FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0054452

Facility Name: The Waterford Care Center

Address: 7445 N Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 338-3300 **Fax #** (773) 338-5868

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1982

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	141	Skilled (SNF)	141	51,606	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	141	TOTALS	141	51,606	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	38,750	2,854	5,647	47,251	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,750	2,854	5,647	47,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.56%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 141 and days of care provided 3,230

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	223,228	19,634	15,133	257,995		257,995		257,995			1
2	Food Purchase		237,876		237,876		237,876	(144)	237,732			2
3	Housekeeping	124,388	36,196		160,584		160,584	1,745	162,329			3
4	Laundry	66,521			66,521		66,521		66,521			4
5	Heat and Other Utilities			148,925	148,925		148,925	(2,262)	146,663			5
6	Maintenance	28,647	4,957	130,927	164,531		164,531	9,719	174,250			6
7	Other (specify):*											7
8	TOTAL General Services	442,784	298,663	294,985	1,036,432		1,036,432	9,058	1,045,490			8
	B. Health Care and Programs											
9	Medical Director			37,800	37,800		37,800		37,800			9
10	Nursing and Medical Records	2,060,943	55,289	7,218	2,123,450		2,123,450	2,995	2,126,445			10
10a	Therapy											10a
11	Activities	100,314	1,823	408	102,545		102,545		102,545			11
12	Social Services	139,535		7,531	147,066		147,066		147,066			12
13	CNA Training											13
14	Program Transportation			759	759		759		759			14
15	Other (specify):*							9,062	9,062			15
16	TOTAL Health Care and Programs	2,300,792	57,112	53,716	2,411,620		2,411,620	12,057	2,423,677			16
	C. General Administration											
17	Administrative	74,834		574,475	649,309		649,309	(92,493)	556,816			17
18	Directors Fees											18
19	Professional Services			87,730	87,730	(2,599)	85,131	173,298	258,429			19
20	Dues, Fees, Subscriptions & Promotions			22,717	22,717		22,717	(4,033)	18,684			20
21	Clerical & General Office Expenses	261,827	1,126	3,036,709	3,299,662		3,299,662	(2,849,952)	449,710			21
22	Employee Benefits & Payroll Taxes			504,753	504,753		504,753		504,753			22
23	Inservice Training & Education											23
24	Travel and Seminar			144	144		144	528	672			24
25	Other Admin. Staff Transportation			9,901	9,901		9,901	1,182	11,083			25
26	Insurance-Prop.Liab.Malpractice			379,542	379,542		379,542	3,947	383,489			26
27	Other (specify):*							45,195	45,195			27
28	TOTAL General Administration	336,661	1,126	4,615,971	4,953,758	(2,599)	4,951,159	(2,722,328)	2,228,831			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,080,237	356,901	4,964,672	8,401,810	(2,599)	8,399,211	(2,701,213)	5,697,998			29

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

Facility Name & ID Number The Waterford Care Center #0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,001	26,001		26,001	204,958	230,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,267	20,267		20,267	115,644	135,911			32
33	Real Estate Taxes					2,599	2,599	150,633	153,232			33
34	Rent-Facility & Grounds			676,836	676,836		676,836	(661,623)	15,213			34
35	Rent-Equipment & Vehicles							8,584	8,584			35
36	Other (specify):*							17,311	17,311			36
37	**TOTAL Ownership**			723,104	723,104	2,599	725,703	(164,493)	561,210			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		296,292	514,745	811,037		811,037	(3,686)	807,351			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,003	332,003		332,003		332,003			42
43	Other (specify):*			6,165	6,165		6,165	(6,165)	(0)			43
44	**TOTAL Special Cost Centers**		296,292	852,913	1,149,205		1,149,205	(9,851)	1,139,354			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,080,237	653,193	6,540,689	10,274,119		10,274,119	(2,875,557)	7,398,562			45

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,117)	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	93,811	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	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	(978)	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	(2,958,363)	21		24
25	Fund Raising, Advertising and Promotional	(5,141)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(67,765)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,942,697)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	67,140		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 67,140		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,875,557)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

