		FOR BHF USE				

LL1

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

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

I. IDPH License ID Number: 0050070

Facility Name: Warren Park Hlth Living Ctr

Address: 6700 North 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		PROPRIETARY		GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

Ownership type checked: [X] PROPRIETARY

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) ______ 05/24/2020 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA
Partner
(Firm Name & Address) Marcum, LLP
9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

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

Facility Name & ID Number: Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF			3,548	3,548	8
9	SNF/PED					9
10	ICF	38,592	495		39,087	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,592	495	3,548	42,635	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.72%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 3,381

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	280,225	22,243	62,003	364,471		364,471		364,471			1
2	Food Purchase		238,716		238,716	(21,777)	216,939	(28)	216,911			2
3	Housekeeping	222,714	42,675		265,389		265,389	1,548	266,937			3
4	Laundry	35,011	11,255	5,237	51,503		51,503		51,503			4
5	Heat and Other Utilities			132,805	132,805		132,805	(10,023)	122,782			5
6	Maintenance	94,267	35,915	119,274	249,456		249,456	3,051	252,507			6
7	Other (specify):*							2,575	2,575			7
8	**TOTAL General Services**	632,217	350,804	319,319	1,302,340	(21,777)	1,280,563	(2,878)	1,277,685			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	2,069,255	259,360	45,132	2,373,747		2,373,747	(34,564)	2,339,183			10
10a	Therapy	211,112			211,112		211,112		211,112			10a
11	Activities	139,872	35,411	954	176,237		176,237		176,237			11
12	Social Services	168,385		31,389	199,774		199,774		199,774			12
13	CNA Training											13
14	Program Transportation			3,780	3,780		3,780	(310)	3,470			14
15	Other (specify):*							21,667	21,667			15
16	**TOTAL Health Care and Programs**	2,588,624	294,771	85,455	2,968,850		2,968,850	(13,207)	2,955,643			16
	C. General Administration											
17	Administrative	133,787		458,075	591,862		591,862	(374,290)	217,572			17
18	Directors Fees											18
19	Professional Services			328,163	328,163	(1,477)	326,686	(149,349)	177,337			19
20	Dues, Fees, Subscriptions & Promotions			46,088	46,088		46,088	(15,313)	30,775			20
21	Clerical & General Office Expenses	162,183	1,099	418,525	581,807		581,807	(209,253)	372,554			21
22	Employee Benefits & Payroll Taxes			650,113	650,113	21,777	671,890		671,890			22
23	Inservice Training & Education											23
24	Travel and Seminar			681	681		681	46	727			24
25	Other Admin. Staff Transportation			8,247	8,247		8,247	2,769	11,016			25
26	Insurance-Prop.Liab.Malpractice			414,038	414,038		414,038	3,477	417,515			26
27	Other (specify):*							40,238	40,238			27
28	**TOTAL General Administration**	295,970	1,099	2,323,930	2,620,999	20,300	2,641,299	(701,674)	1,939,624			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,516,811	646,674	2,728,704	6,892,189	(1,477)	6,890,712	(717,759)	6,172,953			29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			196,927	196,927		196,927	(2,197)	194,730			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,443	12,443		12,443	290,778	303,221			32
33	Real Estate Taxes					1,477	1,477	161,690	163,167			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(764,523)	15,477			34
35	Rent-Equipment & Vehicles			16,385	16,385		16,385	10,591	26,976			35
36	Other (specify):*							52,484	52,484			36
37	TOTAL Ownership			1,005,755	1,005,755	1,477	1,007,232	(251,177)	756,055			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,236	756,136	846,372		846,372	(950)	845,422			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			307,043	307,043		307,043		307,043			42
43	Other (specify):*	72,158		64,067	136,225		136,225	(136,225)	(0)			43
44	TOTAL Special Cost Centers	72,158	90,236	1,127,246	1,289,640		1,289,640	(137,175)	1,152,465			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,588,969	736,910	4,861,705	9,187,584	0	9,187,584	(1,106,112)	8,081,472			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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,304)	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	(6,491)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(28)	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	(1,517)	21		18
19	Entertainment				19
20	Contributions	(4,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(225,254)	21		24
25	Fund Raising, Advertising and Promotional	(1,800)	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	(205,359)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (455,853)		$	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)	(650,258)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (650,258)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,106,111)		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 Living Ctr

