FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0054452

Facility Name: Waterford Care Center

Address: 7445 North 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
		X	"Sub-S" Corp.		
			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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	51,465	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	51,465	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	40,253	2,354	4,406	47,013	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,253	2,354	4,406	47,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.35%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 3,962

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: 12/31/18 Fiscal Year: 12/31/18

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

STATE OF ILLINOIS

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	269,498	32,742	8,988	311,228		311,228		311,228			1
2	Food Purchase		260,771		260,771		260,771	(129)	260,642			2
3	Housekeeping	163,218	25,341		188,559		188,559	1,281	189,840			3
4	Laundry	87,867	5,904	2,905	96,676		96,676		96,676			4
5	Heat and Other Utilities			147,854	147,854		147,854	(1,178)	146,676			5
6	Maintenance	35,412	8,205	105,008	148,625		148,625	6,185	154,810			6
7	Other (specify):*							2,464	2,464			7
8	**TOTAL General Services**	555,995	332,963	264,755	1,153,713		1,153,713	8,623	1,162,336			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	2,686,945	230,788	48,462	2,966,195		2,966,195	2,781	2,968,976			10
10a	Therapy	49,549			49,549		49,549		49,549			10a
11	Activities	89,345	7,061	5,964	102,370		102,370		102,370			11
12	Social Services	158,553		1,680	160,233		160,233		160,233			12
13	CNA Training											13
14	Program Transportation			16,334	16,334		16,334		16,334			14
15	Other (specify):*							15,223	15,223			15
16	**TOTAL Health Care and Programs**	2,984,392	237,849	100,040	3,322,281		3,322,281	18,004	3,340,285			16
	C. General Administration											
17	Administrative	103,160		504,778	607,938		607,938	(388,145)	219,793			17
18	Directors Fees											18
19	Professional Services			269,494	269,494	(250)	269,244	(68,101)	201,143			19
20	Dues, Fees, Subscriptions & Promotions			42,925	42,925		42,925	(14,915)	28,010			20
21	Clerical & General Office Expenses	129,296	1,249	345,623	476,168		476,168	(148,071)	328,097			21
22	Employee Benefits & Payroll Taxes			603,457	603,457		603,457		603,457			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,423	1,423		1,423	64	1,487			24
25	Other Admin. Staff Transportation			496	496		496	1,465	1,961			25
26	Insurance-Prop.Liab.Malpractice			353,774	353,774		353,774	2,003	355,777			26
27	Other (specify):*							31,098	31,098			27
28	**TOTAL General Administration**	232,456	1,249	2,121,970	2,355,675	(250)	2,355,425	(584,602)	1,770,823			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,772,843	572,061	2,486,765	6,831,669	(250)	6,831,419	(557,975)	6,273,444			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 Waterford Care Center #0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,747	23,747		23,747	220,580	244,327			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,527	57,527		57,527	528,921	586,448			32
33	Real Estate Taxes					250	250	264,548	264,798			33
34	Rent-Facility & Grounds			1,054,000	1,054,000		1,054,000	(1,033,946)	20,054			34
35	Rent-Equipment & Vehicles			12,271	12,271		12,271	8,604	20,875			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,147,545	1,147,545	250	1,147,795	(11,292)	1,136,503			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,611	793,337	886,948		886,948	(702)	886,246			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			336,836	336,836		336,836		336,836			42
43	Other (specify):*	70,751		51,455	122,206		122,206	(122,206)				43
44	**TOTAL Special Cost Centers**	70,751	93,611	1,181,628	1,345,990		1,345,990	(122,908)	1,223,082			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,843,594	665,672	4,815,938	9,325,204		9,325,204	(692,176)	8,633,028			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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(2,551)	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	(554,908)	30		9
10	Interest and Other Investment Income	(6,011)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	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	(750)	21		18
19	Entertainment	(30)	21		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(212,600)	21		24
25	Fund Raising, Advertising and Promotional	(1,956)	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	(232,349)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,011,784)		$	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)	319,608		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 319,608		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (692,176)		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

