

		FOR BHF USE					

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**2017**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2017)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0053462</u></p> <p><b>Facility Name:</b> <u>Waverly Place of Stockton</u></p> <p><b>Address:</b> <u>501 Front Street</u> <u>Stockton</u> <u>61085</u>  Number City Zip Code</p> <p><b>County:</b> <u>Jo Davies</u></p> <p><b>Telephone Number:</b> <u>815-947-2215</u> <b>Fax #</b> <u>815-947-2651</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/01/15</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mendel S Schneider</u> <b>Telephone Number:</b> <u>847-933-1274</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/17</u> to <u>12/31/17</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td rowspan="2" style="vertical-align: top;"><b>Paid Preparer</b></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>See Accountant's Report Attached</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Mendel S Schneider CPA &amp; Associates, PC</u> <u>4051 Old Orchard Rd Skokie, IL 60076</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	<b>Paid Preparer</b>	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>See Accountant's Report Attached</u>		(Firm Name & Address) <u>Mendel S Schneider CPA &amp; Associates, PC</u> <u>4051 Old Orchard Rd Skokie, IL 60076</u>		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>
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Facility Name & ID Number Waverly Place of Stockton

# 0053462 Report Period Beginning: 01/01/17 Ending: 12/31/17

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,885	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	49	TOTALS	49	17,885	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,046	2,046	8
9	SNF/PED					9
10	ICF	9,568	2,996		12,564	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,568	2,996	2,046	14,610	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 81.69%

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve days in Section B.)

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

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

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

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

**I. On what date did you start providing long term care at this location?**  
Date started 04/01/15

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 04/01/15 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 49 and days of care provided 2,046

Medicare Intermediary NGS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Waverly Place of Stockton # 0053462 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	138,338	3,429	7,222	148,989		148,989		148,989		1
2	Food Purchase		106,143		106,143	(1,500)	104,643		104,643		2
3	Housekeeping	69,999	8,741	5,738	84,478		84,478		84,478		3
4	Laundry	5,477	8,137		13,614		13,614		13,614		4
5	Heat and Other Utilities			43,705	43,705		43,705		43,705		5
6	Maintenance	42,540		41,441	83,981		83,981		83,981		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	256,354	126,450	98,106	480,910	(1,500)	479,410		479,410		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	847,639	111,244	8,804	967,687		967,687		967,687		10
10a	Therapy			333,950	333,950		333,950		333,950		10a
11	Activities	24,021	1,574		25,595		25,595		25,595		11
12	Social Services	49,446		2,110	51,556		51,556		51,556		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	921,106	112,818	356,864	1,390,788		1,390,788		1,390,788		16
	<b>C. General Administration</b>										
17	Administrative	101,946			101,946		101,946		101,946		17
18	Directors Fees										18
19	Professional Services			88,381	88,381		88,381		88,381		19
20	Dues, Fees, Subscriptions & Promotions			53,069	53,069		53,069	(27,536)	25,533		20
21	Clerical & General Office Expenses	42,929	26,462	84,911	154,302		154,302	(8,006)	146,296		21
22	Employee Benefits & Payroll Taxes			201,563	201,563	1,500	203,063		203,063		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,172	12,172		12,172		12,172		24
25	Other Admin. Staff Transportation			33,134	33,134		33,134	(33,134)			25
26	Insurance-Prop.Liab.Malpractice			40,629	40,629		40,629		40,629		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	144,875	26,462	513,859	685,196	1,500	686,696	(68,676)	618,020		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,322,335	265,730	968,829	2,556,894		2,556,894	(68,676)	2,488,218		29

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

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

Facility Name &amp; ID Number

Waverly Place of Stockton

#0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							48,352	48,352			30
31	Amortization of Pre-Op. & Org.							14,840	14,840			31
32	Interest			79,565	79,565		79,565	57,069	136,634			32
33	Real Estate Taxes							17,347	17,347			33
34	Rent-Facility & Grounds			97,125	97,125		97,125	(97,125)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			176,690	176,690		176,690	40,483	217,173			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			69,683	69,683		69,683		69,683			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,096	103,096		103,096		103,096			42
43	Other (specify):* <b>Bad Debt</b>			34,665	34,665		34,665	(34,665)				43
44	<b>TOTAL Special Cost Centers</b>			207,444	207,444		207,444	(34,665)	172,779			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,322,335	265,730	1,352,963	2,941,028		2,941,028	(62,858)	2,878,170			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 Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,898)	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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(33,134)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,095)	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	(34,665)	43		24
25	Fund Raising, Advertising and Promotional	(27,536)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,911)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (123,239)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	60,381		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 60,381		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (62,858)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Waverly Place of Stockton

ID# 0053462

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Waverly Place of Stockton# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(27,536)	0	0	0	0	0	0	0	0	0	0	(27,536)	20
21	Clerical & General Office Expenses	(8,006)	0	0	0	0	0	0	0	0	0	0	(8,006)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(33,134)	0	0	0	0	0	0	0	0	0	0	(33,134)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(68,676)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(68,676)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(68,676)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(68,676)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(19,898)	68,250	0	0	0	0	0	0	0	0	0	48,352	30
31	Amortization of Pre-Op. & Org.	0	14,840	0	0	0	0	0	0	0	0	0	14,840	31
32	Interest	0	57,069	0	0	0	0	0	0	0	0	0	57,069	32
33	Real Estate Taxes	0	17,347	0	0	0	0	0	0	0	0	0	17,347	33
34	Rent-Facility & Grounds	0	(97,125)	0	0	0	0	0	0	0	0	0	(97,125)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(19,898)</b>	<b>60,381</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>40,483</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(34,665)	0	0	0	0	0	0	0	0	0	0	(34,665)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(34,665)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(34,665)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(123,239)</b>	<b>60,381</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(62,858)</b>	<b>45</b>



**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Nudell	50	Bellwood Nursing Center	Bellwood			
Jeremy Goldberg	50	Willow of Marengo	Marengo			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 97,125	Waverly Healthcare realty	100.00%	\$	(97,125)	1
2	V	33 Real Estate Tax				17,347	17,347	2
3	V	32 Interest				57,069	57,069	3
4	V	31 Amortization				14,840	14,840	4
5	V	30 Depreciation				68,250	68,250	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 97,125			\$ 157,506	\$ * 60,381	14

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

Facility Name & ID Number

Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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 Waverly Place of Stockton # 0053462 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending: 12/31/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

Facility Name & ID Number

Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	MB		X	Mortgage	\$6,882.11	12/01/17	\$ 1,200,000	\$ 1,171,085	12/01/22	4.5000	\$ 57,069	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	MB		X	Working Capital		11/22/16	355,000	100,000		4.2500	16,458	6					
7	Joseph Brandman	X		Due to Prior Owner		04/01/15	269,388	269,388		15.0000	40,997	7					
8	Jeremy Goldberg	X		Working Capital		04/01/15		312,086			22,110	8					
9	<b>TOTAL Facility Related</b>				\$6,882.11		\$ 1,824,388	\$ 1,852,559			\$ 136,634	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,824,388	\$ 1,852,559			\$ 136,634	15					

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

\* 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.)

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2016 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>	\$	17,698	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.)			\$	17,349	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	(349)	3	
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	17,696	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	17,347	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2012	8			
		2013	9			
		2014	17,689	10		
		2015	17,351	11		
		2016	17,349	12		
<u>17349 x1.02</u>						
		<b>FOR BHF USE ONLY</b>				
		13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Waverly Place of Stockton COUNTY Jo Davies

FACILITY IDPH LICENSE NUMBER 0053462

CONTACT PERSON REGARDING THIS REPORT Michael Nudell

TELEPHONE 773-338-4400 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-002-158-03</u>	<u>Nursing Home</u>	\$ <u>17,349.00</u>	\$ <u>17,349.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>17,349.00</u></u>	\$ <u><u>17,349.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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 Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,242 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 174,200 2. Number of Years Over Which it is Being Amortized: 15  
3. Current Period Amortization: 14,840 4. Dates Incurred: 12/01/16

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>12/1/2016</u>	<u>\$ 150,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 150,000</b>	<b>3</b>



Facility Name & ID Number Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49		2016		\$ 1,050,000	\$ 26,923	39	\$ 26,923	\$	\$ 26,923	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
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 Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,050,000	\$ 26,923		\$ 26,923	\$	\$ 26,923	70

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

Facility Name & ID Number Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 150,000	\$ 41,327	\$ 21,429	\$ (19,898)	7	\$ 21,429	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 150,000	\$ 41,327	\$ 21,429	\$ (19,898)		\$ 21,429	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 1,350,000	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,250	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,352	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,898)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,352	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Waverly Place of Stockton

# 0053462

Report Period Beginning: 01/01/17

Ending: 12/31/17

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

	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	10a-3	hrs	\$	2,525	\$ 144,261	\$	2,525	\$ 144,261	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		49	2,869		49	2,869	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,819	186,820		2,819	186,820	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				58,796		58,796	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs				10,887		10,887	11
12	Other (specify): <u>LABS</u>	39-3								12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	5,393	\$ 333,950	\$ 69,683	5,393	\$ 403,633	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (172,428)	\$ (172,428)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	913,511	913,511	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,314	1,314	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Related Homes,ESCRC</u>	269,476	8,674	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,011,873	\$ 751,071	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		1,050,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		150,000	16
17	Accumulated Depreciation (book methods)		(68,250)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		174,200	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,840)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 1,441,110	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,011,873	\$ 2,192,181	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 163,578	\$ 163,578	26
27	Officer's Accounts Payable	312,086	312,086	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000	100,000	29
30	Accrued Salaries Payable	56,320	56,320	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,042	6,042	31
32	Accrued Real Estate Taxes(Sch.IX-B)		17,696	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	747	747	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Prior Owner</u>	269,388	269,388	36
37	<u>Due to Related Homes</u>		49,000	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 908,161	\$ 974,857	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,171,085	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,171,085	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 908,161	\$ 2,145,942	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 103,712	\$ 46,239	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,011,873	\$ 2,192,181	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>87,884</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>18,044</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>105,928</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>332,784</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(335,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(2,216)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>103,712</b>	<b>24</b> *

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



**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,273,812	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,273,812	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,273,812	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	480,910	31
32	Health Care	1,390,788	32
33	General Administration	685,196	33
<b>B. Capital Expense</b>			
34	Ownership	176,690	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	104,348	35
36	Provider Participation Fee	103,096	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,941,028	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	332,784	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 332,784	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,514,570	44
45	Private Pay - Net Inpatient Revenue	529,300	45
46	Medicare - Net Inpatient Revenue	1,014,403	46
47	Other-(specify) <u>Medicare B</u>	215,539	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,273,812	49

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

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

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

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

Facility Name & ID Number Waverly Place of Stockton

# 0053462

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,040	2,080	\$ 82,373	\$ 39.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,387	9,547	298,960	31.31	3
4	Licensed Practical Nurses	3,844	3,844	105,755	27.51	4
5	CNAs & Orderlies	24,413	29,452	360,551	12.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,660	1,900	24,021	12.64	9
10	Activity Assistants					10
11	Social Service Workers	2,072	2,112	49,446	23.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,177	12,704	138,338	10.89	15
16	Dishwashers					16
17	Maintenance Workers	2,030	2,030	42,540	20.96	17
18	Housekeepers	5,587	6,017	69,999	11.63	18
19	Laundry	520	569	5,477	9.63	19
20	Administrator	2,080	2,120	101,946	48.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,095	2,699	42,929	15.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	66,905	75,074	\$ 1,322,335 *	\$ 17.61	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	144	\$ 7,222	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	4	234	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	70	2,110	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	218	\$ 21,566		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	171	\$ 8,569	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	171	\$ 8,569		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gina Miller	Administrator	0	\$ 82,677	Workers' Compensation Insurance	\$ 35,139	IDPH License Fee	\$ 1,990	
Courtney Potter	Administrator	0	19,269	Unemployment Compensation Insurance	14,648	Advertising: Employee Recruitment	20,000	
				FICA Taxes	101,158	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	50,618	Patient Background Checks	2,004	
				Employee Meals	1,500	Advertising	27,536	
				Illinois Municipal Retirement Fund (IMRF)*		Sec of State	250	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,946			Jo Davies Health Dep	200	
B. Administrative - Other						Mis Subs	1,089	
Description			Amount			Less: Public Relations Expense (		
			\$			Non-allowable advertising	(27,536)	
						Yellow page advertising (		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 203,063	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,533	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Mendel S Schneider	Accounting		\$ 14,000				Out-of-State Travel	\$
Richard Peelo	Accounting		4,200					
Terril Consulting	MDS Consulting		30,860				In-State Travel	
Mix Solutions	Consultant		21,771				Resident Transportation	10,991
Thompson & Kopp	Accounting		5,000					
MTS Consulting	Consultant		3,265				Seminar Expense	
Integra Scripts	Consultant		6,486				Illinois Healthcare Association	1,181
Personnel Planners	UC Consultant		2,799					
							Entertainment Expense (	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 88,381	TOTAL		\$	TOTAL	\$ 12,172

\* Attach copy of IMRF notifications

\*\*See instructions.

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,000 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. \_\_\_\_\_
- (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 \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 103,096  
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. \$ 1,500 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - 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? No
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? \_\_\_\_\_
- (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