



Facility Name & ID Number Warren Park Health & Living Center

# 0050070 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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	51	Skilled (SNF)	51	18,615	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,355	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	39,827	1,005	3,895	44,727	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,827	1,005	3,895	44,727	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.49%

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

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

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

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

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 3,357

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Warren Park Health & Living Center # 0050070 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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		4,951	619,176	624,127		624,127		624,127		1
2	Food Purchase		36		36		36		36		2
3	Housekeeping		2,546	196,557	199,103		199,103	1,372	200,475		3
4	Laundry		5	132,128	132,133		132,133		132,133		4
5	Heat and Other Utilities			125,765	125,765		125,765	(4,795)	120,970		5
6	Maintenance	82,142	19,749	108,392	210,283		210,283	11,526	221,809		6
7	Other (specify):*							1,512	1,512		7
8	<b>TOTAL General Services</b>	82,142	27,287	1,182,018	1,291,447		1,291,447	9,615	1,301,062		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	1,683,565	156,937	13,158	1,853,660		1,853,660	(11,386)	1,842,274		10
10a	Therapy	105,024			105,024		105,024		105,024		10a
11	Activities	107,222	39,593	2,484	149,299		149,299		149,299		11
12	Social Services	261,333		22,111	283,444		283,444		283,444		12
13	CNA Training										13
14	Program Transportation			3,767	3,767		3,767		3,767		14
15	Other (specify):*							12,335	12,335		15
16	<b>TOTAL Health Care and Programs</b>	2,157,144	196,530	45,720	2,399,394		2,399,394	949	2,400,343		16
	<b>C. General Administration</b>										
17	Administrative	134,532		401,437	535,969		535,969	(333,083)	202,886		17
18	Directors Fees										18
19	Professional Services			250,684	250,684		250,684	(14,249)	236,435		19
20	Dues, Fees, Subscriptions & Promotions			80,056	80,056		80,056	(23,729)	56,327		20
21	Clerical & General Office Expenses	145,577	367	236,847	382,791		382,791	(96,704)	286,087		21
22	Employee Benefits & Payroll Taxes			497,704	497,704		497,704		497,704		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,245	3,245		3,245	113	3,358		24
25	Other Admin. Staff Transportation			15,354	15,354		15,354	3,639	18,993		25
26	Insurance-Prop.Liab.Malpractice			297,043	297,043		297,043	2,768	299,811		26
27	Other (specify):*							27,080	27,080		27
28	<b>TOTAL General Administration</b>	280,109	367	1,782,370	2,062,846		2,062,846	(434,166)	1,628,680		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,519,395	224,184	3,010,108	5,753,687		5,753,687	(423,601)	5,330,086		29

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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>D. Ownership</b>											
30	Depreciation			135,817	135,817		135,817	121,421	257,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,712	58,712		58,712	297,051	355,763			32
33	Real Estate Taxes							173,041	173,041			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(706,802)	13,198			34
35	Rent-Equipment & Vehicles			5,013	5,013		5,013	19,580	24,593			35
36	Other (specify):*							7,000	7,000			36
37	<b>TOTAL Ownership</b>			919,542	919,542		919,542	(88,708)	830,834			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,065	524,200	617,265		617,265	(993)	616,272			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			317,947	317,947		317,947		317,947			42
43	Other (specify):*	66,289		40,944	107,233		107,233	(107,233)				43
44	<b>TOTAL Special Cost Centers</b>	66,289	93,065	883,091	1,042,445		1,042,445	(108,226)	934,219			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,585,684	317,249	4,812,741	7,715,674		7,715,674	(620,536)	7,095,138			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,173)	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	(107,629)	30		9
10	Interest and Other Investment Income	(3,100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(5,503)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143,431)	21		24
25	Fund Raising, Advertising and Promotional	(18,070)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,770)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(395,468)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (686,144)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	65,608		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 65,608		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (620,536)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52
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**Warren Park Health & Living Center**

Report Period Beginning:                     ID#                    0050070                      
 Ending:   01/01/17                      
  12/31/17                    