The Waterford Care Center

ID# 0054452

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (3,415)	20	1
2	Resident Expense	(31,260)	10	2
3	Marketing & Promotional Expense	(6,165)	43	3
4	City of Chicago - Use Tax	(187)	21	4
5	Bank Fees	(12,849)	21	5
6	Sequestration	(6,565)	21	6
7	Patient Needs	(96)	10	7
8	Non-Allowable Legal Fees	(2,925)	19	8
9	Additional R&M	7,968	06	9
10	Bldg Co - Accounting Fees	(7,647)	19	10
11	Bldg Co - Bank Charges and Fees	(95)	21	11
12	Bldg Co - Legal & Professional Services	(1,583)	19	12
13	Bldg Co - Amortization	(2,946)	36	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,765)		49

The Waterford Care Center

ID# 0054452

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(144)											(144)	2
3	Housekeeping			1,745									1,745	3
4	Laundry													4
5	Heat and Other Utilities	(4,117)		1,855									(2,262)	5
6	Maintenance	7,968		1,751									9,719	6
7	Other (specify):*													7
8	**TOTAL General Services**	3,707		5,351									9,058	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(31,356)		34,351									2,995	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			9,062									9,062	15
16	**TOTAL Health Care and Programs**	(31,356)		43,414									12,057	16
	C. General Administration													
17	Administrative			(71,225)	82,982				(104,250)				(92,493)	17
18	Directors Fees													18
19	Professional Services	(12,155)	9,230	2,005	174,218								173,298	19
20	Fees, Subscriptions & Promotions	(8,556)		4,523									(4,033)	20
21	Clerical & General Office Expenses	(2,979,037)	95	128,990									(2,849,952)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			528									528	24
25	Other Admin. Staff Transportation			1,182									1,182	25
26	Insurance-Prop.Liab.Malpractice			3,947									3,947	26
27	Other (specify):*			27,112					18,083				45,195	27
28	**TOTAL General Administration**	(2,999,748)	9,325	97,062	257,200				(86,167)				(2,722,328)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,027,397)	9,325	145,826	257,200				(86,167)				(2,701,213)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Waterford Care Center # 0054452 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	93,811	106,928	4,219									204,958	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		114,078	1,566									115,644	32
33	Real Estate Taxes		150,633										150,633	33
34	Rent-Facility & Grounds		(676,836)	15,213									(661,623)	34
35	Rent-Equipment & Vehicles			8,584									8,584	35
36	Other (specify):*	(2,946)	20,257										17,311	36
37	TOTAL Ownership	90,865	(284,940)	29,582									(164,493)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(41)	(2,934)	(711)					(3,686)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(6,165)											(6,165)	43
44	TOTAL Special Cost Centers	(6,165)				(41)	(2,934)	(711)					(9,851)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,942,697)	(275,615)	175,408	257,200	(41)	(2,934)	(711)	(86,167)				(2,875,557)	45

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 676,836	7445 Sheridan Road LLC	100.00%	$	$ (676,836)	1
2	V	32	Interest		7445 Sheridan Road LLC	100.00%	19,012	19,012	2
3	V	19	Accounting Fees		7445 Sheridan Road LLC	100.00%	1,270	1,270	3
4	V	21	Bank Charges		7445 Sheridan Road LLC	100.00%	95	95	4
5	V	19	Legal & Professional Fees		7445 Sheridan Road LLC	100.00%	1,583	1,583	5
6	V								6
7	V	32	Interest	432	Deauville Associates, LLC	100.00%	95,498	95,066	7
8	V	19	Accounting		Deauville Associates, LLC	100.00%	6,377	6,377	8
9	V	36	MIP Expense		Deauville Associates, LLC	100.00%	17,311	17,311	9
10	V	33	Real Estate Taxes		Deauville Associates, LLC	100.00%	150,633	150,633	10
11	V	30	Depreciation		Deauville Associates, LLC	100.00%	106,928	106,928	11
12	V	36	Amortization		Deauville Associates, LLC	100.00%	2,946	2,946	12
13	V								13
14	Total			$ 677,268			$ 401,653	$ * (275,615)	14

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DAMEN HEALTHCARE GROUP, LLC	100.00%	$ 1,855	$ 1,855	15
16	V	3	HOUSEKEEPING		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,745	1,745	16
17	V	6	MAINTENANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,751	1,751	17
18	V	10	NURSING	4,769	DAMEN HEALTHCARE GROUP, LLC	100.00%	39,120	34,351	18
19	V	15	NURSING PAYROLL TAXES		DAMEN HEALTHCARE GROUP, LLC	100.00%	9,062	9,062	19
20	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,005	2,005	20
21	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC	100.00%	4,523	4,523	21
22	V	21	OFFICE EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	128,990	128,990	22
23	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	528	528	23
24	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,182	1,182	24
25	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	3,947	3,947	25
26	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC	100.00%	27,112	27,112	26
27	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	4,219	4,219	27
28	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,566	1,566	28
29	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC	100.00%	15,213	15,213	29
30	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC	100.00%	974	974	30
31	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC	100.00%	7,610	7,610	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	17	MANAGEMENT FEES	71,225	DAMEN HEALTHCARE GROUP, LLC	100.00%		(71,225)	36
37	V								37
38	V								38
39	Total			$ 75,994			$ 251,402	$ * 175,408	39

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES - JA	$	JK MANAGEMENT GROUP, LLC	100.00%	$ 39,929	$ 39,929	15
16	V	17	MANAGEMENT FEES - KP		JK MANAGEMENT GROUP, LLC	100.00%	43,053	43,053	16
17	V	19	BOOKKEEPING		JK MANAGEMENT GROUP, LLC	100.00%	174,083	174,083	17
18	V	19	DATA PROCESSING		JK MANAGEMENT GROUP, LLC	100.00%	135	135	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 257,200	$ * 257,200	39

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & MEDICAL SUPPLIES	$ 404	INTEGRA HEALTHCARE EQUIPMENT	100.00%	$ 363	$ (41)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 404			$ 363	$ * (41)	39

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICARE DRUGS	$ 37,941	PHARMORE INC	100.00%	$ 35,007	$ (2,934)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,941			$ 35,007	$ * (2,934)	39

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	LABORATORY EXPENSE	$ 9,676	LIFESCAN LABORATORY	100.00%	$ 8,965	$ (711)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,676			$ 8,965	$ * (711)	39

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 503,250	SFMA, INC	100.00%	$	$ (503,250)	15
16	V								16
17	V	17	ADMIN SALARY		SFMA, INC	100.00%	399,000	399,000	17
18	V	27	ADMIN BENEFITS		SFMA, INC	100.00%	18,083	18,083	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 503,250			$ 417,083	$ * (86,167)	39

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jonathan Aaron	25.60%	AMBERWOOD CARE CENTER	ROCKFORD, IL	7445 SHERIDAN RD		BUILDING COMPANY	1
2	Kenneth Ripstein	25.50%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	JK MANAGEMENT GROUP LLC	MORTON GROVE, IL	MANAGEMENT COMPANY	2
3	Ari Shabat Investment Trust u/a/d October 18, 2016	15.00%	CITADEL CARE CENTER-KANKAKEE	KANKAKEE, IL	DAMEN HEALTHCARE GROUP	MORTON GROVE, IL	BOOKKEEPING	3
4	Chaim Yitzchak Shabat Investment Trust u/a/d October 18, 2016	15.00%	CITADEL CARE CENTER-ELGIN	ELGIN, IL	MISTY MEADOWS		ASSISTED LIVING	4
5	Raphaela Stern	4.95%	CITADEL CARE CENTER-WILMETTE	WILMETTE, IL	PHARMORE DRUGS	SKOKIE	PHARMACY	5
6	Stern Family Investment Trust u/a/d June 11, 2015	4.95%	CITADEL ESTATES-HAZEL CREST	HAZEL CREST, IL	SFMA	SKOKIE	MANAGEMENT COMPANY	6
7	Illana Teller	4.00%			LIFESCAN LABORATORY, INC	SKOKIE	LABORATORY CO	7
8	Marcella Graf	3.00%			INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	8
9	Yakov Kohen	2.00%			LIFELINE AMBULANCE	CHICAGO	AMBULANCE	9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jonathan Aaron	Owner	Administrative	25.60%	See Attached	7.99	19.98%	Alloc Mgmt Fee	$ 39,929	17-7	1
2	Kenneth Ripstein	Owner	Administrative	25.50%	See Attached	10.57	26.43%	Alloc Mgmt Fee	43,053	17-7	2
3	Marcella Graf	Owner	Clerical	3.00%	See Attached	7.99	19.98%	Alloc. Salary	21,496	21-7	3
4	Dan Shabat	Relative	Administrative	0.00%	N/A	24	40.00%	Alloc. Salary	199,500	17-7	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	$ 303,978		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 The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: DAMEN HEALTHCARE GROUP, LLC
Street Address: 5611 DEMPSTER
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (224) 470-2044
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	236,674	8	$ 9,291	$	47,251	$ 1,855	1
2	3	HOUSEKEEPING	PATIENT DAYS	236,674	8	8,740		47,251	1,745	2
3	6	MAINTENANCE	PATIENT DAYS	236,674	8	8,770		47,251	1,751	3
4	10	NURSING	PATIENT DAYS	236,674	8	195,949	195,949	47,251	39,120	4
5	15	NURSING PAYROLL TAXES	PATIENT DAYS	236,674	8	45,391		47,251	9,062	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	236,674	8	10,042		47,251	2,005	6
7	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	236,674	8	22,657		47,251	4,523	7
8	21	OFFICE EXPENSE	PATIENT DAYS	236,674	8	646,091	586,242	47,251	128,990	8
9	24	SEMINARS AND EDUCATION	PATIENT DAYS	236,674	8	2,647		47,251	528	9
10	25	AUTO EXPENSE	PATIENT DAYS	236,674	8	5,921		47,251	1,182	10
11	26	INSURANCE	PATIENT DAYS	236,674	8	19,769		47,251	3,947	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	236,674	8	135,801		47,251	27,112	12
13	30	DEPRECIATION	PATIENT DAYS	236,674	8	21,131		47,251	4,219	13
14	32	INTEREST EXPENSE	PATIENT DAYS	236,674	8	7,844		47,251	1,566	14
15	34	RENT	PATIENT DAYS	236,674	8	76,200		47,251	15,213	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	236,674	8	4,878		47,251	974	16
17	35	AUTO LEASE	PATIENT DAYS	236,674	8	38,115		47,251	7,610	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,237	$ 782,192		$ 251,402	25

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: JK MANAGEMENT GROUP, LLC
Street Address: 5611 DEMPSTER
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (224) 470-2044
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	MANAGEMENT FEES - JA	DIRECT			$	$		$ 39,929	1
2	17	MANAGEMENT FEES - KP	DIRECT						43,053	2
3	19	BOOKKEEPING	DIRECT						174,083	3
4	19	DATA PROCESSING	DIRECT						135	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					$	$		$ 257,200	25

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME & MEDICAL SUPPLIES	DIRECT			$	$		$ 363	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					$	$		$ 363	25

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PHARMORE DRUGS
Street Address: 3531 W. HOWARD
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-7455
Fax Number: (847) 679-1344

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Medicare Drugs	Direct Allocation			$	$		$ 35,007	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					$	$		$ 35,007	25

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifescan Laboratory
Street Address: 5255 Golf Rd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663-8300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory Expense	Direct Allocation			$	$		$ 8,965	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					$	$		$ 8,965	25

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SFMA Inc
Street Address: 7520 North Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-1195
Fax Number: (847) 982-0991

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SALARY	DIRECT ALLOCATION			$	$		$ 399,000	1
2	15	ADMIN BENEFITS	DIRECT ALLOCATION						18,083	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					$	$		$ 417,083	25

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Mortgage - Sheridan		X				$	$ 5,987,495			$ 19,012	1
2	Mortgage - Deauville		X								95,498	2
3												3
4												4
5					-							5
	Working Capital											
6	Line of Credit		X					425,000			20,268	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 6,412,495			$ 134,777	9
	B. Non-Facility Related*											
10	Allocated from Damen HC Gro	X									1,566	10
11	Interest Income - Bldg Co.		X								(432)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ 1,134	14
15	TOTALS (line 9+line14)						$	$ 6,412,495			$ 135,911	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 17,311 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 The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 59,225	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.)		$ 209,858	2
3. Under or (over) accrual (line 2 minus line 1).		$ 150,633	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 2,599	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 153,232	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	156,477	8
	2012	171,340	9
	2013	173,659	10
	2014	177,157	11
	2015	209,858	12

*Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Waterford Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054452

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-308-005-0000	Long Term Care Property	$ 209,857.79	$ 209,857.79
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 209,857.79	$ 209,857.79

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Waterford Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054452

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,216 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1984	$ 195,934	1
2					2
3	TOTALS			$ 195,934	3

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	141		1994	1977	$ 2,183,500	$ 106,928	39	$ 55,987	$ (50,941)	$ 1,852,318	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	63,831		20			63,830	9
10	Various			1994	33,446		20			33,440	10
11	Various			1995	40,581		20			40,569	11
12	Various			1996	19,396		20	300	300	19,395	12
13	Various			1997	99,588		20	4,977	4,977	97,661	13
14	Various			1998	26,433		20	1,322	1,322	24,672	14
15	Various			1999	80,052		20	4,003	4,003	69,554	15
16	Various			2000	87,666		20	4,383	4,383	72,432	16
17	Various			2001	59,253		20	2,827	2,827	45,991	17
18	Various			2002	46,347		20			46,347	18
19	Various			2003	55,449		20	2,772	2,772	37,768	19
20	Various			2004	91,388		20	744	744	86,051	20
21	Various			2005	9,567		20	362	362	6,550	21
22	Various			2006	14,506		20	725	725	7,485	22
23	Various			2007	279,182		20	16,835	16,835	155,813	23
24	Various			2008	33,896		20	1,911	1,911	17,015	24
25	Various			2009	22,853		20	1,143	1,143	9,141	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		985,286			35,275	35,275	534,044	67
68	Related Party Allocations (Pages 12H & 12I)		56,247	2,293		2,812	519	5,625	68
69	Financial Statement Depreciation			26,001			(26,001)		69
70	TOTAL (lines 4 thru 69)		$ 4,288,467	$ 135,222		$ 136,379	$ 1,157	$ 3,225,700	70

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,288,467	$ 135,222		$ 136,379	$ 1,157	$ 3,225,700	1
2	Overbed Light	2014	3,267		20	163	163	340	2
3	Replace Elevator Relay Board	2014	2,916		20	146	146	352	3
4	Exhaust Hood & Fire Prevention System	2015	18,900		20	945	945	1,811	4
5	Replace Awning With Sunbrella Acrylic Canvas	2015	4,182		20	418	418	836	5
6	Custom Radiator Covers,Remove 750 Sq Ft Tile	2015	5,250		20	525	525	1,050	6
7	New Corridor Wall,Framing,Doors:Closet,Dining Rm,Therapy Rr	2015	6,175		20	618	618	1,235	7
8	Landscaping:Repair Edging,Mulch,New Tree	2015	2,575		20	258	258	515	8
9	12 Wireless Access Points	2016	3,540		20	354	354	354	9
10	Install New Firewall, Access Points	2016	2,656		20	266	266	266	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,337,928	$ 135,222		$ 140,071	$ 4,849	$ 3,232,460	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Deauville Associates	1982	3,174		20			3,174	9
10	Deauville Associates	1983	22,098		20			22,098	10
11	Deauville Associates	1984	78,473		20			78,473	11
12	Deauville Associates	1985	65,697		20			65,697	12
13	Deauville Associates	1986	11,600		20			11,600	13
14	Deauville Associates	1987	17,548		20			17,548	14
15	Deauville Associates	1990	16,762		20			16,762	15
16	Deauville Associates	1991	36,643		20			36,643	16
17	Deauville Associates	1992	27,806		20			27,806	17
18	Nurses Station	2006	50,000		20	2,500	2,500	27,500	18
19	Window Replacement	2007	60,000		20	3,000	3,000	30,000	19
20	Physical Therapy Room	2007	29,808		20	1,490	1,490	14,904	20
21	Windows	2007	118,715		20	5,936	5,936	59,358	21
22	Boilers	2006	33,629		20	1,681	1,681	18,496	22
23	Door Handles, Locks	2007	13,243		20	662	662	6,621	23
24	Shower Room	2007	18,866		20	943	943	9,433	24
25	Nurses Call System 3rd Floor	2007	9,492		20	475	475	4,746	25
26	Shower Room	2007	23,046		20	1,152	1,152	11,523	26
27	Window Treatments	2007	10,090		20	505	505	5,046	27
28	Nurses Call System 2nd Floor	2007	4,746		20	237	237	2,373	28
29	Fire Alarm System & Sprinklers	2010	40,518		20	2,026	2,026	14,181	29
30	Fire Dampers/Injector Pump	2012	4,790		20	240	240	1,198	30
31	Boiler/Piping/Air Vent/Asbestos Insulation Abatement	2012	33,310		20	1,666	1,666	8,328	31
32	Concrete Patio and Walkways	2013	4,250		20	213	213	851	32
33	Chiller/Actuator/Compressor	2013	9,720		20	486	486	1,944	33
34	TOTAL (lines 1 thru 33)		$ 744,024	$		$ 23,212	$ 23,212	$ 496,303	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 744,024	$		$ 23,212	$ 23,212	$ 496,303	1
2	Wardrobe Doors	2013	4,898		20	245	245	980	2
3	Soffit Project	2013	21,285		20	1,064	1,064	4,257	3
4	Wiring	2013	4,863		20	243	243	972	4
5	2nd floor rooms & hallway:flooring and baseboards	2014	16,860		20	843	843	2,529	5
6	Compressor replacement, chiller repairs	2014	9,482		20	474	474	1,422	6
7	Boiler pump replacement	2014	20,020		20	1,001	1,001	3,003	7
8	Replace rusted piping	2014	5,200		20	260	260	780	8
9	New water heater	2014	3,850		20	193	193	578	9
10	Solar shades and accessories	2014	2,845		20	142	142	427	10
11	Door restrictors and emergency phones for elevators	2014	6,428		20	321	321	964	11
12	3 call lights	2014	2,890		20	145	145	434	12
13	Call lights, other electrical work	2014	2,915		20	146	146	437	13
14	New piping and various plumbing fixtures	2014	3,800		20	190	190	570	14
15	Installation of Baseboard in Corridor and Public areas	2014	3,550		20	178	178	533	15
16	Installation of flooring and wall tile, sink, faucet,mirror,grab bars and	2014	7,200		20	360	360	1,080	16
17	lighting for shower room								17
18	Custom Lobby Unit with Quartz trasaction top	2014	2,666		20	133	133	400	18
19	New drywall and sofit along both hallways, install new	2014	10,538		20	527	527	1,581	19
20	accordian door in conference room								20
21	Lower Level Hallway:Build out wall to cover heatin pipe,	2014	5,600		20	280	280	840	21
22	install drop ceiling, raise sofit								22
23	Prime & paint sofits in each of 4 hallways on 1st & 2nd flrs	2014	2,725		20	136	136	409	23
24	Replace 28 sprinkler heads	2014	3,500		20	175	175	525	24
25	17 resident bathrooms:tile wet walls, plumbing repairs,	2014	11,050		20	553	553	1,658	25
26	remove & reinstall sink								26
27	Resident Room Closets:remove & restructure, new doors,	2014	25,811		20	1,291	1,291	3,872	27
28	new wood frames								28
29	Curtain roller shades, handrails, tile, PVC flooring, wall gaurds	2014	59,336		20	2,967	2,967	8,900	29
30	Wall paper, porcelain tile, glass mosaic for various residents rms								30
31	and hallways								31
32	New vertical and horizontal stairway bars	2014	3,950		20	198	198	593	32
33									33
34	TOTAL (lines 1 thru 33)		$ 985,286	$		$ 35,275	$ 35,275	$ 534,044	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen HC Group	2015	56,247	2,293	20	2,812	519	5,625	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)		$ 56,247	$ 2,293		$ 2,812	$ 519	$ 5,625	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 56,247	$ 2,293		$ 2,812	$ 519	$ 5,625	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 56,247	$ 2,293		$ 2,812	$ 519	$ 5,625	34

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 989,582	$ 1,755	$ 89,919	$ 88,164	10	$ 722,754	71
72	Current Year Purchases	11,281	170	969	799	10	969	72
73	Fully Depreciated Assets	228,788				10	228,788	73
74								74
75	TOTALS	$ 1,229,650	$ 1,925	$ 90,887	$ 88,962		$ 952,510	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		2011 Lexus	2011	$ 37,057	$	$	$	5	$ 37,057	76
77										77
78										78
79										79
80	TOTALS			$ 37,057	$	$	$		$ 37,057	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)	$ 5,800,569	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,147	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 230,958	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 93,811	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,222,027	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	Exhaust Fan Assembly	$ 8,250	92
93			93
94			94
95		$ 8,250	95

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Damen HC Group				15,213			5
6								6
7	TOTAL				$ 15,213 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 974 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	Allocated from Damen HC Group		$	$ 7,610	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 7,610	21

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 53,307	$		$ 53,307	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,747			4,747	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			446,156			446,156	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				130,807		130,807	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					10,535	165,485		176,020	13
14	TOTAL			$		$ 514,745	$ 296,292		$ 811,037	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 The Waterford Care Center **#** 0054452 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$ 12,400	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,189,460	1,189,460	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	268,945	268,945	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	59,578	181,995	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,519,483	$ 1,652,800	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,308	24,308	16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	568,675	568,675	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 592,983	$ 592,983	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,112,466	$ 2,245,783	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 660,702	$ 663,555	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	425,000	425,000	29
30	Accrued Salaries Payable	172,943	172,943	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,476	8,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,624	1,624	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	261,237	4,381,237	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,529,982	$ 5,652,835	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,987,495	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	417,020	417,020	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 417,020	$ 6,404,515	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,947,002	$ 12,057,350	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 165,464	$ (9,811,567)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,112,466	$ 2,245,783	48

***(See instructions.)**

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**Prior Owner 2016 Income**	**(1,883,503)**	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,883,503)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,048,967	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,048,967	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 165,464	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,476,055	1
2	Discounts and Allowances for all Levels	(221,805)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,254,250	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	254,450	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 254,450	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	22,776	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	984	19
20	Radiology and X-Ray	40	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	4,790,586	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,790,586	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,323,086	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,036,432	31
32	Health Care	2,411,620	32
33	General Administration	4,953,758	33
	B. Capital Expense		
34	Ownership	723,104	34
	C. Ancillary Expense		
35	Special Cost Centers	817,202	35
36	Provider Participation Fee	332,003	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,274,119	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,048,967	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,048,967	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,029,831	44
45	Private Pay - Net Inpatient Revenue	478,321	45
46	Medicare - Net Inpatient Revenue	1,323,165	46
47	Other-(specify) Managed Care	299,177	47
48	Other-(specify) Hospice	123,756	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,254,250	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,700	2,097	$ 95,225	$ 45.42	1
2	Assistant Director of Nursing	2,556	2,678	71,593	26.73	2
3	Registered Nurses	17,778	19,321	543,399	28.12	3
4	Licensed Practical Nurses	14,847	16,099	384,481	23.88	4
5	CNAs & Orderlies	80,963	85,485	963,813	11.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,476	2,063	31,832	15.43	9
10	Activity Assistants	5,290	6,143	68,482	11.15	10
11	Social Service Workers	11,163	12,034	139,535	11.59	11
12	Dietician					12
13	Food Service Supervisor	383	491	8,589	17.48	13
14	Head Cook	822	900	9,769	10.85	14
15	Cook Helpers/Assistants	18,127	18,671	204,870	10.97	15
16	Dishwashers					16
17	Maintenance Workers	1,980	2,031	28,647	14.11	17
18	Housekeepers	10,448	11,109	124,388	11.20	18
19	Laundry	5,049	6,088	66,521	10.93	19
20	Administrator	1,552	1,917	74,834	39.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	356	366	9,810	26.80	23
24	Clerical	18,406	20,534	252,017	12.27	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	183	187	2,432	13.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	193,080	208,215	$ 3,080,237 *	$ 14.79	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 15,133	01-03	35
36	Medical Director	Monthly	37,800	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	38	3,785	10-03	38
39	Pharmacist Consultant	Monthly	1,833	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	8	408	11-03	44
45	Social Service Consultant	73	3,655	12-03	45
46	Other(specify) Music Therapy	per visit	3,876	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	119	$ 68,090		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen M. Donohue	Administrator	0	$ 74,834
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,834

B. Administrative - Other

Description	Amount
Management Fees - Damen Healthcare Group	$ 71,225
Management Fees - SFMA	503,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 574,475
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LTC Interiors	Interior Design	$ 2,709
Richard Peelo & Assoc	Accounting Fees	3,500
Marcum LLP	Accounting Fees	49,314
See Attached	Legal Fees	14,655
Personnel Planners	Unemployment Consulting	140
ProPay HR	Payroll Services	5,702
Wescom Solutions/PointClickCare	E.H.R Software	8,210
Thinkanew	Data Processing	3,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 87,730

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,430
Unemployment Compensation Insurance	24,932
FICA Taxes	49,647
Employee Health Insurance	29,380
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,215
Holiday Expense	1,012
Union Pension Contributions	21,482
Employee Medical & Dental	45,525
Employee Welfare	87,900
Other Payroll Taxes	201,231
TOTAL (agree to Schedule V, line 22, col.8)	$ 504,753

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,043
Health Care Worker Background Check	
(Indicate # of checks performed 15)	
Patient Background Checks	150
Dues & Subscriptions	9,014
Licenses and Permits	1,964
Allocated from Damen HC Group	4,523
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,684

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	144
Allocated from Damen HC Group	528
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 672

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $10,348**

(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. $ **3,337** 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.
Deauville Healthcare Center, License #0038612 - 11/1/1992

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **332,003**
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? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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