

Facility Name & ID Number Warren Park Health & Living Center

0050070 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>51</u>	Skilled (SNF)	<u>51</u>	<u>18,666</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>76</u>	Intermediate (ICF)	<u>76</u>	<u>27,816</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>127</u>	TOTALS	<u>127</u>	<u>46,482</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	<u>3,630</u>		<u>2,462</u>	<u>6,092</u>	8	
9	SNF/PED					9	
10	ICF	<u>36,183</u>	<u>512</u>	<u>265</u>	<u>36,960</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>39,813</u>	<u>512</u>	<u>2,727</u>	<u>43,052</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.62%

D. How many bed-hold days during this year were paid by the Department? 145 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 51 and days of care provided 2,462

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Warren Park Health & Living Center # 0050070 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	6,286	595,112		601,398		601,398		601,398		1
2	Food Purchase		5,414		5,414	(933)	4,481	(1)	4,480		2
3	Housekeeping	146,046	30,112		176,158		176,158		176,158		3
4	Laundry	54,470	8,659		63,129		63,129		63,129		4
5	Heat and Other Utilities			95,724	95,724		95,724	(4,639)	91,085		5
6	Maintenance	50,134	34,232	51,379	135,745		135,745	34,315	170,060		6
7	Other (specify):*							988	988		7
8	TOTAL General Services	256,936	673,529	147,103	1,077,568	(933)	1,076,635	30,663	1,107,298		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	1,307,066	55,232	23,527	1,385,825		1,385,825	(585)	1,385,240		10
10a	Therapy	67,080			67,080		67,080		67,080		10a
11	Activities	245,983	10,904	2,400	259,287		259,287		259,287		11
12	Social Services			3,756	3,756		3,756		3,756		12
13	CNA Training										13
14	Program Transportation			65	65		65		65		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,620,129	66,136	33,948	1,720,213		1,720,213	(585)	1,719,628		16
	C. General Administration										
17	Administrative	96,239			96,239		96,239	132,753	228,992		17
18	Directors Fees										18
19	Professional Services			172,812	172,812	(11,660)	161,152	(98,053)	63,099		19
20	Dues, Fees, Subscriptions & Promotions			40,870	40,870		40,870	(22,290)	18,580		20
21	Clerical & General Office Expenses	76,625	776	338,634	416,035		416,035	(234,578)	181,457		21
22	Employee Benefits & Payroll Taxes			418,837	418,837	933	419,770		419,770		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,466	4,466		4,466	2,833	7,299		24
25	Other Admin. Staff Transportation			11,130	11,130		11,130	77	11,207		25
26	Insurance-Prop.Liab.Malpractice			95,609	95,609		95,609	10,057	105,666		26
27	Other (specify):*							33,453	33,453		27
28	TOTAL General Administration	172,864	776	1,082,358	1,255,998	(10,727)	1,245,271	(175,748)	1,069,523		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,049,929	740,441	1,263,409	4,053,779	(11,660)	4,042,119	(145,670)	3,896,449		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Health & Living Center #0050070 Report Period Beginning: 01/01/12 Ending: 12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			66,065	66,065		66,065	63,637	129,702			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,110	17,110		17,110	71,087	88,197			32
33	Real Estate Taxes			82,709	82,709	11,660	94,369	3,964	98,333			33
34	Rent-Facility & Grounds			453,058	453,058		453,058	(453,058)				34
35	Rent-Equipment & Vehicles			21,360	21,360		21,360	(5,453)	15,907			35
36	Other (specify):*											36
37	TOTAL Ownership			640,302	640,302	11,660	651,962	(319,823)	332,139			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,055	261,322	319,377		319,377	(223)	319,154			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			497,113	497,113		497,113	(181,019)	316,094			42
43	Other (specify):*	83,529		1,178	84,707		84,707	(84,707)				43
44	TOTAL Special Cost Centers	83,529	58,055	759,613	901,197		901,197	(265,949)	635,248			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,133,458	798,496	2,663,324	5,595,278		5,595,278	(731,441)	4,863,837			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	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	(5,864)	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	(65,814)	30		9
10	Interest and Other Investment Income	(161)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(400)	21		18
19	Entertainment				19
20	Contributions	(2,100)	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	(220,254)	21		24
25	Fund Raising, Advertising and Promotional	(14,992)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(115)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(418,907)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (728,607)		\$	30

