



Facility Name & ID Number Warren Park Health & Living Center

# 0050070 Report Period Beginning: 01/01/15 Ending: 12/31/15

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>18,615</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>76</u>	Intermediate (ICF)	<u>76</u>	<u>27,740</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>46,355</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
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	<u>1,024</u>		<u>5,300</u>	<u>6,324</u>	8
9	SNF/PED					9
10	ICF	<u>36,914</u>	<u>326</u>	<u>151</u>	<u>37,391</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,938</u>	<u>326</u>	<u>5,451</u>	<u>43,715</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.30%

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

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

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

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

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 5,300

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Warren Park Health & Living Center # 0050070 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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
	<b>A. General Services</b>										
1	Dietary			323,856	323,856		323,856		323,856		1
2	Food Purchase		287,418		287,418	(22,119)	265,299	(87)	265,212		2
3	Housekeeping		3,050	190,502	193,552		193,552	6,238	199,790		3
4	Laundry			126,052	126,052		126,052		126,052		4
5	Heat and Other Utilities			129,258	129,258		129,258	(4,841)	124,417		5
6	Maintenance	72,038	58,357	58,007	188,402		188,402	6,822	195,224		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	72,038	348,825	827,675	1,248,538	(22,119)	1,226,419	8,132	1,234,551		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	1,351,921	60,162	21,331	1,433,414		1,433,414	18,934	1,452,348		10
10a	Therapy	50,334			50,334		50,334		50,334		10a
11	Activities	101,354	40,031	2,448	143,833		143,833		143,833		11
12	Social Services	298,499		5,155	303,654		303,654		303,654		12
13	CNA Training										13
14	Program Transportation			1,153	1,153		1,153		1,153		14
15	Other (specify):*							1,798	1,798		15
16	<b>TOTAL Health Care and Programs</b>	1,802,108	100,193	34,287	1,936,588		1,936,588	20,732	1,957,320		16
	<b>C. General Administration</b>										
17	Administrative	109,485		398,553	508,038		508,038	(322,682)	185,356		17
18	Directors Fees										18
19	Professional Services			199,541	199,541	(2,970)	196,571	(30,069)	166,502		19
20	Dues, Fees, Subscriptions & Promotions			38,071	38,071		38,071	31,908	69,979		20
21	Clerical & General Office Expenses	70,195	1,327	750,699	822,221		822,221	(470,199)	352,022		21
22	Employee Benefits & Payroll Taxes			446,978	446,978	22,119	469,097		469,097		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,360	10,360		10,360	(5,566)	4,794		24
25	Other Admin. Staff Transportation			19,331	19,331		19,331	(2,169)	17,162		25
26	Insurance-Prop.Liab.Malpractice			151,459	151,459		151,459	18,209	169,668		26
27	Other (specify):*							18,210	18,210		27
28	<b>TOTAL General Administration</b>	179,680	1,327	2,014,992	2,195,999	19,149	2,215,148	(762,359)	1,452,789		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,053,826	450,345	2,876,954	5,381,125	(2,970)	5,378,155	(733,496)	4,644,659		29

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

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

Facility Name &amp; ID Number

Warren Park Health &amp; Living Center

#0050070

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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			100,337	100,337		100,337	83,675	184,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,040	43,040		43,040	241,188	284,228			32
33	Real Estate Taxes					2,970	2,970	651	3,621			33
34	Rent-Facility & Grounds			611,000	611,000		611,000	(564,226)	46,774			34
35	Rent-Equipment & Vehicles			30,756	30,756		30,756	(10,274)	20,482			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			785,133	785,133	2,970	788,103	(248,986)	539,117			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,361	601,789	710,150		710,150		710,150			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			302,444	302,444		302,444		302,444			42
43	Other (specify):*	55,502		3,416	58,918		58,918	(58,918)	0			43
44	<b>TOTAL Special Cost Centers</b>	55,502	108,361	907,649	1,071,512		1,071,512	(58,918)	1,012,594			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,109,328	558,706	4,569,736	7,237,770		7,237,770	(1,041,399)	6,196,371			45