Waterford Care Center

ID# 0054452

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Travel	$ (359)	25	1
2	Bank Charges	(1,798)	21	2
3	Sequestration Expense	(45,611)	21	3
4	Patient Needs	(443)	10	4
5	Marketing Salary	(70,751)	43	5
6	Marketing Expense	(6,939)	43	6
7	Credit Card Processing Charges	(58)	21	7
8	Bldg Co - Licenses & Fees	(30,021)	20	8
9	Bldg Co - Accounting Fees	(209)	19	9
10	Bldg Co - Other Professional Fees	(44,892)	19	10
11	Bldg Co - Bank Charges	(4,304)	21	11
12	Bldg Co - Amortization	(9,952)	36	12
13	Additional R&M	15,331	06	13
14	Capitalized R&M	(9,927)	06	14
15	Annual Report Filing Fees	(225)	20	15
16	PAC Dues	(12,197)	20	16
17	Non Allowable Legal Fees	(9,661)	19	17
18	Non Allowable Dues	(333)	20	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**	(232,349)		49

Waterford Care Center

ID# 0054452

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(129)											(129)	2
3	Housekeeping			1,281									1,281	3
4	Laundry													4
5	Heat and Other Utilities	(2,551)		1,373									(1,178)	5
6	Maintenance	5,404		781									6,185	6
7	Other (specify):*			2,464									2,464	7
8	**TOTAL General Services**	2,724		5,899									8,623	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(443)		3,224									2,781	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			15,223									15,223	15
16	**TOTAL Health Care and Programs**	(443)		18,447									18,004	16
	C. General Administration													
17	Administrative			28,797	(416,942)								(388,145)	17
18	Directors Fees													18
19	Professional Services	(54,762)	45,101	(58,440)									(68,101)	19
20	Fees, Subscriptions & Promotions	(45,232)	30,021	296									(14,915)	20
21	Clerical & General Office Expenses	(265,151)	4,304	112,776									(148,071)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			64									64	24
25	Other Admin. Staff Transportation	(359)		1,824									1,465	25
26	Insurance-Prop.Liab.Malpractice			2,003									2,003	26
27	Other (specify):*			31,098									31,098	27
28	**TOTAL General Administration**	(365,504)	79,426	118,418	(416,942)								(584,602)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(363,223)	79,426	142,764	(416,942)								(557,975)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(554,908)	772,057	3,431									220,580	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,011)	534,091	841									528,921	32
33	Real Estate Taxes		264,548										264,548	33
34	Rent-Facility & Grounds		(1,054,000)	20,054									(1,033,946)	34
35	Rent-Equipment & Vehicles			8,604									8,604	35
36	Other (specify):*	(9,952)	9,952											36
37	**TOTAL Ownership**	(570,871)	526,648	32,931									(11,292)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(205)	(497)						(702)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(77,690)		(44,516)									(122,206)	43
44	**TOTAL Special Cost Centers**	(77,690)		(44,516)		(205)	(497)						(122,908)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,011,784)	606,074	131,178	(416,942)	(205)	(497)						(692,176)	45

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Rental Income	$ 1,054,000	7445 Sheridan Road LLC		$	$ (1,054,000)	1
2	V	32	Interest Income	22	7445 Sheridan Road LLC			(22)	2
3	V	20	Licenses & Fees		7445 Sheridan Road LLC		30,021	30,021	3
4	V	19	Accounting Fees		7445 Sheridan Road LLC		209	209	4
5	V	19	Other Professional Fees		7445 Sheridan Road LLC		44,892	44,892	5
6	V	21	Bank Charges & Fees		7445 Sheridan Road LLC		4,304	4,304	6
7	V	32	Interest Expense		7445 Sheridan Road LLC		534,113	534,113	7
8	V	30	Depreciation Expense		7445 Sheridan Road LLC		772,057	772,057	8
9	V	33	Real Estate Tax		7445 Sheridan Road LLC		264,548	264,548	9
10	V	36	Amortization Expense		7445 Sheridan Road LLC		9,952	9,952	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,054,022			$ 1,660,096	$ * 606,074	14

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	3	HOUSEKEEPING	$	DAMEN HEALTHCARE GROUP, LLC		$ 1,281	$ 1,281	15
16	V	5	UTILITIES		DAMEN HEALTHCARE GROUP, LLC		1,373	1,373	16
17	V	6	MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP, LLC		13,974	13,974	17
18	V	6	MAINTENANCE	15,112	DAMEN HEALTHCARE GROUP, LLC		1,919	(13,193)	18
19	V	7	MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC		2,464	2,464	19
20	V	10	NURSING	83,097	DAMEN HEALTHCARE GROUP, LLC		86,321	3,224	20
21	V	15	NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC		15,223	15,223	21
22	V	17	ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC		28,797	28,797	22
23	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC		1,560	1,560	23
24	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC		296	296	24
25	V	21	OFFICE EXPENSE - SALARIES		DAMEN HEALTHCARE GROUP, LLC		147,549	147,549	25
26	V	21	OFFICE EXPENSE - OTHER	49,271	DAMEN HEALTHCARE GROUP, LLC		14,498	(34,773)	26
27	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC		64	64	27
28	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC		1,824	1,824	28
29	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC		2,003	2,003	29
30	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC		31,098	31,098	30
31	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC		3,431	3,431	31
32	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC		841	841	32
33	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC		20,054	20,054	33
34	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC		579	579	34
35	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC		8,025	8,025	35
36	V	43	MARKETING	44,516	DAMEN HEALTHCARE GROUP, LLC			(44,516)	36
37	V	19	BOOKKEEPING FEES	60,000	DAMEN HEALTHCARE GROUP, LLC			(60,000)	37
38	V								38
39	Total			$ 251,996			$ 383,174	$ * 131,178	39

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 504,778	JK MANAGEMENT GROUP, LLC		$	$ (504,778)	15
16	V	17	MGMT FEES - J. AARON				43,117	43,117	16
17	V	17	MGMT FEES - KEN RIPSTEIN				44,719	44,719	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			$ 504,778			$ 87,836	$ * (416,942)	39

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Ambulance	$ 2,162	Lifeline Ambulance		$ 1,957	$ (205)	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			$ 2,162			$ 1,957	$ * (205)	39

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 3,202	INTEGRA HEALTHCARE EQUIPMENT		$ 2,705	$ (497)	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			$ 3,202			$ 2,705	$ * (497)	39

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	26	Insurance	$ 197,590	Biltmore Incorporated Cell		$ 197,590	$	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			$ 197,590			$ 197,590	$ *	39

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 ROAD LLC	CHICAGO	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,	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				6
7	Illana Teller	4.00%	CITADEL OF STERLING	STERLING, IL	LIFESCAN LABORATORY, INC	SKOKIE	LABORATORY CO	7
8	Marcella Graf	3.00%	CITADEL OF NORTHBROOK	NORTHBROOK, IL	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	8
9	Yakov Kohen	2.00%	PA PETERSON AT THE CITADEL	ROCKFORD, IL	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	9
10					BILTMORE INCORPORATED CE	BURLINGTON, VT	INSURANCE	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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	7.05	17.64%	Alloc Mgmt Fee	$ 43,117	17-7	1
2	Kenneth Ripstein	Owner	Administrative	25.50%	See Attached	7.15	17.89%	Alloc Mgmt Fee	44,719	17-7	2
3	Marcella Graf	Owner	Administrative	3.00%	See Attached	6.04	15.10%	Alloc. Salary	28,797	17-7	3
4	Yakov Kohen	Owner	Clerical	2.00%	See Attached	6.04	15.10%	Alloc. Salary	18,331	21-7	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	$ 134,964		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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	3	HOUSEKEEPING	PATIENT DAYS	311,334	11	$ 8,480	$	47,013	$ 1,281	1
2	5	UTILITIES	PATIENT DAYS	311,334	11	9,092		47,013	1,373	2
3	6	MAINTENANCE SALARY	PATIENT DAYS	311,334	11	92,539	92,539	47,013	13,974	3
4	6	MAINTENANCE	PATIENT DAYS	311,334	11	12,710		47,013	1,919	4
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	311,334	11	16,319		47,013	2,464	5
6	10	NURSING	PATIENT DAYS	311,334	11	571,645	571,645	47,013	86,321	6
7	15	NURSING BENEFITS	PATIENT DAYS	311,334	11	100,808		47,013	15,223	7
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	311,334	11	190,702	190,702	47,013	28,797	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	311,334	11	10,332		47,013	1,560	9
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	311,334	11	1,963		47,013	296	10
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	311,334	11	977,110	977,110	47,013	147,549	11
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	311,334	11	96,009		47,013	14,498	12
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	311,334	11	425		47,013	64	13
14	25	AUTO EXPENSE	PATIENT DAYS	311,334	11	12,076		47,013	1,824	14
15	26	INSURANCE	PATIENT DAYS	311,334	11	13,262		47,013	2,003	15
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	311,334	11	205,941		47,013	31,098	16
17	30	DEPRECIATION	PATIENT DAYS	311,334	11	22,724		47,013	3,431	17
18	32	INTEREST EXPENSE	PATIENT DAYS	311,334	11	5,571		47,013	841	18
19	34	RENT	PATIENT DAYS	311,334	11	132,802		47,013	20,054	19
20	35	EQUIPMENT RENTAL	PATIENT DAYS	311,334	11	3,837		47,013	579	20
21	35	AUTO LEASE	PATIENT DAYS	311,334	11	53,145		47,013	8,025	21
22										22
23										23
24										24
25	TOTALS					$ 2,537,492	$ 1,831,996		$ 383,174	25

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	MGMT FEES - J. AARON	PATIENT DAYS	218,070	8	$ 200,000	$	47,013	$ 43,117	1
2	17	MGMT FEES - KEN RIPSTEIN	PATIENT DAYS	262,826	9	250,000		47,013	44,719	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					$ 450,000	$		$ 87,836	25

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: Lifeline Ambulance
Street Address: 2424 S Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	Ambulance	Direct Allocation			$	$		$ 1,957	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					$	$		$ 1,957	25

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 2,705	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					$	$		$ 2,705	25

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: Biltmore Incorporated Cell
Street Address: 30 Main Street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
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	26	Insurance	Direct Allocation			$	$		$ 197,590	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					$	$		$ 197,590	25

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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** 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	Mortgage - Sheridan		X				$	$ 5,959,206			$ 534,113	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				766,348		6.2513	57,527	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,725,554			$ 591,640	9
	B. Non-Facility Related*											
10	Interest Income		X								(6,011)	10
11	Interest Income - Bldg Co		X								(22)	11
12	Allocated from Damen HC Grou	X									841	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,192)	14
15	TOTALS (line 9+line14)						$	$ 6,725,554			$ 586,448	15

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

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

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 240,844	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.)		$ 246,532	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,688	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 258,859	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.)**		$ 250	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.		$ 264,797	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	173,659	8
	2014	177,157	9
	2015	209,858	10
	2016	229,376	11
	2017	246,532	12

2018 Accrual = $246,532 x 1.05 = $258,859

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Waterford Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054452

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 246,532.33	$ 246,532.33
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 246,532.33	$ 246,532.33

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Waterford Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054452