ID# 0050070

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (22,077)	21	1
2	Misc Income - Medical Supplies	(5,440)	10	2
3	Sequestration	(12,159)	21	3
4	Patient Needs	(2,884)	10	4
5	Marketing Salary	(72,158)	43	5
6	Marketing Expense	(64,067)	43	6
7	Bldg Co - Accounting	(11,411)	19	7
8	Bldg Co - Legal Fees	(386)	19	8
9	Bldg Co - Bank Charges	(1,143)	21	9
10	Additional R&M	10,255	06	10
11	Bldg Co - Additional R&M	2,178	06	11
12	Capitalized R&M	(3,072)	06	12
13	PAC Dues	(10,960)	20	13
14	Marketing Auto Lease	(5,321)	35	14
15	Non Allowable Legal	(6,713)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(205,359)		49

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

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

STATE OF ILLINOIS

Warren Park Hlth Living Ctr

ID# 0050070

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(28)											(28)	2
3	Housekeeping			1,548									1,548	3
4	Laundry													4
5	Heat and Other Utilities	(11,304)		1,281									(10,023)	5
6	Maintenance	9,361		(6,524)	215								3,051	6
7	Other (specify):*			2,575									2,575	7
8	TOTAL General Services	(1,971)		(1,121)	215								(2,878)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(8,324)		(25,941)			(299)						(34,564)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							(310)					(310)	14
15	Other (specify):*			21,667									21,667	15
16	TOTAL Health Care and Programs	(8,324)		(4,274)			(299)	(310)					(13,207)	16
	C. General Administration													
17	Administrative			(374,290)									(374,290)	17
18	Directors Fees													18
19	Professional Services	(18,510)	11,797	(143,713)	1,077								(149,349)	19
20	Fees, Subscriptions & Promotions	(16,860)		1,547									(15,313)	20
21	Clerical & General Office Expenses	(262,150)	1,143	51,754									(209,253)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			46									46	24
25	Other Admin. Staff Transportation			2,769									2,769	25
26	Insurance-Prop.Liab.Malpractice			3,477									3,477	26
27	Other (specify):*			40,238									40,238	27
28	TOTAL General Administration	(297,520)	12,940	(418,172)	1,077								(701,674)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(307,815)	12,940	(423,567)	1,292		(299)	(310)					(717,759)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(6,491)		2,552	1,741								(2,197)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		282,972	2,566	5,240								290,778	32
33	Real Estate Taxes		155,581		6,109								161,690	33
34	Rent-Facility & Grounds		(780,000)	23,378	(7,901)								(764,523)	34
35	Rent-Equipment & Vehicles	(5,321)		15,912									10,591	35
36	Other (specify):*		52,484										52,484	36
37	**TOTAL Ownership**	(11,812)	(288,963)	44,408	5,189								(251,177)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(950)						(950)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(136,225)											(136,225)	43
44	**TOTAL Special Cost Centers**	(136,225)					(950)						(137,175)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(455,853)	(276,022)	(379,158)	6,481		(1,249)	(310)					(1,106,112)	45

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 780,000	Warren Park Property, LLC		$	$ (780,000)	1
2	V	33	Real Estate Taxes		Warren Park Property, LLC		155,581	155,581	2
3	V	32	Interest	22	Warren Park Property, LLC		282,994	282,972	3
4	V	19	Accounting		Warren Park Property, LLC		11,411	11,411	4
5	V	19	Legal Fees		Warren Park Property, LLC		386	386	5
6	V	36	MIP Insurance		Warren Park Property, LLC		52,484	52,484	6
7	V	21	Bank Charges		Warren Park Property, LLC		1,143	1,143	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 780,022			$ 504,000	$ * (276,022)	14