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration Expense	\$ (30,371)	21	1
2	Managed Care - Sequestration Expense	(1,938)	21	2
3	Patient Needs	(9,159)	10	3
4	Marketing Salary	(66,289)	43	4
5	Bank Charges	(15,620)	21	5
6	Credit Card Processing Fees	(309)	21	6
7	Capitalized R&M	(16,147)	06	7
8	Additional R&M	7,355	06	8
9	Non-allowable Legal	(14,698)	19	9
10	Building Co - Bank Fees	(2,409)	21	10
11	Building Co - Amortization	(177,577)	36	11
12	Building Company - Professional Fees	(1,875)	19	12
13	Building Co - Accounting Fees	(8,454)	19	13
14	Building Co - Legal Fees	(4,830)	19	14
15	Building Co - Loan and Organizational Costs	(43,842)	36	15
16	Building Co - Taxes & Licenses	(250)	20	16
17	PAC Dues	(9,055)	20	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(395,468)		49

Warren Park Health & Living Center

Report Period Beginning:                     01/01/17                      
 Ending:   12/31/17                    

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:

01/01/17

Ending:

12/31/17

## 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													2
3	Housekeeping			1,372									1,372	3
4	Laundry													4
5	Heat and Other Utilities	(6,173)		1,378									(4,795)	5
6	Maintenance	(8,792)	18,080	2,238									11,526	6
7	Other (specify):*			1,512									1,512	7
8	<b>TOTAL General Services</b>	<b>(14,965)</b>	<b>18,080</b>	<b>6,501</b>									<b>9,615</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(9,159)		(2,227)									(11,386)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			12,335									12,335	15
16	<b>TOTAL Health Care and Programs</b>	<b>(9,159)</b>		<b>10,108</b>									<b>949</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			30,089	(363,172)								(333,083)	17
18	Directors Fees													18
19	Professional Services	(29,856)	15,159	448									(14,249)	19
20	Fees, Subscriptions & Promotions	(27,375)	250	3,396									(23,729)	20
21	Clerical & General Office Expenses	(206,351)	2,409	107,238									(96,704)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			113									113	24
25	Other Admin. Staff Transportation			3,639									3,639	25
26	Insurance-Prop.Liab.Malpractice			2,768									2,768	26
27	Other (specify):*			27,080									27,080	27
28	<b>TOTAL General Administration</b>	<b>(263,583)</b>	<b>17,818</b>	<b>174,771</b>	<b>(363,172)</b>								<b>(434,166)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(287,707)</b>	<b>35,898</b>	<b>191,380</b>	<b>(363,172)</b>								<b>(423,601)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Park Health & Living Center # 0050070 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(107,629)	225,310	3,740									121,421	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,100)	298,865	1,286									297,051	32
33	Real Estate Taxes		173,041										173,041	33
34	Rent-Facility & Grounds		(720,000)	13,198									(706,802)	34
35	Rent-Equipment & Vehicles			19,580									19,580	35
36	Other (specify):*	(221,419)	228,419										7,000	36
37	<b>TOTAL Ownership</b>	<b>(332,148)</b>	<b>205,635</b>	<b>37,804</b>									<b>(88,708)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(993)							(993)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(66,289)		(40,944)									(107,233)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(66,289)</b>		<b>(40,944)</b>		<b>(993)</b>							<b>(108,226)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(686,144)</b>	<b>241,533</b>	<b>188,240</b>	<b>(363,172)</b>	<b>(993)</b>							<b>(620,536)</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: 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		
1	V	34 Rental Income	\$ 720,000	Warren Park Property, LLC	100.00%	\$	(720,000)	1
2	V	32 Interest	14,541	Warren Park Property, LLC	100.00%	313,406	298,865	2
3	V	33 Real Estate Taxes		Warren Park Property, LLC	100.00%	173,041	173,041	3
4	V	19 Professional Fees		Warren Park Property, LLC	100.00%	1,875	1,875	4
5	V	21 Bank Fees		Warren Park Property, LLC	100.00%	2,409	2,409	5
6	V	30 Depreciation Expense		Warren Park Property, LLC	100.00%	225,310	225,310	6
7	V	36 Amortization		Warren Park Property, LLC	100.00%	177,577	177,577	7
8	V	19 Accounting Fees		Warren Park Property, LLC	100.00%	8,454	8,454	8
9	V	19 Legal Fees		Warren Park Property, LLC	100.00%	4,830	4,830	9
10	V	36 Loan and Organizational Costs		Warren Park Property, LLC	100.00%	43,842	43,842	10
11	V	36 MIP Insurance		Warren Park Property, LLC	100.00%	7,000	7,000	11
12	V	06 Repairs		Warren Park Property, LLC	100.00%	18,080	18,080	12
13	V	20 Taxes & Licenses		Warren Park Property, LLC	100.00%	250	250	13
14	Total		\$ 734,541			\$ 976,074	\$ * 241,533	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 HOUSEKEEPING	\$	DAMEN HEALTHCARE GROUP, LLC	100.00%	\$ 1,372	\$ 1,372
16	V	5 UTILITIES		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,378	1,378
17	V	6 MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP, LLC	100.00%	8,044	8,044
18	V	6 MAINTENANCE	7,686	DAMEN HEALTHCARE GROUP, LLC	100.00%	1,880	(5,806)
19	V	7 MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,512	1,512
20	V	10 NURSING	68,829	DAMEN HEALTHCARE GROUP, LLC	100.00%	66,602	(2,227)
21	V	15 NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC	100.00%	12,335	12,335
22	V	17 ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC	100.00%	30,089	30,089
23	V	19 PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC	100.00%	448	448
24	V	20 DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC	100.00%	3,396	3,396
25	V	21 OFFICE EXPENSE - SALARIES		DAMEN HEALTHCARE GROUP, LLC	100.00%	114,039	114,039
26	V	21 OFFICE EXPENSE - OTHER	15,869	DAMEN HEALTHCARE GROUP, LLC	100.00%	9,068	(6,801)
27	V	24 SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	113	113
28	V	25 AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	3,639	3,639
29	V	26 INSURANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,768	2,768
30	V	27 EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC	100.00%	27,080	27,080
31	V	30 DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	3,740	3,740
32	V	32 INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,286	1,286
33	V	34 RENT		DAMEN HEALTHCARE GROUP, LLC	100.00%	13,198	13,198
34	V	35 EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC	100.00%	734	734
35	V	35 AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC	100.00%	18,846	18,846
36	V	43 MARKETING	40,944	DAMEN HEALTHCARE GROUP, LLC	100.00%		(40,944)
37	V						
38	V						
39	Total		\$ 133,328			\$ 321,568	\$ * 188,240