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



Warren Park Health & Living Center

ID# 0050070

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Non-Allowable Travel	\$ (5,180)	25	1
2	Vending Income	(66)	02	2
3	Squestration Expense	(25,177)	21	3
4	Marketing	(3,416)	43	4
5	Bank Charges	(5,160)	21	5
6	Building Company - Accounting Fees	(4,200)	19	6
7	Building Company - Legal Fees	(500)	19	7
8	Building Company - Bank Fees	(1,059)	21	8
9	Building Company - Amortization	(54,751)	36	9
10	Seminar	99	24	10
11	Non-Allowable Auto Lease	(14,067)	35	11
12	PAC Dues	(4,359)	20	12
13	Annual Report	(500)	20	13
14	Non-Allowable Seminar	(5,665)	24	14
15	Non-Allowable Legal	(1,850)	19	15
16	Capitalized R&M	(11,603)	06	16
17	Additional R&M	14,122	06	17
18	Marketing Salary	(55,502)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(178,832)		49

Warren Park Health & Living Center

ID# 0050070  
 Report Period Beginning: 01/01/15  
 Ending: 12/31/15

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	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	(87)											(87)	2
3	Housekeeping			6,238									6,238	3
4	Laundry													4
5	Heat and Other Utilities	(8,579)		3,738									(4,841)	5
6	Maintenance	2,519		4,303									6,822	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(6,147)</b>		<b>14,279</b>									<b>8,132</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			18,934									18,934	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,798									1,798	15
16	<b>TOTAL Health Care and Programs</b>			<b>20,732</b>									<b>20,732</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(322,682)									(322,682)	17
18	Directors Fees													18
19	Professional Services	(6,550)	4,700	(28,219)									(30,069)	19
20	Fees, Subscriptions & Promotions	(6,772)		38,679									31,908	20
21	Clerical & General Office Expenses	(707,375)	1,059	236,117									(470,199)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,566)											(5,566)	24
25	Other Admin. Staff Transportation	(5,180)		3,011									(2,169)	25
26	Insurance-Prop.Liab.Malpractice			18,209									18,209	26
27	Other (specify):*			18,210									18,210	27
28	<b>TOTAL General Administration</b>	<b>(731,442)</b>	<b>5,759</b>	<b>(36,676)</b>									<b>(762,359)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(737,590)</b>	<b>5,759</b>	<b>(1,665)</b>									<b>(733,496)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	(94,207)	177,882										83,675	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,094)	235,891	7,391									241,188	32
33	Real Estate Taxes		651										651	33
34	Rent-Facility & Grounds		(611,000)	46,774									(564,226)	34
35	Rent-Equipment & Vehicles	(14,067)		3,793									(10,274)	35
36	Other (specify):*	(54,751)	54,751											36
37	<b>TOTAL Ownership</b>	<b>(165,119)</b>	<b>(141,825)</b>	<b>57,958</b>									<b>(248,986)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(58,918)											(58,918)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(58,918)</b>											<b>(58,918)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(961,626)</b>	<b>(136,066)</b>	<b>56,293</b>									<b>(1,041,399)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental	\$ 611,000	Warren Park Property, LLC	100.00%	\$	(611,000)	1
2	V	32 Interest	57	Warren Park Property, LLC	100.00%	235,948	235,891	2
3	V	33 Real Estate Taxes		Warren Park Property, LLC	100.00%	651	651	3
4	V	19 Accounting Fees		Warren Park Property, LLC	100.00%	4,200	4,200	4
5	V	19 Legal Fees		Warren Park Property, LLC	100.00%	500	500	5
6	V	21 Bank Fees		Warren Park Property, LLC	100.00%	1,059	1,059	6
7	V	30 Depreciation		Warren Park Property, LLC	100.00%	177,882	177,882	7
8	V	36 Amortization		Warren Park Property, LLC	100.00%	54,751	54,751	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 611,057			\$ 474,991	\$ * (136,066)	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	3 <u>Housekeeping</u>		<u>Damen Healthcare Group</u>	100.00%	6,238	\$	6,238	15
16	V	5 <u>Utilities</u>		<u>Damen Healthcare Group</u>	100.00%	3,738		3,738	16
17	V	6 <u>Repairs &amp; Maintenance</u>		<u>Damen Healthcare Group</u>	100.00%	4,303		4,303	17
18	V	10 <u>Clinical Salaries</u>		<u>Damen Healthcare Group</u>	100.00%	18,934		18,934	18
19	V	15 <u>Clinical Benefits</u>		<u>Damen Healthcare Group</u>	100.00%	1,798		1,798	19
20	V	17 <u>Administrative</u>		<u>Damen Healthcare Group</u>	100.00%	75,871		75,871	20
21	V	19 <u>Professional Fees</u>		<u>Damen Healthcare Group</u>	100.00%	17,753		17,753	21
22	V	20 <u>Dues &amp; Subscriptions</u>		<u>Damen Healthcare Group</u>	100.00%	38,679		38,679	22
23	V	21 <u>Administrative and General</u>		<u>Damen Healthcare Group</u>	100.00%	50,610		50,610	23
24	V	21 <u>Salaries- Administrative &amp; General</u>		<u>Damen Healthcare Group</u>	100.00%	185,507		185,507	24
25	V	25 <u>Travel</u>		<u>Damen Healthcare Group</u>	100.00%	3,011		3,011	25
26	V	26 <u>Insurance</u>		<u>Damen Healthcare Group</u>	100.00%	18,209		18,209	26
27	V	27 <u>Employee Benefits</u>		<u>Damen Healthcare Group</u>	100.00%	18,210		18,210	27
28	V	32 <u>Interest Expense</u>		<u>Damen Healthcare Group</u>	100.00%	7,391		7,391	28
29	V	34 <u>Rent- Facility</u>		<u>Damen Healthcare Group</u>	100.00%	46,774		46,774	29
30	V	35 <u>Rent- Equipment</u>		<u>Damen Healthcare Group</u>	100.00%	3,793		3,793	30
31	V								31
32	V	19 <u>Home Office Expense</u>	45,972	<u>Damen Healthcare Group</u>	100.00%			(45,972)	32
33	V	17 <u>Management Fees</u>	398,553	<u>Damen Healthcare Group</u>	100.00%			(398,553)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 444,525			\$ 500,818	\$ *	56,293	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number Warren Park Health & Living Center # 0050070 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Jonathan Aaron	Relative	Administrative	0%	See Attached	37.94	94.85%	Al Mgmt Fee	\$ 75,871	17-7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 75,871		13	

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

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

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Name of Related Organization Damen Healthcare Group  
 Street Address 5611 Dempster Street  
 City / State / Zip Code Morton Grove, IL 60053  
 Phone Number (224) 470-2044  
 Fax Number ( )

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	3	Housekeeping	Total Expenses	2	\$ 6,577	\$	7,237,772	\$ 6,238	1
2	5	Utilities	Total Expenses	2	3,942		7,237,772	3,738	2
3	6	Repairs & Maintenance	Total Expenses	2	4,538		7,237,772	4,303	3
4	10	Clinical Salaries	Total Expenses	2	19,964	19,964	7,237,772	18,934	4
5	15	Clinical Benefits	Total Expenses	2	1,896		7,237,772	1,798	5
6	17	Administrative	Total Expenses	2	80,000		7,237,772	75,871	6
7	19	Professional Fees	Total Expenses	2	18,719		7,237,772	17,753	7
8	20	Dues & Subscriptions	Total Expenses	2	40,785		7,237,772	38,679	8
9	21	Administrative and General	Total Expenses	2	53,365		7,237,772	50,610	9
10	21	Salaries- Administrative & General	Total Expenses	2	195,603	195,603	7,237,772	185,507	10
11	25	Travel	Total Expenses	2	3,174		7,237,772	3,011	11
12	26	Insurance	Total Expenses	2	19,200		7,237,772	18,209	12
13	27	Employee Benefits	Total Expenses	2	19,201		7,237,772	18,210	13
14	32	Interest Expense	Total Expenses	2	7,793		7,237,772	7,391	14
15	34	Rent- Facility	Total Expenses	2	49,320		7,237,772	46,774	15
16	35	Rent- Equipment	Total Expenses	2	3,999		7,237,772	3,793	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 528,076	\$ 215,567		\$ 500,819	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/15

Ending:

12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MB Financial		X	Mortgage			\$	\$ 6,960,000		\$ 213,781	1									
2	MB Financial		X	Junior Note - Refinance				1,740,000		22,167	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit				970,000		43,040	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 9,670,000		\$ 278,987	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(2,094)	10									
11	Interest Income - Bldg. Co		X							(57)	11									
12	Allocated Damen Healthcare	X								7,391	12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 5,240	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 9,670,000		\$ 284,227	15									

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

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

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

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

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

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$	<b>136,000</b>		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.)		\$	<b>136,651</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>651</b>		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>2,970</b>		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>3,621</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<b>84,058</b>			8
	2011	<b>83,708</b>			9
	2012	<b>132,164</b>			10
	2013	<b>133,953</b>			11
	2014	<b>136,651</b>			12
<b>No Accrual</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2014	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

**NOTES:**

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





Facility Name & ID Number Warren Park Health & Living Center

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**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>2012</u>	<u>\$ 158,750</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 158,750</b>	<b>3</b>

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	\$ 177,882	39	\$ 69,199	\$ (108,683)	\$ 1,421,460	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1990	177,699		20			177,689	9
10	Various		1991	40,276		20			40,267	10
11	Various		1992	26,271		20			26,265	11
12	Various		1993	39,480		20			39,479	12
13	Various		1994	61,455		20	6	6	61,455	13
14	Various		1995	53,672		20	947	947	53,671	14
15	Various		1996	5,720		20	370	370	5,720	15
16	Various		1997	31,153		20	1,558	1,558	29,057	16
17	Various		1998	110,159		20	5,508	5,508	96,009	17
18	Various		1999	22,019		20	1,101	1,101	18,121	18
19	Various		2000	131,428		20	7,838	7,838	121,788	19
20	Various		2001	19,312		20	583	583	14,784	20
21	Various		2002	10,360		20			10,360	21
22	Various		2003	29,173		20	321	321	26,817	22
23	Various		2004	15,972		20			15,972	23
24	Various		2005	5,259		20	173	173	5,259	24
25	Various		2006	13,841		20	756	756	13,227	25
26	Various		2007	13,027		20	945	945	9,551	26
27	Various		2008	36,795		20	2,585	2,585	30,949	27
28	Various		2009	17,450		20	1,098	1,098	6,713	28
29	Various		2011	68,295		20	2,627	2,627	11,060	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			267,197		13,360	13,360	13,360	68
69				100,337		(100,337)		69
70		\$	3,894,762	\$	108,973	\$	2,249,032	70

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

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# 0050070

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## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,894,762	\$ 278,219		\$ 108,973	\$ (169,246)	\$ 2,249,032	1
2	Sprinkler System Repair	2012	5,947		20	595	595	1,834	2
3	Bathroom Remodeling-Fixtures, Tiles, Plumbing, Labor	2012	9,463		20	946	946	2,918	3
4	Condensor & Evaporator	2012	3,589		20	359	359	1,107	4
5	Basement, 2Nd Floor-Replace Key Pad, Run Wire, Install Speaker	2012	3,010		20	301	301	928	5
6	Remove And Install Mixing Valves In Boiler Room	2012	4,388		20	439	439	1,353	6
7	200 Unit- Remove Wallpaper, Outlets, Base, Install Base, Outlets,	2012	7,540		20	754	754	2,325	7
8	Wall And Fence Buildup	2012	5,051		20	505	505	1,557	8
9	Stairwells - Remove & Install Drywall, Repair Steps, Paint	2012	3,380		20	169	169	606	9
10	Boiler Room And Kitchen - Remove And Install New Pipe	2013	3,263		20	84	84	241	10
11	Remove And Install Cast Iron Pipe	2013	3,250		20	83	83	233	11
12	Wall Ac Units	2013	3,271		20	467	467	1,246	12
13	Replace Hydraulic Power Unit And Repipe Elevator	2013	13,885		20	694	694	1,793	13
14	Install Sprinkler Heads In Elevator Rooms	2013	2,986		20	77	77	195	14
15	Wall Ac Units	2013	3,849		20	550	550	1,420	15
16	Replaced Flange Gasket And Seal, Straighted, Realigned Doors Or	2013	5,265		20	135	135	332	16
17	Provide & Install Handrails	2013	3,395		20	679	679	1,584	17
18	Reception & Nurses Station - Installed Custom Cabinetry & Stora	2014	27,928		20	1,396	1,396	2,793	18
19	South Passenger Elevator0Furnish & Install Hall Buttons On Eacl	2014	3,800		20	190	190	364	19
20	Completed Electrical Work In Front Office	2014	2,550		20	128	128	213	20
21	Installed New Sprinkler Heads & Rangepard System Devices	2014	4,957		20	248	248	413	21
22	Retrofit Fume Hood	2014	3,200		20	160	160	267	22
23	Installed Woodgrain Door Coverings	2014	7,268		20	363	363	575	23
24	Installed New Heater & Pump Box	2014	9,129		20	456	456	533	24
25	New Flooring	2014	17,897		20	895	895	1,044	25
26	Installed Paneling On 35 Doors On The First Floor	2014	6,085		20	304	304	355	26
27	Wallcovering Supplies-Activity, Don, Social Service, Care Plan, Ac	2014	12,505		20	625	625	729	27
28	Wallcovering-Activity, Don, Social Service, Care Plan, Admission	2014	4,289		20	214	214	268	28
29	Glass	2014	3,199		20	640	640	800	29
30	Install Handrails, Wallcovering, Corner Guards, Floor, Window T	2014	88,515		20	4,426	4,426	7,376	30
31	1St Floor-Remove Wallpaper, Prime Walls, Install Wall Base, Elec	2014	39,500		20	1,975	1,975	3,456	31
32	Remove Tile & Carpet From Halls, Elevator, Lobby, Dining Room	2014	16,175		20	809	809	1,483	32
33	1 Floor Remodel-Asbestos Inspection Fee	2014	10,617		20	531	531	885	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,233,907	\$ 278,219		\$ 129,170	\$ (149,049)	\$ 2,290,256	34

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

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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	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,233,907	\$ 278,219		\$ 129,170	\$ (149,049)	\$ 2,290,256	1
2	Furnish & Install Conduit, Fittings, & Wire To Generator. Install	2014	6,450		20	323	323	511	2
3	Install Generator In Kitchen, Install New Motor Cantrill, Repair I	2014	3,620		20	181	181	256	3
4	Installed New Fire Pump Annunciator In Front Lobby, Including	2014	4,726		20	236	236	295	4
5	Install 7 Eyewash Stations Complete With Mixing Valves & Copp	2014	10,701		20	535	535	669	5
6	Installation Of Tamper Panel & Associated Devices; Fire Alarm S	2015	11,767		20	490	490	490	6
7	Installed Barring Assembly And Coupler Assembly For Air Cond	2015	2,886		20	144	144	144	7
8	Community Bathrooms - Replaced Hot & Cold Cartridges, Handl	2015	2,875		20	144	144	144	8
9	Installed Oil Return Pump In Passenger Elevator #1	2015	4,917		20	246	246	246	9
10	Front Landscaping Project - New Retaining Wall	2015	11,253		20	563	563	563	10
11	Installation Of New Boiler For Building	2015	9,541		20	477	477	477	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,302,643	\$ 278,219		\$ 132,509	\$ (145,710)	\$ 2,294,051	34

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

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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		\$ 4,302,643	\$ 278,219		\$ 132,509	\$ (145,710)	\$ 2,294,051	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		\$ 4,302,643	\$ 278,219		\$ 132,509	\$ (145,710)	\$ 2,294,051	34

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

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**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		\$ 4,302,643	\$ 278,219		\$ 132,509	\$ (145,710)	\$ 2,294,051	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		\$ 4,302,643	\$ 278,219		\$ 132,509	\$ (145,710)	\$ 2,294,051	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

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

# **0050070**

Report Period Beginning:

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Ending:

**12/31/15**

**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							
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25							
26							
27							
28							
29							
30							
31							
32							
33							
34	<b>TOTAL (lines 1 thru 33)</b>	\$	\$		\$	\$	\$

\*\*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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Healthcare	2015	267,197		20	13,360	13,360	13,360	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)		\$ 267,197	\$		\$ 13,360	\$ 13,360	\$ 13,360	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 267,197	\$		\$ 13,360	\$ 13,360	\$ 13,360	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)	\$ 267,197	\$		\$ 13,360	\$ 13,360	\$ 13,360	34

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

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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	\$ 244,949	\$	\$ 32,393	\$ 32,393	10	\$ 118,573	71
72	Current Year Purchases	82,653		8,933	8,933	10	8,933	72
73	Fully Depreciated Assets	566,353				10	566,353	73
74								74
75	TOTALS	\$ 893,955	\$	\$ 41,326	\$ 41,326		\$ 693,859	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		DODGE TRUCK	2014	\$ 24,444	\$	\$ 4,677	\$ 4,677	5	\$ 7,296	76
77		DODGE CARAVAN	2014	30,172		5,500	5,500	5	8,960	77
78										78
79										79
80	TOTALS			\$ 54,616	\$	\$ 10,177	\$ 10,177		\$ 16,256	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,409,963	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	278,219	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	184,012	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	(94,207)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	3,004,166	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Various Improvements	\$ 588,957	92
93			93
94			94
95		\$ 588,957	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?  YES  NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	<u>Allocated from Damen Healthcare</u>			<u>46,774</u>			5
6							6
7	<b>TOTAL</b>			\$ <b>46,774</b>			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: \$ 8,705 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>Facility</u>	<u>2015 Land Rover</u>	\$ <u>981.43</u>	\$ <u>11,777</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>981.43</b>	\$ <b>11,777</b>	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. /2016 \$ \_\_\_\_\_

13. /2017 \$ \_\_\_\_\_

14. /2018 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	\$		\$ 279,111	\$		\$ 279,111	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,401			3,401	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			313,572			313,572	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 prescripts				105,566		105,566	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>					5,705	2,795		8,500	13
14	TOTAL			\$		\$ 601,789	\$ 108,361		\$ 710,150	14

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

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

# **0050070**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/15** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 263,023	\$ 265,902	1
2	Cash-Patient Deposits	60,243	60,243	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,493,895	1,493,895	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,388	12,388	6
7	Other Prepaid Expenses	179,640	179,640	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	250,548	2,281,584	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,259,737	\$ 4,293,652	10
<b>B. Long-Term Assets</b>				
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	672,161	672,161	15
16	Equipment, at Historical Cost	261,041	578,541	16
17	Accumulated Depreciation (book methods)	(254,817)	(1,993,777)	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):	617,170	1,344,818	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,295,555	\$ 3,459,243	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,555,292	\$ 7,752,895	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 547,179	\$ 547,180	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,243	60,243	28
29	Short-Term Notes Payable	970,000	970,000	29
30	Accrued Salaries Payable	106,214	106,214	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,004	4,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,876	1,876	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	68,943	68,943	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,758,459	\$ 1,758,460	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		1,740,000	39
40	Mortgage Payable		6,960,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 8,700,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,758,459	\$ 10,458,460	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,796,833	\$ (2,705,565)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,555,292	\$ 7,752,895	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,035,357</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity Restatement</b>	<b>221,893</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,257,250</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>299,583</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(760,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(460,417)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,796,833</b>	<b>24</b> *

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

Facility Name &amp; ID Number Warren Park Health &amp; Living Center

# 0050070

Report Period Beginning: 01/01/15

Ending:

12/31/15

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,761,702	1
2	Discounts and Allowances for all Levels	(1,605,267)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,156,435	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,977,640	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,977,640	8
<b>C. Other Operating Revenue</b>			
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	165,381	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,059	19
20	Radiology and X-Ray	540	20
21	Other Medical Services	4,984	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 192,964	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,094	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,094	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	208,220	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 208,220	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,537,353	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,248,538	31
32	Health Care	1,936,588	32
33	General Administration	2,195,999	33
<b>B. Capital Expense</b>			
34	Ownership	785,133	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	769,068	35
36	Provider Participation Fee	302,444	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,237,770	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	299,583	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 299,583	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,164,186	44
45	Private Pay - Net Inpatient Revenue	73,805	45
46	Medicare - Net Inpatient Revenue	532,264	46
47	Other-(specify) <u>Managed Care</u>	353,852	47
48	Other-(specify) <u>Hospice</u>	32,328	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,156,435	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.

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

# **0050070**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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	2,032	2,232	\$ 131,027	\$ 58.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,459	6,832	219,481	32.13	3
4	Licensed Practical Nurses	12,267	13,257	315,808	23.82	4
5	CNAs & Orderlies	50,929	55,036	664,243	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,612	1,704	50,334	29.54	8
9	Activity Director	2,092	2,232	40,801	18.28	9
10	Activity Assistants	5,101	5,392	60,553	11.23	10
11	Social Service Workers	18,841	19,917	298,499	14.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,586	3,878	72,038	18.58	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,115	2,173	109,485	50.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,819	4,048	70,195	17.34	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	1,937	2,111	21,362	10.12	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,606	1,606	55,502	34.56	33
34	TOTAL (lines 1 - 33)	112,396	120,418	\$ 2,109,328 *	\$ 17.52	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,331	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,448	11-03	44
45	Social Service Consultant	Monthly	5,155	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	12,000	10-03	47
48	Outside Services - Dietary		323,856	01-03	48
49	TOTAL (lines 35 - 48)		\$ 356,990		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Josh Williams	Administrator	0	\$ 109,485	Workers' Compensation Insurance	\$ 52,837	IDPH License Fee	\$		
				Unemployment Compensation Insurance	36,228	Advertising: Employee Recruitment	1,513		
				FICA Taxes	158,676	Health Care Worker Background Check			
				Employee Health Insurance	197,656	(Indicate # of checks performed <u>58</u> )	3,269		
				Employee Meals	22,119	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Fees	5,694		
				Other Employee Benefits	1,582	Dues and Subscriptions	20,823		
						Allocated from Damen Healthcare	38,679		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 109,485						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 469,097	Less: Public Relations Expense	( )		
Management Fees			\$ 398,553			Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 398,553	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
FRR / Marcum	Accounting		\$ 72,906			\$	Out-of-State Travel	\$	
First Real Estate Services	Appraisal Services		2,750						
Legat Architechts	Architectual Consulting		181						
Personnel Planners	Unemployment Consulting		1,093				In-State Travel		
Keisha Bernard	Billing Consulting		4,748						
Damen Healthcare Group	Consulting		20,332				Seminar Expense	4,794	
Hamilton & Burton	Liability Management		250						
Legal	See Attached		17,310						
Rehab Management Systems	Medicare Consulting		6,000						
eHealth Solutions	Risk Management Services		4,329						
Damen Healthcare Group	Data Processing		25,640						
See Supplemental Schedule			44,003				Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 199,540	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 4,794

\* Attach copy of IMRF notifications

\*\*See instructions.



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

Report Period Beginning:

01/01/15

Ending:

12/31/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$13,208
- (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. \$ 836 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO        If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Warren Park Nursing Pavilion #30036079 05/01/2008
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 302,444  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,119 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.