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

STATE OF ILLINOIS

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jonathan H Aaron 2008 Trust	38.00%	CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	WARREN PARK PROPERTY, LL	CHICAGO	BUILDING COMPANY	1
2	Jonathan B Stern 2001 Trust	30.00%	CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	DAMEN HEALTHCARE GROUP,	SKOKIE, IL	BOOKKEEPING	2
3	Todd A. Stern 2001 Trust	8.00%	CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4	Evan Michael Stern 2005 Trust	8.00%	THE WATERFORD CARE CENTER LLC	CHICAGO, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5	Ilana D Aaron 2008 Trust	8.00%	CITADEL CARE CENTER-STERLING LLC	STERLING, IL	INTEGRA HEALTHCARE EQUII	ELMHURST	DME	5
6	Devora Goldstein	8.00%	THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7			PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				7
8			SKOKIE MEADOWS LLC	SKOKIE, IL				8
9			THE CITADEL OF SKOKIE LLC	SKOKIE, IL				9
10			THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				10
11			THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	$	Damen Healthcare Group, LLC		$ 1,548	$ 1,548	15
16	V	5	Utilities		Damen Healthcare Group, LLC		1,281	1,281	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		12,114	12,114	17
18	V	6	Maintenance	20,231	Damen Healthcare Group, LLC		1,593	(18,638)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		2,575	2,575	19
20	V	10	Nursing	130,217	Damen Healthcare Group, LLC		104,276	(25,941)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		21,667	21,667	21
22	V	17	Administrative	458,075	Damen Healthcare Group, LLC		26,874	(431,201)	22
23	V	19	Professional Fees	144,000	Damen Healthcare Group, LLC		287	(143,713)	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		1,547	1,547	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		150,798	150,798	25
26	V	21	Office Expense - Other	110,008	Damen Healthcare Group, LLC		10,964	(99,044)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		46	46	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		2,769	2,769	28
29	V	26	Insurance		Damen Healthcare Group, LLC		3,477	3,477	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		40,238	40,238	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		2,552	2,552	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		2,566	2,566	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		15,477	15,477	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		7,901	7,901	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		855	855	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		15,057	15,057	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		30,038	30,038	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		26,874	26,874	38
39	Total			$ 862,531			$ 483,373	$ * (379,158)	39

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	3755 W Chase, LLC		$ 215	$ 215	15
16	V	30	Depreciation		3755 W Chase, LLC		1,741	1,741	16
17	V	32	Interest Expense		3755 W Chase, LLC		5,240	5,240	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		6,109	6,109	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		1,077	1,077	19
20	V								20
21	V	34	Rent	7,901	3755 W Chase, LLC			(7,901)	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			$ 7,901			$ 14,382	$ * 6,481	39

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 369,917	Biltmore Incorporated Cell		$ 369,917	$	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			$ 369,917			$ 369,917	$ *	39

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supply/DME Rental	$ 1,932	Integra Healthcare Equipment		$ 1,633	$ (299)	15
16	V	39	Ancillary Expense	6,126	Integra Healthcare Equipment		5,176	(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			$ 8,058			$ 6,809	$ * (1,249)	39

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Patient Transportation	$ 1,640	Lifeline Ambulance LLC		$ 1,330	$ (310)	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			$ 1,640			$ 1,330	$ * (310)	39

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number: Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Jonathan Aaron	Relative	Administrative		See Attached	4.81	12.03%	Alloc Mgt Fee	$ 30,038	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	$ 30,038		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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization: Damen Healthcare Group, LLC
Street Address: 3755 W. Chase Ave.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (224) 470-2044
Fax Number: (224) 470-2952