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	2	
		Amount	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)	(2,834)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,834)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (731,441)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Warren Park Health & Living Center

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Loss on Vehicle	\$ (7,476)	06	1
2	Bank Charges	(2,803)	21	2
3	Marketing Travel	(1,178)	43	3
4	Cope Dues	(5,962)	20	4
5	Building Co. - Franchise Tax	(250)	21	5
6	Building Co. - Accounting Fees	(1,250)	19	6
7	Building Co. - Legal Fees	(3,050)	19	7
8	Building Co. - Closing Costs	(30,423)	36	8
9	Building Co. - Amortization - Loan Costs	(12,755)	31	9
10	Non Allowable Salary	(12,200)	43	10
11	Non Allowable Legal	(315)	19	11
12	Non Allowable Auto Lease	(15,598)	35	12
13	PPA - Medical Supplies	(585)	10	13
14	Additional R&M	23,956	06	14
15	Marketing Salary	(71,329)	43	15
16	Building Co. - Bank Charges	(45)	21	16
17	Building Co. - Amortization - Goodwill	(5,209)	31	17
18	PPA - Other Professional Fees	(9,233)	19	18
19	PPA - Office Expenses	(82,183)	21	19
20	PPA - IL Provider Tax	(181,019)	42	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	(418,907)		49

Warren Park Health & Living Center

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

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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Park Health & Living Center# 0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1)											(1)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,864)		1,225									(4,639)	5
6	Maintenance	16,480		10,524	7,311								34,315	6
7	Other (specify):*			225		763							988	7
8	TOTAL General Services	10,615		11,974	7,311	763							30,663	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(585)											(585)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(585)											(585)	16
	C. General Administration													
17	Administrative				132,753								132,753	17
18	Directors Fees													18
19	Professional Services	(13,848)	4,300	(88,505)									(98,053)	19
20	Fees, Subscriptions & Promotions	(23,054)		764									(22,290)	20
21	Clerical & General Office Expenses	(306,050)	295	61,656	9,521								(234,578)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,833									2,833	24
25	Other Admin. Staff Transportation			77									77	25
26	Insurance-Prop.Liab.Malpractice		10,057										10,057	26
27	Other (specify):*			11,893		21,560							33,453	27
28	TOTAL General Administration	(342,952)	14,652	(11,282)	142,274	21,560							(175,748)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(332,922)	14,652	692	149,585	22,323							(145,670)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Park Health & Living Center# 0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(65,814)	126,357	3,094									63,637	30
31	Amortization of Pre-Op. & Org.	(17,964)	17,964											31
32	Interest	(161)	67,618	3,630									71,087	32
33	Real Estate Taxes			3,964									3,964	33
34	Rent-Facility & Grounds		(453,058)										(453,058)	34
35	Rent-Equipment & Vehicles	(15,598)		10,145									(5,453)	35
36	Other (specify):*	(30,423)	30,423											36
37	TOTAL Ownership	(129,960)	(210,696)	20,833									(319,823)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(223)						(223)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(181,019)											(181,019)	42
43	Other (specify):*	(84,707)											(84,707)	43
44	TOTAL Special Cost Centers	(265,726)					(223)						(265,949)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(728,607)	(196,044)	21,525	149,585	22,323	(223)						(731,441)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 453,058	Warren Park Property	100.00%	\$	(453,058)	1
2	V	Real Estate Taxes	116,526	Warren Park Property	100.00%	2,291	(114,235)	2
3	V	32 Interest Expense		Warren Park Property	100.00%	67,618	67,618	3
4	V	21 Franchise Tax		Warren Park Property	100.00%	250	250	4
5	V	19 Accounting Fees		Warren Park Property	100.00%	1,250	1,250	5
6	V	19 Legal Fees		Warren Park Property	100.00%	3,050	3,050	6
7	V	30 Depreciation Expense		Warren Park Property	100.00%	126,357	126,357	7
8	V	36 Closing Costs		Warren Park Property	100.00%	30,423	30,423	8
9	V	31 Amortization - Loan Costs		Warren Park Property	100.00%	12,755	12,755	9
10	V	26 Insurance Expense		Warren Park Property	100.00%	10,057	10,057	10
11	V	21 Bank Charges		Warren Park Property	100.00%	45	45	11
12	V	31 Amortization - Goodwill		Warren Park Property	100.00%	5,209	5,209	12
13	V							13
14	Total		\$ 569,584			\$ 259,305	\$ * (310,279)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,225	\$	1,225	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	10,524		10,524	16
17	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	225		225	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	1,495		1,495	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	764		764	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	61,656		61,656	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	2,833		2,833	21
22	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	77		77	22
23	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	11,893		11,893	23
24	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	3,094		3,094	24
25	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	3,630		3,630	25
26	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	3,964		3,964	26
27	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	9,790		9,790	27
28	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	355		355	28
29	V								29
30	V								30
31	V								31
32	V	19 HOME OFFICE	90,000	DYNAMIC HEALTH CARE CONS.				(90,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 90,000			\$ 111,525	\$ *	21,525	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 7,311	\$	7,311	15
16	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	21,912		21,912	16
17	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	24,893		24,893	17
18	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				18
19	V	17 ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	18,467		18,467	21
22	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	18,930		18,930	22
23	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	5,885		5,885	24
25	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	22,942		22,942	25
26	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	19,724		19,724	26
27	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	9,347		9,347	27
28	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	174		174	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		\$			\$ 149,585	\$ *	149,585	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 763	\$	763	15
16	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	1,188		1,188	16
17	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,718		1,718	17
18	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				18
19	V	27 EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	5,944		5,944	21
22	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	1,328		1,328	22
23	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,011		1,011	24
25	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	6,149		6,149	25
26	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,470		2,470	26
27	V	27 EMP. BEN.- S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,737		1,737	27
28	V	27 EMP. BEN.- E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	15		15	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		\$			\$ 22,323	\$ *	22,323	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 DME and Medical Supplies	1,211	Integra Healthcare Equipment	100.00%	988	\$ (223)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,211			\$ 988	\$ * (223)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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	DEVORA GOLDSTEIN	8.000%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	WARREN PARK, LLC		BUILDING CO.	1
2	EVAN M. STERN 2005 TRUST	8.000%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULT	2
3	ILANA D. AARON 2008 MINORITY TRUST	8.000%	OTTAWA PAVILION, LTD.	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	JONATHAN B. STERN 2001 TRUST	30.000%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	4
5	JONATHAN H. AARON 2008 TRUST	38.000%	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	TODD A. STERN 2001 TRUST	8.000%	WATERFRONT TERRACE, INC.	CHICAGO				6
7			WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				7
8			WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				8
9			WOODBRIIDGE NURSING PAVILION, LTD.	CHICAGO				9
10			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (SLR GALESBURG)					10
11			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLR GENESEO)					11
12			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLR PONTIAC)					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