\* 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	17 MANAGEMENT FEES	\$ 401,437	EDN MANAGEMENT GROUP, LLC	100.00%	\$	(401,437)
16	V	17 MGMT FEES - J. AARON		EDN MANAGEMENT GROUP, LLC	100.00%	38,265	38,265
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		\$ 401,437			\$ 38,265	\$ * (363,172)

\* 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 & MEDICAL SUPPLIES	\$ 4,670	INTEGRA HEALTHCARE EQUIPMENT	100.00%	\$ 3,677	\$ (993)	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>		\$ 4,670			\$ 3,677	\$ *	(993) 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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	Jonathan Aaron	Relative	Administrative	0	See Attached	8.03	20.08%	Alloc Mgmt Fee	\$ 38,265	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	\$ 38,265		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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

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 DAMEN HEALTHCARE GROUP, LLC  
 Street Address 5611 DEMPSTER  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 224) 470-2044  
 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	3	HOUSEKEEPING	PATIENT DAYS	265,967	9	\$ 8,160	\$ 44,729	\$ 1,372	1
2	5	UTILITIES	PATIENT DAYS	265,967	9	8,194	44,729	1,378	2
3	6	MAINTENANCE SALARY	PATIENT DAYS	265,967	9	47,832	47,832	44,729	8,044
4	6	MAINTENANCE	PATIENT DAYS	265,967	9	11,179	44,729	1,880	4
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	265,967	9	8,991	44,729	1,512	5
6	10	NURSING	PATIENT DAYS	265,967	9	396,029	390,195	44,729	66,602
7	15	NURSING BENEFITS	PATIENT DAYS	265,967	9	73,345	44,729	12,335	7
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	265,967	9	178,914	178,914	44,729	30,089
9	19	PROFESSIONAL FEES	PATIENT DAYS	265,967	9	2,661	44,729	448	9
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	265,967	9	20,196	44,729	3,396	10
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	265,967	9	678,098	678,098	44,729	114,039
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	265,967	9	53,921	44,729	9,068	12
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	265,967	9	670	44,729	113	13
14	25	AUTO EXPENSE	PATIENT DAYS	265,967	9	21,637	44,729	3,639	14
15	26	INSURANCE	PATIENT DAYS	265,967	9	16,460	44,729	2,768	15
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	265,967	9	161,021	44,729	27,080	16
17	30	DEPRECIATION	PATIENT DAYS	265,967	9	22,241	44,729	3,740	17
18	32	INTEREST EXPENSE	PATIENT DAYS	265,967	9	7,645	44,729	1,286	18
19	34	RENT	PATIENT DAYS	265,967	9	78,480	44,729	13,198	19
20	35	EQUIPMENT RENTAL	PATIENT DAYS	265,967	9	4,365	44,729	734	20
21	35	AUTO LEASE	PATIENT DAYS	265,967	9	112,060	44,729	18,846	21
22									22
23									23
24									24
25	TOTALS					\$ 1,912,100	\$ 1,295,040	\$ 321,568	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

EDN MANAGEMENT GROUP, LLC

Street Address

5611 DEMPSTER

City / State / Zip Code

MORTON GROVE, IL 60053

Phone Number

( 224) 470-2044

Fax Number

(

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	17	MGMT FEES - J. AARON	PATIENT DAYS	58,446	6	\$ 50,000	\$ 44,729	\$ 38,265	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					\$ 50,000	\$	\$ 38,265	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

1	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 & MEDICAL SUPPLIES	DIRECT		\$	\$		\$ 3,677	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				\$	\$		\$ 3,677	25

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**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: 01/01/17 Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

**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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	HUD-First American Capital Group	X		Mortgage			\$	\$ 8,400,000			\$	5,734					
2	MB Financial	X		Old Mortgage								307,672					
3																	
4																	
5																	
<b>Working Capital</b>																	
6	MB Financial	X		Line of Credit				1,218,381				58,712					
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$	\$ 9,618,381			\$	372,118					
<b>B. Non-Facility Related*</b>																	
10	Interest Income	X										(3,100)					
11	Interest Income - Bldg Co	X										(14,541)					
12	Allocated from Damen Healthcare	X										1,286					
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(16,355)					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 9,618,381			\$	355,763					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 7,000 Line # 36

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

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







Facility Name & ID Number Warren Park Health & Living Center

# 0050070 Report Period Beginning:

01/01/17 Ending:

12/31/17

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: Facility, 50,000, 1995, \$158,750, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 50,000, (blank), \$158,750, 3.

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	\$ 225,310	39	\$ 69,199	\$ (156,111)	\$ 1,559,858	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1990	177,699		20			177,689	9
10	Various		1991	40,276		20			40,267	10
11	Various		1992	26,271		20			26,265	11
12	Various		1993	39,480		20			39,479	12
13	Various		1994	61,455		20			61,449	13
14	Various		1995	53,672		20			53,463	14
15	Various		1996	5,720		20			5,719	15
16	Various		1997	31,153		20	535	535	31,149	16
17	Various		1998	110,159		20	5,508	5,508	107,025	17
18	Various		1999	22,019		20	1,101	1,101	20,323	18
19	Various		2000	131,428		20	7,838	7,838	137,463	19
20	Various		2001	19,312		20	583	583	15,950	20
21	Various		2002	10,360		20			10,360	21
22	Various		2003	29,173		20	321	321	27,458	22
23	Various		2004	15,972		20			15,972	23
24	Various		2005	5,259		20			5,259	24
25	Various		2006	13,841		20	138	138	13,772	25
26	Various		2007	13,027		20	616	616	10,562	26
27	Various		2008	36,795		20	2,261	2,261	35,472	27
28	Various		2009	17,450		20	1,098	1,098	8,909	28
29	Various		2011	68,295		20	2,008	2,008	15,436	29
30	Various		2012	42,368		20	4,068	4,068	20,762	30
31	Various		2013	39,164		20	2,769	2,769	12,582	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

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		47,381	1,931		1,931		4,948	68
69			135,817			(135,817)		69
70		\$ 3,756,478	\$ 363,058		\$ 99,973	\$ (263,085)	\$ 2,457,591	70

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

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

# 0050070

Report Period Beginning:

01/01/17

Ending:

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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>		\$ 3,756,478	\$ 363,058		\$ 99,973	\$ (263,085)	\$ 2,457,591	1
2	Reception & Nurses Station - Installed Custom Cabinetry & Stora	2014	27,928		20	1,396	1,396	5,586	2
3	South Passenger Elevator0Furnish & Install Hall Buttons On Each	2014	3,800		20	190	190	744	3
4	Completed Electrical Work In Front Office	2014	2,550		20	128	128	468	4
5	Installed New Sprinkler Heads & Rangepuard System Devices	2014	4,957		20	248	248	909	5
6	Retrofit Fume Hood	2014	3,200		20	160	160	587	6
7	Installed Woodgrain Door Coverings	2014	7,268		20	363	363	1,302	7
8	Installed New Heater & Pump Box	2014	9,129		20	456	456	1,445	8
9	New Flooring	2014	16,248		20	895	895	2,834	9
10	Installed Paneling On 35 Doors On The First Floor	2014	6,085		20	304	304	963	10
11	Wallcovering Supplies-Activity, Don, Social Service, Care Plan, Ad	2014	12,505		20	625	625	1,980	11
12	Wallcovering-Activity, Don, Social Service, Care Plan, Admission	2014	4,289		20	214	214	697	12
13	Glass	2014	3,199		20	640	640	2,079	13
14	Install Handrails, Wallcovering, Corner Guards, Floor, Window T	2014	88,515		20	4,426	4,426	16,228	14
15	1st Floor-Remove Wallpaper, Prime Walls, Install Wall Base, Elec	2014	39,500		20	1,975	1,975	7,406	15
16	Remove Tile & Carpet From Halls, Elevator, Lobby, Dining Room	2014	16,175		20	809	809	3,100	16
17	1 Floor Remodel-Asbestos Inspection Fee	2014	10,617		20	531	531	1,946	17
18	Furnish & Install Conduit, Fittings, & Wire To Generator. Install	2014	6,450		20	323	323	1,156	18
19	Install Generator In Kitchen, Install New Motor Cantrill, Repair I	2014	3,620		20	181	181	618	19
20	Installed New Fire Pump Annunciator In Front Lobby, Including	2014	4,726		20	236	236	768	20
21	Install 7 Eyewash Stations Complete With Mixing Valves & Copp	2014	10,701		20	535	535	1,739	21
22	Installation Of Tamper Panel & Associated Devices; Fire Alarm S	2015	10,966		20	588	588	1,667	22
23	Front Landscaping Project - New Retaining Wall	2015	11,253		20	563	563	1,454	23
24	Installation Of New Boiler For Building	2015	9,541		20	477	477	1,073	24
25	Installed Barring Assembly & Coupler Assembly For A/C	2015	2,886		20	144	144	301	25
26	Community Bathrooms-Replaced Hot & Cold Cartridges, Handles	2015	2,875		20	144	144	299	26
27	Installed Oil Return Pump In Passenger Elevator # 1	2015	4,917		20	246	246	635	27
28	Room 001 - Room And Public Space Signage	2015	6,535		20	327	327	327	28
29	Plumbing - Install New 30 Gallon Rockford Grease Trap	2016	7,200		20	360	360	630	29
30	Fence - New 48" Pipe Railing - Flange To Concrete	2016	4,886		20	326	326	489	30
31	Plumbing - Installed New Grease Trap	2016	3,200		20	160	160	187	31
32	Replace Cylinder On North Elevator	2016	35,712		20	1,786	1,786	2,827	32
33	Installed New Awning Cover	2016	4,740		20	237	237	454	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,142,650	\$ 363,058		\$ 119,965	\$ (243,093)	\$ 2,520,489	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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**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 12B, Carried Forward</b>	\$ 4,142,650	\$ 363,058		\$ 119,965	\$ (243,093)	\$ 2,520,489	1	
2	Exterior Building - Apply Satin Trim Paint	2016 4,950		20	248	248	309	2	
3	Black Iron Piping For The Day Tank Ot The Main Tank	2016 2,531		20	127	127	137	3	
4	Paint - 1St, 2Nd, 3Rd Flr Rsdnt Rms, Bathrms, 57 A/C Wall Units	2016 339,566		20	16,978	16,978	16,978	4	
5	Mirrors, Electric Work - Rsdnt Rms, Hand/Chair Rails, Doors	2016		20				5	
6	Vinyl Tile - 3Rd Flr, Paint Walls, Wall/Ceiling Mounted Lighting	2016 270,609		20	13,530	13,530	13,530	6	
7	Design Fees, Bathroom Mirrors	2016		20				7	
8	Emergency Phones In Passenger Elevator	2017 5,996		20	799	799	799	8	
9	Generator Diesel Leak Clean Up & Waste Removal	2017 25,072		20	1,045	1,045	1,045	9	
10	Galvanized Steel Insulated Door	2017 3,641		20	152	152	152	10	
11	Roof Repair Work - Patching, Sealing	2017 8,900		20	223	223	223	11	
12	Environmental Consulting Group, Inc - Site Investigation And Act	2017 26,585		20	997	997	997	12	
13	Environmental Consulting Group, Inc - Remedial Action Complet	2017 5,000		20	167	167	167	13	
14	Leaking Pipes Repair In Room 223	2017 4,200		20	210	210	210	14	
15	Install Sink, Drains In Kitchen	2017 3,850		20	193	193	193	15	
16	Radiator Repair	2017 4,647		20	232	232	232	16	
17	Remove And Replace Section Of Drainage Line In Kitchen	2017 3,450		20	173	173	173	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>	\$ 4,851,646	\$ 363,058		\$ 155,037	\$ (208,021)	\$ 2,555,634	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		\$ 4,851,646	\$ 363,058		\$ 155,037	\$ (208,021)	\$ 2,555,634	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		\$ 4,851,646	\$ 363,058		\$ 155,037	\$ (208,021)	\$ 2,555,634	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		\$ 4,851,646	\$ 363,058		\$ 155,037	\$ (208,021)	\$ 2,555,634	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		\$ 4,851,646	\$ 363,058		\$ 155,037	\$ (208,021)	\$ 2,555,634	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									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.

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 (lines 1 thru 33)	\$	\$		\$	\$	\$	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	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 Group	2015	47,381	1,931	20	1,931		4,948	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)		\$ 47,381	\$ 1,931		\$ 1,931	\$	\$ 4,948	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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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		\$ 47,381	\$ 1,931		\$ 1,931		\$ 4,948	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)	\$ 47,381	\$ 1,931		\$ 1,931		\$ 4,948	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:

01/01/17

Ending:

12/31/17

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	\$ 385,135	\$ 1,646	\$ 59,676	\$ 58,030	10	\$ 211,841	71
72	Current Year Purchases	368,433	163	37,555	37,392	10	37,555	72
73	Fully Depreciated Assets	579,591				10	579,591	73
74								74
75	TOTALS	\$ 1,333,160	\$ 1,809	\$ 97,232	\$ 95,423		\$ 828,987	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	\$	\$ 2,994	\$ 2,994	5	\$ 13,964	76
77		DODGE CARAVAN	2014	30,172		1,975	1,975	5	14,285	77
78										78
79										79
80	TOTALS			\$ 54,616	\$	\$ 4,969	\$ 4,969		\$ 28,249	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,398,172	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 364,867	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 257,238	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (107,629)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,412,870	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	<u>Allocated from Damen Healthcare Group</u>				<u>13,198</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>13,198</b>			7

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.	<u>                    /2018</u>	\$ <u>                    </u>
13.	<u>                    /2019</u>	\$ <u>                    </u>
14.	<u>                    /2020</u>	\$ <u>                    </u>

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: \$ 5,748 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 Damen Healthcare Group</u>		\$	<u>18,846</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	<b>18,846</b>	21

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

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

**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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	229,545	\$		\$	229,545	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				6,012				6,012	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				273,218				273,218	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					93,065			93,065	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): _____						15,425				15,425	13
14	<b>TOTAL</b>			\$		\$	524,200	\$	93,065	\$	617,265	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.

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

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 123,734	\$ 124,640	1
2	Cash-Patient Deposits	55,331	55,331	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,308,144	2,308,144	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	152,690	152,690	6
7	Other Prepaid Expenses	30,612	107,612	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>		174,209	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,670,511	\$ 2,922,626	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	1,774,691	1,774,691	15
16	Equipment, at Historical Cost	422,452	739,952	16
17	Accumulated Depreciation (book methods)	(501,062)	(2,142,360)	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): <u>See Attached Schedule</u>	54,996	765,702	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,751,077	\$ 3,995,485	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,421,588	\$ 6,918,111	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 667,053	\$ 680,337	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,500	50,500	28
29	Short-Term Notes Payable	1,218,381	1,218,381	29
30	Accrued Salaries Payable	232,164	232,164	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,026	10,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,339	5,339	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	24,712	24,712	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,208,175	\$ 2,221,459	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,400,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	7,462		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 7,462	\$ 8,400,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,215,637	\$ 10,621,459	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,205,951	\$ (3,703,348)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,421,588	\$ 6,918,111	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,897,494</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Late Entries</b>	<b>(7,723)</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>1,889,771</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>316,180</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>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>316,180</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>2,205,951</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: 01/01/17

Ending:

12/31/17

**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**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,640,589	1
2	Discounts and Allowances for all Levels	(1,274,662)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,365,927	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,560,201	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,560,201	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	92,920	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,319	19
20	Radiology and X-Ray	1,387	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 102,626	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,100	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,100	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,031,854	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,291,447	31
32	Health Care	2,399,394	32
33	General Administration	2,062,846	33
<b>B. Capital Expense</b>			
34	Ownership	919,542	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	724,498	35
36	Provider Participation Fee	317,947	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,715,674	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	316,180	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 316,180	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,645,011	44
45	Private Pay - Net Inpatient Revenue	158,309	45
46	Medicare - Net Inpatient Revenue	340,821	46
47	Other-(specify) <u>Managed Care</u>	209,248	47
48	Other-(specify) <u>Hospice</u>	12,538	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,365,927	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Warren Park Health & Living Center

# 0050070

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	2,133	2,318	\$ 138,681	\$ 59.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,934	6,450	202,853	31.45	3
4	Licensed Practical Nurses	19,600	21,305	573,695	26.93	4
5	CNAs & Orderlies	57,809	62,836	768,336	12.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,105	3,375	105,024	31.12	8
9	Activity Director	2,033	2,210	44,801	20.27	9
10	Activity Assistants	4,892	5,318	62,421	11.74	10
11	Social Service Workers	14,121	15,349	261,333	17.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,009	4,358	82,142	18.85	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,048	2,226	134,532	60.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,860	2,022	67,240	33.26	23
24	Clerical	6,217	6,758	78,337	11.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,547	1,681	66,289	39.42	33
34	TOTAL (lines 1 - 33)	125,308	136,204	\$ 2,585,684 *	\$ 18.98	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		500	10-03	38
39	Pharmacist Consultant	Per Patient	12,658	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	2,484	11-03	44
45	Social Service Consultant	99	6,111	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	16,000	10-03	47
48	Outside Services - Dietary		619,176	01-03	48
49	TOTAL (lines 35 - 48)	99	\$ 661,129		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%	\$ 134,532	Workers' Compensation Insurance	\$ 53,627	IDPH License Fee	\$ 12,902		
				Unemployment Compensation Insurance	20,044	Advertising: Employee Recruitment	4,723		
				FICA Taxes	186,525	Health Care Worker Background Check (Indicate # of checks performed <u>472.3</u> )	4,723		
				Employee Health Insurance	217,869	Patient Background Checks	660.6		
				Employee Meals		Dues and Subscriptions	18,276		
				Illinois Municipal Retirement Fund (IMRF)*		License and Fees	10,424		
				Employee Benefits - Other	9,938	Allocated from Damen Healthcare Group	3,396		
				Holiday Expense	747				
				401K Employer Match Expense	8,954				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 134,532	TOTAL (agree to Schedule V, line 22, col.8)		\$ 56,327			
B. Administrative - Other							Less: Public Relations Expense ( )		
Description			Amount				Non-allowable advertising ( )		
Management Fees			\$ 401,437				Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 401,437				TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				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	
Marcum	Accounting		\$ 53,761				Out-of-State Travel	\$	
Burke, Montague & Associates	Accounting		750						
Legal	See attached		68,124				In-State Travel		
Personnel Planners	Unemployment Consulting		585						
Blymas Inc	Tax Credit Services		460				Seminar Expense	3,245	
Pendulum LLC	Risk Management Services		3,750				Allocated from Damen Healthcare Group	113	
Casamba Inc	EMR for Therapy		1,950						
Wescom Solutions	Data processing		9,246				Entertainment Expense ( )		
Dynamic Healthcare Consultant	Bookkeeping Services		417				(agree to Sch. V, line 24, col. 8)		
Madison Specs	Property Engineering		1,163				TOTAL	\$ 3,358	
Esolutions Inc	Data processing		2,962						
See Supplemental Schedule			107,516						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 250,684	TOTAL			\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

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

Report Period Beginning:

01/01/17

Ending:

12/31/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$18,110
- (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. \$ 1,367 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. \$ 317,947  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$        Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% LN 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees