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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0050070

Facility Name: Warren Park Hlth & Livng Ctr

Address: 6700 N Damen (Number) Chicago (City) 60645 (Zip Code)

County: Cook

Telephone Number: (773) 465-5000 **Fax #** (773) 743-5983

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2008

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			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 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	51	Skilled (SNF)	51	18,666	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,482	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	1,025		3,416	4,441	8
9	SNF/PED					9
10	ICF	38,416	729	469	39,614	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,441	729	3,885	44,055	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.78%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold 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 05/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 3,416

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		4,663	380,784	385,447		385,447		385,447			1
2	Food Purchase		237,485		237,485	(18,227)	219,258	(253)	219,005			2
3	Housekeeping		2,035	197,213	199,248		199,248	1,627	200,875			3
4	Laundry			132,567	132,567		132,567		132,567			4
5	Heat and Other Utilities			131,809	131,809		131,809	(4,507)	127,302			5
6	Maintenance	79,273	63,990	70,712	213,975		213,975	5,065	219,040			6
7	Other (specify):*											7
8	TOTAL General Services	79,273	308,173	913,085	1,300,531	(18,227)	1,282,304	1,933	1,284,237			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	1,555,307	100,705	21,572	1,677,584		1,677,584	(3,935)	1,673,649			10
10a	Therapy	194,673	22,227		216,900		216,900		216,900			10a
11	Activities	110,348	40,779	2,091	153,218		153,218		153,218			11
12	Social Services	126,826		5,115	131,941		131,941		131,941			12
13	CNA Training											13
14	Program Transportation			3,693	3,693		3,693		3,693			14
15	Other (specify):*							8,449	8,449			15
16	TOTAL Health Care and Programs	1,987,154	163,711	36,671	2,187,536		2,187,536	4,515	2,192,051			16
	C. General Administration											
17	Administrative	129,241		387,015	516,256		516,256	(387,015)	129,241			17
18	Directors Fees											18
19	Professional Services			176,698	176,698	(4,830)	171,868	(15,563)	156,305			19
20	Dues, Fees, Subscriptions & Promotions			94,271	94,271		94,271	(14,386)	79,885			20
21	Clerical & General Office Expenses	103,046	637	343,271	446,954		446,954	(167,890)	279,064			21
22	Employee Benefits & Payroll Taxes			502,373	502,373	18,227	520,600		520,600			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,513	3,513		3,513	493	4,006			24
25	Other Admin. Staff Transportation			10,676	10,676		10,676	1,102	11,778			25
26	Insurance-Prop.Liab.Malpractice			172,245	172,245		172,245	3,680	175,925			26
27	Other (specify):*							25,278	25,278			27
28	TOTAL General Administration	232,287	637	1,690,062	1,922,986	13,397	1,936,383	(554,301)	1,382,082			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,298,714	472,521	2,639,818	5,411,053	(4,830)	5,406,223	(547,853)	4,858,370			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 Park Hlth & Livng Ctr #0050070 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			110,181	110,181		110,181	60,267	170,448			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,021	40,021		40,021	290,379	330,400			32
33	Real Estate Taxes					4,830	4,830	153,850	158,680			33
34	Rent-Facility & Grounds			730,500	730,500		730,500	(716,316)	14,184			34
35	Rent-Equipment & Vehicles			20,973	20,973		20,973	2,839	23,812			35
36	Other (specify):*											36
37	**TOTAL Ownership**			901,675	901,675	4,830	906,505	(208,981)	697,524			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,904	535,371	638,275		638,275	(220)	638,055			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,845	311,845		311,845		311,845			42
43	Other (specify):*	74,023		34,062	108,085		108,085	(108,085)	(0)			43
44	**TOTAL Special Cost Centers**	74,023	102,904	881,278	1,058,205		1,058,205	(108,305)	949,900			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,372,737	575,425	4,422,771	7,370,933		7,370,933	(865,139)	6,505,794			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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(6,236)	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	(182,219)	30		9
10	Interest and Other Investment Income	(2,828)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	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	(1,015)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(232,665)	21		24
25	Fund Raising, Advertising and Promotional	(12,645)	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	(262,457)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (700,104)		$	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)	(165,035)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (165,035)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (865,139)		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 Park Hlth & Livng Ctr

ID# 0050070

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (214)	02	1
2	Sequestration Expense	(30,998)	21	2
3	Managed Care - Sequestration Expense	(2,427)	21	3
4	Patient Needs	(317)	10	4
5	Marketing	(34,062)	43	5
6	Bank Charges	(14,703)	21	6
7	Credit Card Processing Fees	(147)	21	7
8	Capitalized R&M	(8,126)	06	8
9	Additional R&M	11,559	06	9
10	Non-allowable Auto Lease	(5,164)	35	10
11	Marketing Salary	(74,023)	43	11
12	Building Company - Bank Fees	(1,994)	21	12
13	Building Company - Amortization Goodwill	(50,000)	36	13
14	Building Company - Amortization Loan Costs	(4,751)	36	14
15	PAC Dues	(5,958)	20	15
16	P.P. Miscellaneous Expense	(6,200)	21	16
17	Non-allowable Legal	(17,432)	19	17
18	Building Company - Professional Fees	(17,500)	19	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**	(262,457)		49

Warren Park Hlth & Livng Ctr

ID# 0050070

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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													1
2	Food Purchase	(253)											(253)	2
3	Housekeeping			1,627									1,627	3
4	Laundry													4
5	Heat and Other Utilities	(6,236)		1,729									(4,507)	5
6	Maintenance	3,433		1,632									5,065	6
7	Other (specify):*													7
8	**TOTAL General Services**	(3,056)		4,989									1,933	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(317)		(3,618)									(3,935)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,449									8,449	15
16	**TOTAL Health Care and Programs**	(317)		4,832									4,515	16
	C. General Administration													
17	Administrative			(387,015)									(387,015)	17
18	Directors Fees													18
19	Professional Services	(34,932)	17,500	1,869									(15,563)	19
20	Fees, Subscriptions & Promotions	(18,603)		4,217									(14,386)	20
21	Clerical & General Office Expenses	(290,149)	1,994	120,265									(167,890)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			493									493	24
25	Other Admin. Staff Transportation			1,102									1,102	25
26	Insurance-Prop.Liab.Malpractice			3,680									3,680	26
27	Other (specify):*			25,278									25,278	27
28	**TOTAL General Administration**	(343,684)	19,494	(230,111)									(554,301)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(347,057)	19,494	(220,291)									(547,853)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(182,219)	238,553	3,933									60,267	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,828)	291,747	1,460									290,379	32
33	Real Estate Taxes		153,850										153,850	33
34	Rent-Facility & Grounds		(730,500)	14,184									(716,316)	34
35	Rent-Equipment & Vehicles	(5,164)		8,003									2,839	35
36	Other (specify):*	(54,751)	54,751											36
37	TOTAL Ownership	(244,962)	8,401	27,580									(208,981)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(220)							(220)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(108,085)											(108,085)	43
44	TOTAL Special Cost Centers	(108,085)				(220)							(108,305)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(700,104)	27,895	(192,710)		(220)							(865,139)	45

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Rental Income	$ 730,500	Warren Park Property, LLC	100.00%	$	$ (730,500)	1
2	V	32	Interest	398	Warren Park Property, LLC	100.00%	292,145	291,747	2
3	V	33	Real Estate Taxes		Warren Park Property, LLC	100.00%	153,850	153,850	3
4	V	19	Professional Fees		Warren Park Property, LLC	100.00%	17,500	17,500	4
5	V	21	Bank Fees		Warren Park Property, LLC	100.00%	1,994	1,994	5
6	V	30	Depreciation Expense		Warren Park Property, LLC	100.00%	238,553	238,553	6
7	V	36	Amortization - Goodwill		Warren Park Property, LLC	100.00%	50,000	50,000	7
8	V	36	Amortization - Loan Costs		Warren Park Property, LLC	100.00%	4,751	4,751	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 730,898			$ 758,793	$ * 27,895	14

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$	DAMEN HEALTHCARE GROUP, LLC	100.00%	$ 1,729	$ 1,729	15
16	V	3	HOUSEKEEPING		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,627	1,627	16
17	V	6	MAINTENANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,632	1,632	17
18	V	10	NURSING	40,092	DAMEN HEALTHCARE GROUP, LLC	100.00%	36,474	(3,618)	18
19	V	15	NURSING PAYROLL TAXES		DAMEN HEALTHCARE GROUP, LLC	100.00%	8,449	8,449	19
20	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,869	1,869	20
21	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC	100.00%	4,217	4,217	21
22	V	21	OFFICE EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	120,265	120,265	22
23	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	493	493	23
24	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,102	1,102	24
25	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	3,680	3,680	25
26	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC	100.00%	25,278	25,278	26
27	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	3,933	3,933	27
28	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,460	1,460	28
29	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC	100.00%	14,184	14,184	29
30	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC	100.00%	908	908	30
31	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC	100.00%	7,095	7,095	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	17	MANAGEMENT FEES	387,015	DAMEN HEALTHCARE GROUP, LLC	100.00%		(387,015)	36
37	V								37
38	V								38
39	Total			$ 427,107			$ 234,397	$ * (192,710)	39

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	17	MANAGEMENT FEES	$ 37,228	EDN MANAGEMENT GROUP	100.00%	$ 37,228	$	15
16	V	19	BOOKKEEPING SERVICES	130,950	EDN MANAGEMENT GROUP	100.00%	130,950		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			$ 168,178			$ 168,178	$ *	39

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	DME & MEDICAL SUPPLIES	$ 2,177	INTEGRA HEALTHCARE EQUIPMENT	100.00%	$ 1,957	$ (220)	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			$ 2,177			$ 1,957	$ * (220)	39

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Jonathan H. Aaron 2008 Trust	38.00%	CITADEL CARE CENTER-KANKAKEE	KANKAKEE, IL	EDN MANAGEMENT GROUP, LL	MORTON GROVE, IL	MANAGEMENT COMPANY	1
2	Devora Goldstein	8.00%	CITADEL CARE CENTER-ELGIN	ELGIN, IL	WARREN PARK PROPERTY, LLC		BUILDING COMPANY	2
3	Todd A. Stern 2001 Trust	8.00%	CITADEL CARE CENTER-WILMETTE	WILMETTE, IL	DAMEN HEALTHCARE GROUP,	MORTON GROVE, IL	BOOKKEEPING	3
4	Jonathan B. Stern 2001 Trust	30.00%	THE WATERFORD CARE CENTER	CHICAGO, IL	MISTY MEADOWS	METROPOLIS, IL	SENIOR LIVING	4
5	Evan M. Stern 2005 Trust	8.00%	CITADEL ESTATES-HAZEL CREST	HAZEL CREST, IL	SEASONS HOSPICE	PARK RIDGE, IL	HOSPICE	5
6	Ilana D. Aaron 2008 Minority Trust	8.00%			INTEGRA HEALTHCARE EQUI	ELMHURST	DME	6
7					LIFELINE AMBULANCE	CHICAGO	AMBULANCE	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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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								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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Jonathan Aaron	Relative	Administrative	0%	See Attached	7.45	18.63%	Alloc Mgmt Fee	$ 37,228	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 37,228		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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: DAMEN HEALTHCARE GROUP, LLC
Street Address: 5611 DEMPSTER
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (224) 470-2044
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	5	UTILITIES	PATIENT DAYS	236,674	8	$ 9,291	$	44,055	$ 1,729	1
2	3	HOUSEKEEPING	PATIENT DAYS	236,674	8	8,740		44,055	1,627	2
3	6	MAINTENANCE	PATIENT DAYS	236,674	8	8,770		44,055	1,632	3
4	10	NURSING	PATIENT DAYS	236,674	8	195,949	195,949	44,055	36,474	4
5	15	NURSING PAYROLL TAXES	PATIENT DAYS	236,674	8	45,391		44,055	8,449	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	236,674	8	10,042		44,055	1,869	6
7	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	236,674	8	22,657		44,055	4,217	7
8	21	OFFICE EXPENSE	PATIENT DAYS	236,674	8	646,091	586,242	44,055	120,265	8
9	24	SEMINARS AND EDUCATION	PATIENT DAYS	236,674	8	2,647		44,055	493	9
10	25	AUTO EXPENSE	PATIENT DAYS	236,674	8	5,921		44,055	1,102	10
11	26	INSURANCE	PATIENT DAYS	236,674	8	19,769		44,055	3,680	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	236,674	8	135,801		44,055	25,278	12
13	30	DEPRECIATION	PATIENT DAYS	236,674	8	21,131		44,055	3,933	13
14	32	INTEREST EXPENSE	PATIENT DAYS	236,674	8	7,844		44,055	1,460	14
15	34	RENT	PATIENT DAYS	236,674	8	76,200		44,055	14,184	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	236,674	8	4,878		44,055	908	16
17	35	AUTO LEASE	PATIENT DAYS	236,674	8	38,115		44,055	7,095	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,237	$ 782,192		$ 234,397	25

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: EDN MANAGEMENT GROUP, LLC
Street Address: 5611 DEMPSTER
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (224) 470-2044
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	17	MANAGEMENT FEES	DIRECT			$	$		$ 37,228	1
2	19	BOOKKEEPING	DIRECT						130,950	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					$	$		$ 168,178	25

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: INTEGRA HEALTHCARE EQUIPMENT
Street Address: 747 CHURCH ROAD
City / State / Zip Code: ELMHURST, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	DME & MEDICAL SUPPLIES	DIRECT			$	$		$ 1,957	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					$	$		$ 1,957	25

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	MB Financial		X	Mortgage			$	$ 6,960,000			$ 269,986	1
2	MB Financial		X	Junior Note - Refinance				1,740,000			22,113	2
3												3
4												4
5					-							5
	Working Capital											
6	MB Financial		X	Line of Credit				908,556			40,021	6
7	MB Financial		X	Construction				172,272			46	7
8					-							8
9	TOTAL Facility Related						$	$ 9,780,828			$ 332,165	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,828)	10
11	Interest Income - Bldg Co		X								(398)	11
12	Allocated - Damen Healthcare	X									1,460	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (1,766)	14
15	TOTALS (line 9+line14)						$	$ 9,780,828			$ 330,399	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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	4,467	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.)	$	158,317	2
3. Under or (over) accrual (line 2 minus line 1).	$	153,850	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	4,830	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** $ 14,989 **For** 2012 **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.	$	158,680	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	83,708	8
	2012	132,164	9
	2013	133,953	10
	2014	136,651	11
	2015	158,317	12

Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Hlth & Livng Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050070

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-31-302-008-0000	Long Term Care Property	$ 62,697.01	$ 62,697.01
2.	11-31-302-043-0000	Long Term Care Property	$ 95,620.09	$ 95,620.09
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 158,317.10	$ 158,317.10

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 X 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Hlth & Livng Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050070

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

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

	(A) 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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,400 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2012	$ 158,750	1
2					2
3	TOTALS			$ 158,750	3

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	127		2008	1969	$ 2,698,750	$ 238,553	39	$ 69,199	$ (169,354)	$ 1,490,659	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	177,699		20			177,689	9
10	Various			1991	40,276		20			40,267	10
11	Various			1992	26,271		20			26,265	11
12	Various			1993	39,480		20			39,479	12
13	Various			1994	61,455		20			61,449	13
14	Various			1995	53,672		20			53,463	14
15	Various			1996	5,720		20	83	83	5,719	15
16	Various			1997	31,153		20	1,558	1,558	30,615	16
17	Various			1998	110,159		20	5,508	5,508	101,517	17
18	Various			1999	22,019		20	1,101	1,101	19,222	18
19	Various			2000	131,428		20	7,838	7,838	129,625	19
20	Various			2001	19,312		20	583	583	15,367	20
21	Various			2002	10,360		20			10,360	21
22	Various			2003	29,173		20	321	321	27,138	22
23	Various			2004	15,972		20			15,972	23
24	Various			2005	5,259		20			5,259	24
25	Various			2006	13,841		20	407	407	13,634	25
26	Various			2007	13,027		20	670	670	9,947	26
27	Various			2008	36,795		20	2,261	2,261	33,211	27
28	Various			2009	17,450		20	1,098	1,098	7,811	28
29	Various			2011	68,295		20	2,369	2,369	13,429	29
30	Various			2012	42,368		20	4,068	4,068	16,695	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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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)		52,443	2,138		2,622	484	2,622	68
69	Financial Statement Depreciation			110,181			(110,181)		69
70	TOTAL (lines 4 thru 69)		$ 3,722,376	$ 350,872		$ 99,684	$ (251,188)	$ 2,347,411	70

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,722,376	$ 350,872		$ 99,684	$ (251,188)	$ 2,347,411	1
2	Boiler Room And Kitchen - Remove And Install New Pipe	2013	3,263		20	84	84	324	2
3	Remove And Install Cast Iron Pipe	2013	3,250		20	83	83	316	3
4	Wall Ac Units	2013	3,271		20	467	467	1,713	4
5	Replace Hydraulic Power Unit And Repipe Elevator	2013	13,885		20	694	694	2,488	5
6	Install Sprinkler Heads In Elevator Rooms	2013	2,986		20	77	77	271	6
7	Wall Ac Units	2013	3,849		20	550	550	1,970	7
8	Replaced Flange Gasket And Seal, Straighted, Realigned Doors Or	2013	5,265		20	135	135	467	8
9	Provide & Install Handrails	2013	3,395		20	679	679	2,263	9
10	Reception & Nurses Station - Installed Custom Cabinetry & Stora	2014	27,928		20	1,396	1,396	4,189	10
11	South Passenger Elevator0Furnish & Install Hall Buttons On Each	2014	3,800		20	190	190	554	11
12	Completed Electrical Work In Front Office	2014	2,550		20	128	128	340	12
13	Installed New Sprinkler Heads & Rangeguard System Devices	2014	4,957		20	248	248	661	13
14	Retrofit Fume Hood	2014	3,200		20	160	160	427	14
15	Installed Woodgrain Door Coverings	2014	7,268		20	363	363	939	15
16	Installed New Heater & Pump Box	2014	9,129		20	456	456	989	16
17	New Flooring	2014	17,897		20	895	895	1,939	17
18	Installed Paneling On 35 Doors On The First Floor	2014	6,085		20	304	304	659	18
19	Wallcovering Supplies-Activity, Don, Social Service, Care Plan, Ac	2014	12,505		20	625	625	1,355	19
20	Wallcovering-Activity, Don, Social Service, Care Plan, Admission	2014	4,289		20	214	214	482	20
21	Glass	2014	3,199		20	640	640	1,440	21
22	Install Handrails, Wallcovering, Corner Guards, Floor, Window T	2014	88,515		20	4,426	4,426	11,802	22
23	1St Floor-Remove Wallpaper, Prime Walls, Install Wall Base, Elec	2014	39,500		20	1,975	1,975	5,431	23
24	Remove Tile & Carpet From Halls, Elevator, Lobby, Dining Room	2014	16,175		20	809	809	2,291	24
25	1 Floor Remodel-Asbestos Inspection Fee	2014	10,617		20	531	531	1,416	25
26	Furnish & Install Conduit, Fittings, & Wire To Generator. Installa	2014	6,450		20	323	323	833	26
27	Install Generator In Kitchen, Install New Motor Cantrill, Repair I	2014	3,620		20	181	181	437	27
28	Installed New Fire Pump Annunciator In Front Lobby, Including	2014	4,726		20	236	236	532	28
29	Install 7 Eyewash Stations Complete With Mixing Valves & Coppe	2014	10,701		20	535	535	1,204	29
30	Installation Of Tamper Panel & Associated Devices; Fire Alarm S	2015	11,767		20	588	588	1,079	30
31	Front Landscaping Project - New Retaining Wall	2015	11,253		20	563	563	891	31
32	Installation Of New Boiler For Building	2015	9,541		20	477	477	596	32
33	Installed Barring Assembly & Coupler Assembly For A/C	2015	2,886		20	144	144	156	33
34	TOTAL (lines 1 thru 33)		$ 4,080,097	$ 350,872		$ 118,861	$ (232,011)	$ 2,397,866	34

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,080,097	$ 350,872		$ 118,861	$ (232,011)	$ 2,397,866	1
2	Community Bathrooms-Replaced Hot & Cold Cartridges, Handles	2015	2,875		20	144	144	156	2
3	Installed Oil Return Pump In Passenger Elevator # 1	2015	4,917		20	246	246	389	3
4	Install New 30 Gallon Rockford Grease Trap	2016	7,200		20	270	270	270	4
5	New 48" Pipe Railing - Flange To Concrete (Outside Fence)	2016	4,886		20	122	122	122	5
6	Installed New Grease Trap	2016	3,200		20	27	27	27	6
7	Installed New Awning Cover	2016	4,740		20	237	237	237	7
8	Exterior Building - Apply Satin Trim Paint	2016	4,950		20	248	248	248	8
9	Cylinder Replacement On North Elevator	2016	35,711		20	1,786	1,786	1,786	9
10	Black Iron Piping For The Day Tank To The Main Tank	2016	2,531		20	127	127	127	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)		$ 4,151,107	$ 350,872		$ 122,066	$ (228,806)	$ 2,401,226	34

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,151,107	$ 350,872		$ 122,066	$ (228,806)	$ 2,401,226	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)		$ 4,151,107	$ 350,872		$ 122,066	$ (228,806)	$ 2,401,226	34

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,151,107	$ 350,872		$ 122,066	$ (228,806)	$ 2,401,226	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)		$ 4,151,107	$ 350,872		$ 122,066	$ (228,806)	$ 2,401,226	34

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Damen Healthcare Group	2015	52,443	2,138	20	2,622	484	2,622	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)		$ 52,443	$ 2,138		$ 2,622	$ 484	$ 2,622	34

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 52,443	$ 2,138		$ 2,622	$ 484	$ 2,622	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)		$ 52,443	$ 2,138		$ 2,622	$ 484	$ 2,622	34

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 266,882	$ 1,637	$ 35,507	$ 33,870	10	$ 154,581	71
72	Current Year Purchases	130,620	159	5,851	5,692	10	5,851	72
73	Fully Depreciated Assets	568,702				10	568,702	73
74								74
75	TOTALS	$ 966,204	$ 1,796	$ 41,359	$ 39,563		$ 729,134	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		DODGE TRUCK	2014	$ 24,444	$	$ 3,675	$ 3,675	5	$ 10,970	76
77		DODGE CARAVAN	2014	30,172		3,350	3,350	5	12,310	77
78										78
79										79
80	TOTALS			$ 54,616	$	$ 7,025	$ 7,025		$ 23,280	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)	$ 5,330,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 352,668	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 170,449	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (182,219)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,153,641	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	Various Improvements	$ 980,605	92
93			93
94			94
95		$ 980,605	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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 - Damen Healthcare Group				14,184			5
6								6
7	TOTAL				$ 14,184 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 5,874 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2015 Range Rover	$ 904	$ 10,844	17
18	Allocated - Damen Healthcare Group			7,095	18
19					19
20					20
21	TOTAL		$ 904	$ 17,939	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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$		$ 224,112	$		$ 224,112	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,642			2,642	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			302,496			302,496	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				102,397		102,397	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					6,121	507		6,628	13
14	TOTAL			$		$ 535,371	$ 102,904		$ 638,275	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Warren Park Hlth & Livng Ctr **#** 0050070 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 49,313	$ 138,153	1
2	Cash-Patient Deposits	55,331	55,331	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,728,946	1,728,946	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	126,846	126,846	6
7	Other Prepaid Expenses	174,739	174,739	7
8	Accounts Receivable (owners or related parties)		33,795	8
9	Other(specify): See Attached Schedule	36,060	2,385,021	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,171,235	$ 4,642,831	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,750	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	733,257	733,257	15
16	Equipment, at Historical Cost	396,157	713,657	16
17	Accumulated Depreciation (book methods)	(364,998)	(2,173,157)	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 Schedule	1,005,724	1,678,621	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,770,140	$ 3,809,878	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,941,375	$ 8,452,709	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 840,060	$ 840,060	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,331	55,331	28
29	Short-Term Notes Payable	908,556	1,080,828	29
30	Accrued Salaries Payable	162,462	162,462	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,167	5,167	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,835	3,835	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	68,470	68,470	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,043,881	$ 2,216,153	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,740,000	39
40	Mortgage Payable		6,960,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,700,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,043,881	$ 10,916,153	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,897,494	$ (2,463,444)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,941,375	$ 8,452,709	48

***(See instructions.)**

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,796,833	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,796,834	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	387,401	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	(286,741)	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)**	$ 100,660	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)**	$ 1,897,494	24 *

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

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,361,831	1
2	Discounts and Allowances for all Levels	(523,991)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,837,840	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,791,701	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,791,701	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	100,331	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,453	19
20	Radiology and X-Ray	978	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 110,762	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,828	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,828	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	15,203	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,203	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,758,334	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,300,531	31
32	Health Care	2,187,536	32
33	General Administration	1,922,986	33
	B. Capital Expense		
34	Ownership	901,675	34
	C. Ancillary Expense		
35	Special Cost Centers	746,360	35
36	Provider Participation Fee	311,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,370,933	40
41	**Income before Income Taxes (line 30 minus line 40)****	387,401	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 387,401	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,302,420	44
45	Private Pay - Net Inpatient Revenue	113,915	45
46	Medicare - Net Inpatient Revenue	212,855	46
47	Other-(specify) Managed Care	200,886	47
48	Other-(specify) Hospice	7,764	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,837,840	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 Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2,060	2,163	$ 129,894	$ 60.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,737	5,105	154,380	30.24	3
4	Licensed Practical Nurses	19,835	21,770	567,971	26.09	4
5	CNAs & Orderlies	54,917	61,080	701,197	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,330	6,646	194,673	29.29	8
9	Activity Director	2,011	2,213	44,385	20.06	9
10	Activity Assistants	5,172	5,937	65,963	11.11	10
11	Social Service Workers	6,865	7,227	126,826	17.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,477	3,928	79,273	20.18	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,710	2,159	129,241	59.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	887	887	24,986	28.17	23
24	Clerical	5,437	5,528	78,060	14.12	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	130	178	1,865	10.48	31
32	Other Health Care(specify)					32
33	Other(specify)	2,080	2,080	74,023	35.59	33
34	TOTAL (lines 1 - 33)	115,648	126,901	$ 2,372,737 *	$ 18.70	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	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	1,439 patients	9,572	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,091	11-03	44
45	Social Service Consultant	83	5,115	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	12,000	10-03	47
48	Outside Services - Dietary		380,784	01-03	48
49	TOTAL (lines 35 - 48)	83	$ 413,762		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Josh Williams	Administrator	0%	$ 129,241
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 129,241

B. Administrative - Other

Description	Amount
Management Fees	$ 387,015
TOTAL (agree to Schedule V, line 17, col. 3)	$ 387,015
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Services	$ 14,409
ProPay HR	Payroll Services	8,550
HW&CO	Healthcare Consulting	5,925
Madison Specs	Property Engineering	6,588
Personnel Planners	Unemployment Consulting	1,350
Team TSI Corp	Data Mining	3,819
Legal	See Attached	38,966
Marcum	Accounting	31,431
Casamba	EMR for Therapy	3,925
Cerner Corporation	Revenue Cycle Management	1,877
eHealth Data Systems	Risk Management Services	4,276
See Supplemental Schedule		55,583
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 176,698

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,215
Unemployment Compensation Insurance	43,728
FICA Taxes	181,514
Employee Health Insurance	195,824
Employee Meals	18,227
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	14,371
Holiday Expense	2,789
Pension	4,932
TOTAL (agree to Schedule V, line 22, col.8)	$ 520,600

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	$ 3,980
Advertising: Employee Recruitment	46,560
Health Care Worker Background Check	1,072
(Indicate # of checks performed 27)	
Patient Background Checks 107	1,072
Dues and Subscriptions	17,726
License and Fees	5,257
Allocated - Damen Healthcare Group	4,217
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,884

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,513
Allocated - Damen Healthcare Group	493
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,006

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Warren Park Hlth & Livng Ctr # 0050070 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **ICLTC $18,056**

(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. $ **330** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Warren Park Nursing Pavilion #30036079 05/01/2008

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **311,845**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **18,227** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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