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 Health & Living Center # 0050070 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Maury Aaron	Relative	Administrative	0.00	See Attached	4.98	9.96%	Alloc. Salary	\$ 24,893	17-7	1	
2	Sharon Aaron	Relative	Clerical	0.00	See Attached	4.38	10.95%	Alloc. Salary	9,347	21-7	2	
3	Jonathon Aaron	Relative	Administrative	0.00	See Attached	40	100.00%	Salary	91,821	17-1	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	\$ 126,061		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	413,728	13	\$ 11,773	\$ 43,052	\$ 1,225	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	43,052	10,524	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	413,728	13	2,165	43,052	225	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369	43,052	1,495	4	
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,728	13	7,338	43,052	764	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	43,052	61,656	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227	43,052	2,833	7	
8	25	AUTO EXP.	PATIENT DAYS	413,728	13	736	43,052	77	8	
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,728	13	114,290	43,052	11,893	9	
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732	43,052	3,094	10	
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887	43,052	3,630	11	
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096	43,052	3,964	12	
13	35	AUTO RENTAL	PATIENT DAYS	413,728	13	94,085	43,052	9,790	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415	43,052	355	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,071,756	\$ 456,183	\$ 111,525	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	58,740	58,740	4.98	7,311	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	4.38	21,912	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	4.98	24,893	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	47,000	47,000	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	52,765	52,765	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	102,086	102,086	-		6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	73,867	73,867	7.50	18,467	7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	152,170	152,170	6.22	18,930	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	8	117,701	117,701	2.00	5,885	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	184,393	184,393	5.60	22,942	11
12	17	ADMIN. CMP. - CFO (NON-OW)	WGHTD. AVG. HOURS	45	10	180,028	180,028	4.93	19,724	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	85,386	85,386	4.38	9,347	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	15,265	15,265	0.32	174	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,481,401	\$ 1,481,401		\$ 149,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,127	4.98	763	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,847	4.38	1,188	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	13,801	4.98	1,718	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	36,183			4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,278			5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,829			6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	23,776	7.50	5,944	7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,672	6.22	1,328	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,076			9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	8	20,219	2.00	1,011	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	49,423	5.60	6,149	11
12	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	45	10	22,545	4.93	2,470	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,870	4.38	1,737	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	1,340	0.32	15	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 253,986	\$	\$ 22,323	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Integra Healthcare Equipment, LLC
 Street Address 747 Church Road
 City / State / Zip Code Elmhurst, IL
 Phone Number (630) 834-3700
 Fax Number (630) 834-1500

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	DME and Medical Supplies	Direct Allocation					988	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				\$	\$		\$ 988	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	MB Financial		X	Note Payable			\$	\$ 4,854,813		\$ 67,618	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	MB Financial		X	Line of Credit				1,234,000		14,439	6								
7	Pharmacy Note		X	Note Payable				14,221		1,275	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 6,103,034		\$ 83,332	9								
B. Non-Facility Related*																			
10	Interest Income		X							(161)	10								
11	Allocated from Dynamic		X							3,630	11								
12	Vehicle Interest		X							1,396	12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ 4,865	14								
15	TOTALS (line 9+line14)						\$	\$ 6,103,034		\$ 88,197	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	86,000		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.)		\$	87,672		2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,672		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	85,000		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.)		\$	11,660		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 \$ 11,167 For 09/10 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.		\$	98,332		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	107,372	8	FOR BHF USE ONLY	
	2008	108,449	9	13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
	2009	80,552	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2010	84,058	11	15	LESS REFUND FROM LINE 6 \$ 15
	2011	83,708	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2012 Accrual = \$83,708 x 1.02 = \$85,000 (Rounded)					
Allocated from Dynamic HC Consultants - \$3,964					

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Health & Living Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050070

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11-31-302-008-0000</u>	<u>Long-Term Care Facility</u>	\$ <u>32,885.38</u>	\$ <u>32,885.38</u>
2.	<u>11-31-302-043-0000</u>	<u>Long-Term Care Facility</u>	\$ <u>50,823.36</u>	\$ <u>50,823.36</u>
3.	<u>10-23-404-059-0000</u>	<u>Allocated from Dynamic</u>	\$ <u>37,266.21</u>	\$ <u>3,877.87</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>120,974.95</u></u>	\$ <u><u>87,586.61</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 158,750</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 158,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	127	2008	1969	\$ 2,698,750	\$ 126,357	39	\$ 69,199	\$ (57,158)	\$ 1,213,863	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1990	177,699		20			177,689	9
10	Various		1991	40,276		20			40,267	10
11	Various		1992	26,271		20	316	316	26,265	11
12	Various		1993	39,480		20	1,920	1,920	37,800	12
13	Various		1994	61,455		20	3,073	3,073	56,276	13
14	Various		1995	53,672		20	2,684	2,684	47,359	14
15	Various		1996	5,720		20	286	286	4,778	15
16	Various		1997	31,153		20	1,558	1,558	24,384	16
17	Various		1998	142,888		20	7,144	7,144	103,146	17
18	Various		1999	22,019		20	1,101	1,101	14,818	18
19	Various		2000	160,109		20	7,883	7,883	98,824	19
20	Various		2001	19,312		20	583	583	13,036	20
21	Various		2002	10,360		20	433	433	10,360	21
22	Various		2003	29,173		20	2,596	2,596	24,816	22
23	Various		2004	15,972		20	1,597	1,597	13,495	23
24	Various		2005	5,259		20	526	526	4,035	24
25	Various		2006	13,841		20	1,614	1,614	10,600	25
26	Various		2007	13,027		20	1,213	1,213	6,632	26
27	Various		2008	36,795		20	3,766	3,766	20,983	27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67	Related Building Company (Pages 12F & 12G)						
68	Related Party Allocations (Pages 12H & 12I)	46,160	1,184		1,319	135	25,498
69	Financial Statement Depreciation		66,065			(66,065)	
70	TOTAL (lines 4 thru 69)	\$ 3,649,390	\$ 193,606		\$ 108,810	\$ (84,796)	\$ 1,974,923

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,649,390	\$ 193,606		\$ 108,810	\$ (84,796)	\$ 1,974,923	1
2	Chicago Elevator	2009	3,950		20	68	68	350	2
3	Outside Roofing	2009	4,750		20	81	81	370	3
4	Canopy Buildot	2009	8,750		20	150	150	664	4
5	Elevator Repair And Motor	2011	5,015		20	86	86	230	5
6	Pipes And Heating	2011	3,790		20	65	65	142	6
7	Security System	2011	3,095		20	413	413	877	7
8	Freezer Repair	2011	3,050		20	52	52	101	8
9	Windows Replacement	2011	4,200		20	72	72	139	9
10	Outside Room Roofing	2011	35,360		20	604	604	944	10
11	Elevator Work	2011	13,785		20	511	511	831	11
12	Sprinkler System Repair	2012	5,947		20	297	297	297	12
13	Bathroom Remodeling-Fixtures, Tiles, Plumbing, Labor	2012	9,463		20	473	473	473	13
14	Condensor & Evaporator	2012	3,589		20	179	179	179	14
15	Security System	2012	3,010		20	151	151	151	15
16	Remove And Install Mixing Valves	2012	4,388		20	219	219	219	16
17	2Nd Floor Remodels- Wallpaper, Painting, Electrical	2012	7,540		20	377	377	377	17
18	Wall And Fence Buildup	2012	5,051		20	253	253	253	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,774,123	\$ 193,606		\$ 112,860	\$ (80,746)	\$ 1,981,521	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Dynamic Health Care Consultants	1993	46,160	1,184	35	1,319	135	25,498	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 46,160	\$ 1,184		\$ 1,319	\$ 135	\$ 25,498	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	\$ 131,610	\$	\$ 8,055	\$ 8,055	10	\$ 100,821	71
72	Current Year Purchases	48,787	335	4,879	4,544	10	4,879	72
73	Fully Depreciated Assets	529,410		30	30	10	529,308	73
74								74
75	TOTALS	\$ 709,807	\$ 335	\$ 12,964	\$ 12,629		\$ 635,009	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	\$	\$	\$	5	\$ 21,583	76
77		1999 Lexus RX300	2003	16,000				5	16,000	77
78		Allocated from Dynamic	2012	26,110	1,576	3,879	2,303	5	7,367	78
79										79
80	TOTALS			\$ 63,693	\$ 1,576	\$ 3,879	\$ 2,303		\$ 44,950	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)	\$ 4,706,373	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 129,703	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,814)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,661,480	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		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,117 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Dynamic</u>		\$	\$ <u>9,790</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>9,790</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	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	\$		\$ 107,917	\$		\$ 107,917	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,728			36,728	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			116,677			116,677	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				46,676		46,676	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Supplemental</u>						11,379		11,379	13
14	TOTAL			\$		\$ 261,322	\$ 58,055		\$ 319,377	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/12**

(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	\$ 182,806	\$ 289,223	1
2	Cash-Patient Deposits	58,293	58,293	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,394,531	2,394,531	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,863	69,863	6
7	Other Prepaid Expenses	8,082	8,082	7
8	Accounts Receivable (owners or related parties)	685,921	685,921	8
9	Other(specify): See Attached Schedule	400,233	438,387	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,799,729	\$ 3,944,300	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,750	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	256,896	256,896	15
16	Equipment, at Historical Cost	59,046	376,546	16
17	Accumulated Depreciation (book methods)	(139,309)	(1,601,475)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	25,369	1,155,855	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 202,002	\$ 3,045,322	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,001,731	\$ 6,989,622	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 351,181	\$ 1,044,376	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,996	58,996	28
29	Short-Term Notes Payable	1,248,221	1,248,221	29
30	Accrued Salaries Payable	155,187	155,187	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,798	7,798	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,000	85,000	32
33	Accrued Interest Payable	2,078	2,078	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,908,461	\$ 2,601,656	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		4,854,813	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,854,813	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,908,461	\$ 7,456,469	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,093,270	\$ (466,847)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,001,731	\$ 6,989,622	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,509,985	1
2	Restatements (describe):		2
3	Rouding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,509,983	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	914,585	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	(348,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Member's Capital	17,102	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 583,287	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,093,270	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center

0050070

Report Period Beginning: 01/01/12

Ending:

12/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,193,402	1
2	Discounts and Allowances for all Levels	(841,028)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,352,374	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	842,890	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 842,890	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	68,612	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,079	19
20	Radiology and X-Ray	730	20
21	Other Medical Services	12,850	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 89,271	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	161	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 161	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	225,167	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 225,167	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,509,863	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,077,568	31
32	Health Care	1,720,213	32
33	General Administration	1,255,998	33
B. Capital Expense			
34	Ownership	640,302	34
C. Ancillary Expense			
35	Special Cost Centers	404,084	35
36	Provider Participation Fee	497,113	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,595,278	40
41	Income before Income Taxes (line 30 minus line 40)**	914,585	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 914,585	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,019,505	44
45	Private Pay - Net Inpatient Revenue	62,465	45
46	Medicare - Net Inpatient Revenue	269,930	46
47	Other-(specify) <u>Hospice</u>	474	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,352,374	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Warren Park Health & Living Center**

0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	2,038	2,203	\$ 111,038	\$ 50.40	1
2	Assistant Director of Nursing	2,276	2,529	83,435	32.99	2
3	Registered Nurses	5,348	5,683	156,880	27.61	3
4	Licensed Practical Nurses	15,736	17,519	417,541	23.83	4
5	CNAs & Orderlies	48,103	51,543	518,862	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,174	5,523	67,080	12.15	8
9	Activity Director	2,986	3,185	60,435	18.97	9
10	Activity Assistants	14,311	15,277	185,548	12.15	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	41	46	906	19.70	13
14	Head Cook	207	230	3,284	14.28	14
15	Cook Helpers/Assistants	254	281	2,096	7.46	15
16	Dishwashers					16
17	Maintenance Workers	2,055	2,363	50,134	21.22	17
18	Housekeepers	12,262	13,734	146,046	10.63	18
19	Laundry	4,926	5,391	54,470	10.10	19
20	Administrator	2,038	2,091	96,239	46.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,144	2,280	41,278	18.10	23
24	Clerical	1,752	1,866	35,347	18.94	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	1,838	1,916	19,310	10.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,489	2,651	83,529	31.51	33
34	TOTAL (lines 1 - 33)	125,978	136,311	\$ 2,133,458 *	\$ 15.65	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	84	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	96	3,200	10-03	38
39	Pharmacist Consultant	96	8,327	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	49	2,400	11-03	44
45	Social Service Consultant	65	3,756	12-03	45
46	Other(specify)				46
47	<u>Psychiatric Consultant</u>	234	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	624	\$ 33,883		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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Jonathan Aaron	Administrator	0%	\$ 91,821	Workers' Compensation Insurance	\$ 74,007	IDPH License Fee	\$			
Vickie Davis	Administrator	0%	4,418	Unemployment Compensation Insurance	38,410	Advertising: Employee Recruitment	25			
				FICA Taxes	160,914	Health Care Worker Background Check	4,430			
				Employee Health Insurance	135,947	(Indicate # of checks performed <u>443</u>)				
				Employee Meals	933	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,337			
				Chicago Head Tax	1,932	Licenses & Permits	6,024			
				Other Employee Benefits	7,626	Allocated from Dynamic	764			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,239	TOTAL (agree to Schedule V, line 22, col.8)			\$ 419,769	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,580
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel			
							Seminar Expense	4,466		
							Allocated from Dynamic	2,833		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		\$ 7,299
C. Professional Services										
Vendor/Payee	Type		Amount							
Personnel Planners	Unemployment Consultant		\$ 1,410							
First Real Estate Services	Appraisal Fee		2,750							
Frost, Ruttenberg, & Rothblatt	Accounting		28,741							
Dynamic HC Consultants	Bookkeeping		90,000							
Various	Legal		22,817							
Health Data Systems	Data Processing		17,245							
Adj. on Page 5A	Legal		315							
eHealth Data Solutions	Data Processing		300							
Adj. on Page 5A	Other Professional		9,233							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 172,811							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2007					FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Health & Living Center# 0050070

Report Period Beginning:

01/01/12

Ending:

12/31/12**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. ILCLTC - \$12,573
- (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. \$ 2,248 Line 10-02
- (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 Pavillion #30036079 05/01/2008
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 316,094
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? N/A
- (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. \$ 933 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT