,702	1,929	32,364	16.78	23
24	Clerical	14,376	15,706	289,428	18.43	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	3,878	4,297	75,041	17.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	20,263	21,866	341,251	15.61	33
34	TOTAL (lines 1 - 33)	378,987	443,858	$ 10,406,652 *	$ 23.45	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	61,168	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	65,102	10-03	38
39	Pharmacist Consultant	Monthly	21,309	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	8,815	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 156,394		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	846	21,160	10-03	52
53	TOTAL (lines 50 - 52)	846	$ 21,160		53

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Staci Palmer	Administrator	0	$ 122,118
Lafayette Barlow	Assistant Admin	0	54,687
Kate Gilday	Executive Director	0	99,037
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 275,842

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 36,586
ProPay HR	Payroll Processing	54,890
Onyx Procurement Solutions	Procurement Services	15,170
Achieve Accreditation	Accreditation Services	11,315
Compliagent	Compliance	3,844
Cortex Health Inc	Data Processing	15,070
Language Line Services	Interpreter	4,153
Hygieneering	Environmental Consultant	2,134
Telemedicine	Risk Prevention Software	5,346
PatientPing, Inc.	Care Collarborative Software	6,000
See Attached	Legal	422,261
See Supplemental Schedule		15,739
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 592,508

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,695
Unemployment Compensation Insurance	78,130
FICA Taxes	796,109
Employee Health Insurance	466,772
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	95,778
401K Expense	31,630
Voluntary Benefit Contributions	30,899
Employee Physical Exams	29,716
Other Employee Benefits	47,757
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,675,486

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,706
Advertising: Employee Recruitment	483
Health Care Worker Background Check	
(Indicate # of checks performed 165)	1,646
Patient Background Checks 757	7,570
Dues & Subscriptions	53,025
Licenses & Fees	2,670
See Supplemental Schedule	5,545
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 72,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,471
See Supplemental Schedule	221
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,692

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Barr Gold Coast # 0052415 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $44,195, IHCA - $22,813**

(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. $ **64,178** 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. $ **435,666**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **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