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 772,057	39	$ 55,987	$ (716,070)	$ 1,964,292	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			19,395	12
13	Various			1997	99,588		20	1,919	1,919	99,585	13
14	Various			1998	26,433		20	1,320	1,320	26,433	14
15	Various			1999	80,052		20	4,003	4,003	77,559	15
16	Various			2000	87,666		20	4,383	4,383	81,198	16
17	Various			2001	59,253		20	2,827	2,827	51,645	17
18	Various			2002	46,347		20			46,347	18
19	Various			2003	55,449		20	2,772	2,772	43,313	19
20	Various			2004	91,388		20	744	744	87,540	20
21	Various			2005	9,567		20	362	362	7,274	21
22	Various			2006	14,506		20	725	725	8,935	22
23	Various			2007	279,182		20	13,751	13,751	180,647	23
24	Various			2008	33,896		20	1,911	1,911	20,585	24
25	Various			2009	22,853		20	1,143	1,143	11,427	25
26	Various			2014	6,183		20	309	309	1,311	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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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)		1,202,684			46,145	46,145	619,210	67
68	Related Party Allocations (Pages 12H & 12I)		42,543	1,734		1,734		6,177	68
69	Financial Statement Depreciation			23,747			(23,747)		69
70	TOTAL (lines 4 thru 69)		$ 4,498,345	$ 797,538		$ 140,036	$ (657,503)	$ 3,490,710	70

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 4,498,345	$ 797,538		$ 140,036	$ (657,503)	$ 3,490,710	1
2	Exhaust Hood & Fire Prevention System	2015	18,900		20	945	945	3,701	2
3	Replace Awning With Sunbrella Acrylic Canvas	2015	4,182		20	418	418	1,673	3
4	Custom Radiator Covers,Remove 750 Sq Ft Tile	2015	5,250		20	525	525	2,100	4
5	New Corridor Wall,Framing,Doors:Closet,Dining Rm,Therapy Rm	2015	6,175		20	618	618	2,470	5
6	Landscaping:Repair Edging,Mulch,New Tree	2015	2,575		20	258	258	1,030	6
7	Install New Firewall, Access Points	2016	2,656		20	133	133	399	7
8	12 Wireless Access Points	2016	3,540		20	177	177	384	8
9	Installed Galvanized Steel Door - Basement Stairwell	2017	5,613		20	936	936	1,871	9
10	Installed 4 New Wander Systems - 3Rd Floor Elevators	2017	8,980		20	449	449	898	10
11	Tuckpointed Lintel - Outer Walls	2017	7,200		20	240	240	480	11
12	Redrilled Holes And Recased - Elevator	2017	26,790		20	558	558	1,116	12
13	Installed 4 New Wanderguards System - Elevator	2017	4,469		20	149	149	298	13
14	Install 100 Amp 3 Phase Fusible Disconnet - Elevator	2017	2,685		20	101	101	201	14
15	Replaced Bad Raveler, Added Junction Box - Elevator	2017	4,900		20	184	184	368	15
16	Installed 11 Exhaust Fans - Roof	2017	16,500		20	413	413	826	16
17	Drained Old And Installed New A/C Piping - Elevator/Employee Lo	2017	4,859		20	243	243	486	17
18	Removed Faulty Draft Inducer - Chimney	2017	2,535		20	127	127	254	18
19	Installed Brone Recirculating Pump - Basement Valve Room	2017	3,800		20	190	190	380	19
20	4 New Alarms W/Keypads And Push Buttons On 1St & 2Nd Fl	2017	3,166		20	317	317	369	20
21	Bedrooms Entry Door Lighting, Window Cornices, Electric Outlets	2018	18,943		20	1,894	1,894	1,894	21
22	New A/C Chiller Compressors	2018	9,347		20	623	623	623	22
23	Repair Walls, Install Lvt, Paint In Corridors, Conf Rm, Day Rm	2018	15,958		20	266	266	266	23
24	Repair Boiler & Ah Heating Coils	2018	4,705		20	235	235	235	24
25	Repair Main Circulating Pump	2018	2,722		20	136	136	136	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	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)		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	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)		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	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)		$ 4,684,795	$ 797,538		$ 150,169	$ (647,370)	$ 3,513,167	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Various	2006	83,629		20	4,181	4,181	54,358	18
19	Various	2007	288,006		20	14,400	14,400	171,804	19
20	Various	2010	40,518		20	2,026	2,026	18,233	20
21	Various	2012	38,100		20	1,906	1,906	13,338	21
22	Various	2013	45,016		20	2,251	2,251	13,507	22
23	Various	2014	210,216		20	10,511	10,511	52,557	23
24	Light Fixtures, Wall Vinyl & Flooring in Corridors, Nrs Station, Da	2017	94,839		20	4,742	4,742	9,484	24
25	Bedrooms & Window Cornices	2018	55,023		20	2,751	2,751	2,751	25
26	Repair Walls, Install LVT, Paint in Corridors, Conf Rm, Day Rm	2018	67,536		20	3,377	3,377	3,377	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,202,684	$		$ 46,145	$ 46,145	$ 619,210	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,202,684	$		$ 46,145	$ 46,145	$ 619,210	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)		$ 1,202,684	$		$ 46,145	$	$ 619,210	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Management	2015	42,543	1,734	20	1,734		6,177	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)		$ 42,543	$ 1,734		$ 1,734	$	$ 6,177	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 42,543	$ 1,734		$ 1,734	$	$ 6,177	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)		$ 42,543	$ 1,734		$ 1,734	$	$ 6,177	34

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,016,156	$ 1,697	$ 93,709	$ 92,012	10	$ 832,646	71
72	Current Year Purchases	14,519		450	450	10	450	72
73	Fully Depreciated Assets	233,478				10	233,478	73
74								74
75	TOTALS	$ 1,264,152	$ 1,697	$ 94,159	$ 92,462		$ 1,066,574	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)	$ 6,181,939	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 799,235	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 244,328	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (554,908)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,616,798	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Allocated from Damen HC				20,054			6
7	TOTAL				$ 20,054 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 579 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	Facility		$ 1,023.57	$ 12,271	17
18	Allocated from Damen HC			8,025	18
19					19
20					20
21	TOTAL		$ 1,023.57	$ 20,296	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 Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

Facility Name & ID Number Waterford Care Center | STATE OF ILLINOIS # 0054452 | Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$		$ 338,287	$		$ 338,287	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			81,497			81,497	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			348,530			348,530	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				93,611		93,611	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					25,023			25,023	13
14	TOTAL			$		$ 793,337	$ 93,611		$ 886,948	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.

STATE OF ILLINOIS

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 274,096	$ 293,453	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,552,325	1,552,325	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	33,222	33,222	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		126,654	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,859,643	$ 2,005,654	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,908,407	13
14	Buildings, at Historical Cost		5,968,441	14
15	Leasehold Improvements, at Historical Cost	111,120	328,518	15
16	Equipment, at Historical Cost	82,248	3,028,911	16
17	Accumulated Depreciation (book methods)	(38,158)	(1,700,315)	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	1,093,074	735,225	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,248,284	$ 10,269,187	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,107,927	$ 12,274,841	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 848,843	$ 849,052	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	766,348	1,028,151	29
30	Accrued Salaries Payable	237,450	237,450	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,105	12,105	31
32	Accrued Real Estate Taxes(Sch.IX-B)		258,859	32
33	Accrued Interest Payable	4,034	4,034	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,302	8,468	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,876,082	$ 2,398,119	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,697,403	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	72,020	4,226,909	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 72,020	$ 9,924,312	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,948,102	$ 12,322,431	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,159,825	$ (47,590)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,107,927	$ 12,274,841	48

*(See instructions.)

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 393,468	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 393,467	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	776,358	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	(10,000)	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)**	$ 766,358	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)**	$ 1,159,825	24 *

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 9,315,086	1
2	Discounts and Allowances for all Levels	(1,534,806)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,780,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,190,350	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,190,350	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	105,353	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,087	19
20	Radiology and X-Ray	4,481	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 124,921	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,011	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,011	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,101,562	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,153,713	31
32	Health Care	3,322,281	32
33	General Administration	2,355,675	33
	B. Capital Expense		
34	Ownership	1,147,545	34
	C. Ancillary Expense		
35	Special Cost Centers	1,009,154	35
36	Provider Participation Fee	336,836	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,325,204	40
41	**Income before Income Taxes (line 30 minus line 40)****	776,358	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 776,358	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,601,727	44
45	Private Pay - Net Inpatient Revenue	419,740	45
46	Medicare - Net Inpatient Revenue	537,909	46
47	Other-(specify) Managed Care	199,952	47
48	Other-(specify) Hospice	20,952	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,780,280	49

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

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

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

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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,887	2,120	$ 95,048	$ 44.83	1
2	Assistant Director of Nursing	2,012	2,261	73,613	32.56	2
3	Registered Nurses	19,157	21,525	675,011	31.36	3
4	Licensed Practical Nurses	22,339	25,101	669,458	26.67	4
5	CNAs & Orderlies	77,486	87,063	1,139,184	13.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,610	2,933	49,549	16.89	8
9	Activity Director	872	980	14,050	14.34	9
10	Activity Assistants	5,250	5,899	75,295	12.76	10
11	Social Service Workers	6,436	7,232	158,553	21.92	11
12	Dietician					12
13	Food Service Supervisor	1,958	2,200	50,162	22.80	13
14	Head Cook	4,873	5,475	70,191	12.82	14
15	Cook Helpers/Assistants	9,967	11,199	149,145	13.32	15
16	Dishwashers					16
17	Maintenance Workers	1,996	2,242	35,412	15.79	17
18	Housekeepers	12,162	13,666	163,218	11.94	18
19	Laundry	5,840	6,562	87,867	13.39	19
20	Administrator	1,887	2,120	103,160	48.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,920	2,157	57,022	26.44	23
24	Clerical	5,075	5,702	72,274	12.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,033	1,161	15,011	12.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,246	3,647	90,371	24.78	33
34	TOTAL (lines 1 - 33)	188,005	211,244	$ 3,843,594 *	$ 18.20	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	168	$ 8,988	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant	Quarterly	1,600	10-03	37
38	Nurse Consultant	Per Visit	2,071	10-03	38
39	Pharmacist Consultant	Monthly	20,016	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	115	5,964	11-03	44
45	Social Service Consultant	26	1,680	12-03	45
46	Other(specify)				46
47	Nurse Consultant	Monthly	24,775	10-03	47
48					48
49	TOTAL (lines 35 - 48)	309	$ 92,694		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

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Donohue	Administrator	0	$ 103,160
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,160

B. Administrative - Other

Description	Amount
Management Fees - JK Management	$ 504,778
TOTAL (agree to Schedule V, line 17, col. 3)	$ 504,778
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 32,826
See Attached	Legal Fees	52,244
Damen Healthcare Group	Bookkeeping Fees	60,000
Personnel Planners	Unemployment Consultant	1,065
Achieve Accreditation	Accreditation Services	12,298
Correll Co.	401K Consultant	1,595
Burke, Montague & Associates	Audit Financial Statements	675
McCabe Kirshner P.C.	Actuarial Study	1,563
MTS Consulting	Tax Consultant	825
ProPay HR	Payroll Services	25,022
See Supplemental Schedule		81,380
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 269,493

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,766
Unemployment Compensation Insurance	15,796
FICA Taxes	287,893
Employee Health Insurance	204,196
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	8,432
Dental / Vision Insurance	2,622
Employee Benefits - Other	1,459
Holiday Expense	1,843
401K Employer Match Expense	3,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 603,457

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	73
Health Care Worker Background Check	
(Indicate # of checks performed 8)	83
Patient Background Checks 57	570
Dues and Subscriptions	25,530
Licenses and Fees	1,458
Allocated Damen Healthcare	296
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,010

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,423
Allocated from Damen Healthcare	64
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,487

**See instructions.

Facility Name & ID Number Waterford Care Center # 0054452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **HCCI $24,393**

(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. $ **31,424** 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 ____ 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **336,836**
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? **N/A** 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. $ **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