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	396,623	14	$ 14,400	$	42,635	$ 1,548	1
2	5	Utilities	Patient Days	396,623	14	11,913		42,635	1,281	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	112,690	42,635	12,114	3
4	6	Maintenance	Patient Days	396,623	14	14,821		42,635	1,593	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951		42,635	2,575	5
6	10	Nursing	Patient Days	396,623	14	970,057	948,342	42,635	104,276	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561		42,635	21,667	7
8	17	Administrative	Patient Days	396,623	14	250,000	250,000	42,635	26,874	8
9	19	Professional Fees	Patient Days	396,623	14	2,669		42,635	287	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390		42,635	1,547	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	1,402,841	42,635	150,798	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995		42,635	10,964	12
13	24	Seminars & Education	Patient Days	396,623	14	431		42,635	46	13
14	25	Auto Expense	Patient Days	396,623	14	25,762		42,635	2,769	14
15	26	Insurance	Patient Days	396,623	14	32,350		42,635	3,477	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325		42,635	40,238	16
17	30	Depreciation	Patient Days	396,623	14	23,745		42,635	2,552	17
18	32	Interest Expense	Patient Days	396,623	14	23,867		42,635	2,566	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975		42,635	15,477	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500		42,635	7,901	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954		42,635	855	21
22	35	Auto Lease	Patient Days	396,623	14	140,073		42,635	15,057	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000		42,635	30,038	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000		42,635	26,874	24
25	TOTALS					$ 4,467,270	$ 2,713,873		$ 483,373	25

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 3755 W Chase, LLC
Street Address: 3755 W. Chase Ave.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (224) 470-2044
Fax Number: (224) 470-2952

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Patient Days	396,623	14	$ 2,000	$	42,635	$ 215	1
2	30	Depreciation	Patient Days	396,623	14	16,199		42,635	1,741	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		42,635	5,240	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		42,635	6,109	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		42,635	1,077	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					$ 133,796	$		$ 14,382	25

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Biltmore Incorporated Cell
Street Address: 30 Main street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
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	26	Insurance	Direct Allocation			$	$		$ 369,917	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					$	$		$ 369,917	25

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Integra Healthcare Equipment, LLC
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	10	Medical Supply/DME Rental	Direct			$	$		$ 1,633	1
2	39	Ancillary Expense	Direct						5,176	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,809	25

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifeline Ambulance
Street Address: 2424 S Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	14	Patient Transportation	Direct			$	$		$ 1,330	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					$	$		$ 1,330	25

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD - First American Capital Group		X	Mortgage			$	$ 8,024,114			$ 282,994	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Fifth Third Bank		X	Line of Credit				300,406			12,443	6
7												7
8												8
9	TOTAL Facility Related						$	$ 8,324,520			$ 295,437	9
	B. Non-Facility Related*											
10	Interest Income - Bldg. Co		X								(22)	10
11	Allocated from Damen HC	X									2,566	11
12	Allocated from 3755 Chase	X									5,240	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,784	14
15	TOTALS (line 9+line14)						$	$ 8,324,520			$ 303,221	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 52,484 Line # 36

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	192,125	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.)	$	192,215	2
3. Under or (over) accrual (line 2 minus line 1).	$	90	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	195,411	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.)	$	1,477	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ______ For ______ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	196,978	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	158,317	8
2016	173,041	9
2017	185,984	10
2018	182,976	11
2019	186,106	12

2020 Accrual = $186,106 x 1.05 = $195,411

Allocated from 3755 Chase $6,109

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Hlth Living Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050070

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-31-302-043-0000	Long Term Care Property	$ 112,366.12	$ 112,366.12
2.	11-31-302-008-0000	Long Term Care Property	$ 73,739.67	$ 73,739.67
3.	10-26-318-023-0000	Allocated from Home Office	$ 172,792.10	$ 18,574.29
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 358,897.89	$ 204,680.08

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Hlth Living Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050070

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	50,000	1995	$ 158,750	1
2	Allocated from 3755 W Chase		2019	72,258	2
3	TOTALS	50,000		$ 231,008	3

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		2008	1969	$ 2,698,750	$	39	$ 69,199	$ 69,199	$ 1,767,455	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	177,699		20	10	10	177,699	9
10	Various			1991	40,276		20	8	8	40,276	10
11	Various			1992	26,271		20	6	6	26,271	11
12	Various			1993	39,480		20	1	1	39,480	12
13	Various			1994	61,455		20	7	7	61,455	13
14	Various			1995	53,672		20	209	209	53,672	14
15	Various			1996	5,720		20	1	1	5,720	15
16	Various			1997	31,153		20	3	3	31,153	16
17	Various			1998	110,159		20	189	189	110,060	17
18	Various			1999	22,019		20	192	192	22,019	18
19	Various			2000	131,428		20	2,353	2,353	127,712	19
20	Various			2001	19,312		20	656	656	17,773	20
21	Various			2002	10,360		20			10,360	21
22	Various			2003	29,173		20	320	320	28,420	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			13,841	25
26	Various			2007	13,027		20	379	379	11,953	26
27	Various			2008	36,795		20	194	194	36,747	27
28	Various			2009	17,450		20	436	436	11,468	28
29	Various			2011	68,295		20	3,261	3,261	22,712	29
30	Various			2012	42,368		20	2,118	2,118	31,016	30
31	Various			2013	39,164		20	1,780	1,780	18,994	31
32	Various			2014	281,462		20	13,912	13,912	95,151	32
33	Various			2015	48,973		20	2,449	2,449	13,342	33
34	Various			2016	673,394		20	33,670	33,670	139,256	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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		84,599			4,230	4,230	7,739	67
68	Related Party Allocations (Pages 12H & 12I)		409,462	2,667		2,333	(334)	18,036	68
69	Financial Statement Depreciation			196,927			(196,927)		69
70	TOTAL (lines 4 thru 69)		$ 5,206,988	$ 199,594		$ 137,916	$ (61,678)	$ 2,961,010	70

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,206,988	$ 199,594		$ 137,916	$ (61,678)	$ 2,961,010	1
2	Emergency Phones In Passenger Elevator	2017	5,996		20	300	300	1,099	2
3	Generator Diesel Leak Clean Up & Waste Removal	2017	25,072		20	1,254	1,254	4,806	3
4	Galvinized Steel Insulated Door	2017	3,641		20	182	182	698	4
5	Roof Repair Work - Patching, Sealing	2017	8,900		20	445	445	1,558	5
6	Environmental Consulting Group, Inc - Site Investigation & Actio	2017	26,585		20	1,329	1,329	4,984	6
7	Environmental Consulting Group, Inc - Remedial Action Complet	2017	5,000		20	250	250	917	7
8	Leaking Pipe Repair In Room 223	2017	4,200		20	210	210	840	8
9	Install Sink & Drain In Kitchen	2017	3,850		20	193	193	754	9
10	Radiator Repair	2017	4,647		20	232	232	910	10
11	Remove & Replace Section Of Drainage Line In Kitchen	2017	3,450		20	173	173	662	11
12	Lint Filter For Dryer Duct	2018	3,277		20	164	164	369	12
13	Elevator Car Top Selector - #1 South Passenger Elevator	2018	9,757		20	488	488	1,260	13
14	Replace Water Pump And Fan Belt	2020	3,072		20	154	154	154	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)		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
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)		$ 5,314,435	$ 199,594		$ 143,290	$ (56,305)	$ 2,980,021	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	#1 South & #2 North Elevator Repairs-Pistons/Cylinders/Hydrauli	2019	70,187		20	3,509	3,509	7,018	9
10	FAC HUD RR - DOORS DONE RIGHT 061920 10768	2020	4,331		20	217	217	217	10
11	FAC HUD RR - ON-LINE COMMUNICATIONS 061620 1017283	2020	10,080		20	504	504	504	11
12					20				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)		$ 84,599	$		$ 4,230	$ 4,230	$ 7,739	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 84,599	$		$ 4,230	$ 4,230	$ 7,739	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 84,599	$		$ 4,230	$ 4,230	$ 7,739	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 3737 Chase	2019	409,462	1,741	35	2,333	592	18,036	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Healthcare	2015		926	20		(926)		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)		$ 409,462	$ 2,667		$ 2,333	$ (334)	$ 18,036	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 409,462	$ 2,667		$ 2,333	$ (334)	$ 18,036	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 409,462	$ 2,667		$ 2,333	$ (334)	$ 18,036	34

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 615,543	$ 884	$ 58,537	$ 57,653	10	$ 298,349	71
72	Current Year Purchases	39,490	600	3,817	3,217	10	3,817	72
73	Fully Depreciated Assets	719,071	143	143		10	719,071	73
74								74
75	TOTALS	$ 1,374,104	$ 1,627	$ 62,497	$ 60,870		$ 1,021,237	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 - MIDWAY	1993	$	$	$ (21,583)	$ (21,583)		$	76
77		1999 Lexus RX300	2003							77
78		DODGE TRUCK	2014	24,444		4,492	4,492	5	24,444	78
79		See Attached		30,172		6,034	6,034		24,269	79
80	TOTALS			$ 54,616	$	$ (11,057)	$ (11,057)		$ 48,713	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)	$ 6,974,163	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,221	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 194,730	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,491)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,049,971	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	Elevator	$ 19,856	92
93	A/C EXF Replacement	18,119	93
94			94
95		$ 37,975	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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Damen Healthcare				15,477			5
6								6
7	TOTAL				$ 15,477 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 11,919 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Damen Healthcare		$	$ 15,057	17
18					18
19					19
20					20
21	TOTAL		$	$ 15,057	21

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$		$ 308,815	$		$ 308,815	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			77,866			77,866	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			339,353			339,353	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				90,072		90,072	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					30,102	164		30,266	13
14	TOTAL			$		$ 756,136	$ 90,236		$ 846,372	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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,629,995	$ 1,773,391	1
2	Cash-Patient Deposits	55,331	55,331	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,119,098	2,119,098	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	404,986	404,986	6
7	Other Prepaid Expenses	4,239	4,239	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	10,702	336,294	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,224,351	$ 4,693,339	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		347,500	13
14	Buildings, at Historical Cost		3,834,064	14
15	Leasehold Improvements, at Historical Cost	1,786,301	1,786,301	15
16	Equipment, at Historical Cost	483,941	1,445,730	16
17	Accumulated Depreciation (book methods)	(1,116,185)	(2,759,781)	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	221,308	641,732	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,375,365	$ 5,295,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,599,716	$ 9,988,885	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 317,016	$ 317,046	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,500	50,500	28
29	Short-Term Notes Payable	300,406	300,406	29
30	Accrued Salaries Payable	272,968	272,968	30
31	Accrued Taxes Payable (excluding real estate taxes)	180,904	180,904	31
32	Accrued Real Estate Taxes(Sch.IX-B)		195,411	32
33	Accrued Interest Payable	945	25,082	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,057,700	1,057,700	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,180,439	$ 2,400,017	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,024,114	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)**	$	$ 8,024,114	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,180,439	$ 10,424,131	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,419,277	$ (435,246)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,599,716	$ 9,988,885	48

*(See instructions.)

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,504,907	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,504,907	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	914,370	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 914,370	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)**	$ 3,419,277	24 *

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

Facility Name & ID Number Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,401,471	1
2	Discounts and Allowances for all Levels	(2,325,032)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,076,439	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,083,348	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,083,348	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	373	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,342	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,715	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	940,452	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 940,452	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,101,954	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,302,340	31
32	Health Care	2,968,850	32
33	General Administration	2,620,999	33
	B. Capital Expense		
34	Ownership	1,005,755	34
	C. Ancillary Expense		
35	Special Cost Centers	982,597	35
36	Provider Participation Fee	307,043	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,187,584	40
41	**Income before Income Taxes (line 30 minus line 40)****	914,370	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 914,370	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,348,901	44
45	Private Pay - Net Inpatient Revenue	93,280	45
46	Medicare - Net Inpatient Revenue	1,396,426	46
47	Other-(specify) Managed Care	101,408	47
48	Other-(specify) Hospice	136,424	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,076,439	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 Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,006	2,112	$ 125,696	$ 59.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,093	9,571	323,169	33.77	3
4	Licensed Practical Nurses	20,990	22,094	692,610	31.35	4
5	CNAs & Orderlies	52,488	55,251	927,780	16.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,447	6,786	211,112	31.11	8
9	Activity Director	2,013	2,119	46,359	21.88	9
10	Activity Assistants	5,881	6,190	93,513	15.11	10
11	Social Service Workers	8,751	9,211	168,385	18.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,096	3,259	53,249	16.34	14
15	Cook Helpers/Assistants	13,168	13,862	226,976	16.37	15
16	Dishwashers					16
17	Maintenance Workers	3,903	4,109	94,267	22.94	17
18	Housekeepers	13,286	13,985	222,714	15.93	18
19	Laundry	1,955	2,058	35,011	17.02	19
20	Administrator	2,128	2,240	133,787	59.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,976	2,080	64,304	30.92	23
24	Clerical	5,312	5,592	97,879	17.50	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,976	2,080	72,158	34.69	33
34	TOTAL (lines 1 - 33)	154,468	162,598	$ 3,588,969 *	$ 22.07	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,000	10-03	38
39	Pharmacist Consultant	Monthly	18,357	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	18	954	11-03	44
45	Social Service Consultant	21	1,389	12-03	45
46	Other(specify) MDS Consultant	Monthly	24,775	10-03	46
47	Psychiatric	Monthly	30,000	12-03	47
48	Outside Services - Dietary	Monthly	62,003	01-03	48
49	TOTAL (lines 35 - 48)	39	$ 143,678		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Warren Park Hlth Living Ctr # 0050070 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joshua Williams	Administrator	0	$ 133,787
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 133,787

B. Administrative - Other

Description	Amount
Management Fees - Damen Healthcare Group, LLC	$ 458,075
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 458,075

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 34,540
ProPay HR	Payroll Services	18,610
E-Health Data Solutions LLC	Risk Management Services	5,254
eSolutions Inc	Data Processing	2,130
Health Data Systems	Data Processing	4,504
IIT/SourceTech	Data Processing	2,565
National Datacare Corporation	Data Processing	3,158
Point Click Care Technologies, Inc.	Clinical Software	66,146
Prime Care Technologies	Data Processing	2,405
Reside Admissions	Data Processing	2,614
See Attached	Legal	29,420
See Supplemental Schedule		156,818
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 328,163

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,619
Unemployment Compensation Insurance	24,598
FICA Taxes	274,556
Employee Health Insurance	223,129
Employee Meals	21,777
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	4,735
Dental / Vision Insurance	878
Pension Expense	36,488
Employee Benefits - Other	15,101
Holiday Expense	7,454
401K Employer Match Expense	13,555
TOTAL (agree to Schedule V, line 22, col.8)	$ 671,890

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,925
Health Care Worker Background Check	
(Indicate # of checks performed 489)	4,891
Patient Background Checks 438	4,380
Dues & Subscriptions	16,619
Licenses & Fees	1,413
See Supplemental Schedule	1,547
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,775

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	681
See Supplemental Schedule	46
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 727

**See instructions.

Facility Name & ID Number **Warren Park Hlth Living Ctr** **#** **0050070** **Report Period Beginning:** **01/01/20** **Ending:** **12/31/20**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $21,920**

(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. $ **6,118** 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 5/1/2008

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **307,043**
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. $ **21,777** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ ______

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