

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0054452</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>The Waterford Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>7445 N Sheridan Road</u> <u>Chicago</u> <u>60626</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>			
Telephone Number: <u>(773) 338-3300</u> Fax # <u>(773) 338-5868</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>7/1/1982</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☒ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ 05/23/2021	
		* Subject to the attached Accountants' Consulting Report (Date)	
		Paid Preparer	
		(Print Name and Title) <u>Steven N Lavenda, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number The Waterford Care Center

0054452 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>141</u>	Skilled (SNF)	<u>141</u>	<u>51,606</u>	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	<u>141</u>	TOTALS	<u>141</u>	<u>51,606</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>38,082</u>	<u>2,386</u>	<u>5,213</u>	<u>45,681</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>38,082</u>	<u>2,386</u>	<u>5,213</u>	<u>45,681</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.52%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/1/1982

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/1982 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 141 and days of care provided 4,791

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	339,520	39,535	8,580	387,635		387,635		387,635			1
2	Food Purchase		246,918		246,918		246,918	(129)	246,789			2
3	Housekeeping	211,221	42,037	2,000	255,258		255,258	1,659	256,917			3
4	Laundry	103,318	6,617	2,918	112,853		112,853		112,853			4
5	Heat and Other Utilities			151,061	151,061		151,061	(10,358)	140,703			5
6	Maintenance	52,204	11,920	133,698	197,822		197,822	(10,335)	187,487			6
7	Other (specify):*							2,759	2,759			7
8	TOTAL General Services	706,263	347,027	298,257	1,351,547		1,351,547	(16,404)	1,335,143			8
	B. Health Care and Programs											
9	Medical Director			36,600	36,600		36,600		36,600			9
10	Nursing and Medical Records	3,191,388	347,548	49,396	3,588,332		3,588,332	(20,684)	3,567,648			10
10a	Therapy	41,072			41,072		41,072		41,072			10a
11	Activities	123,322	2,450	2,663	128,435		128,435		128,435			11
12	Social Services	103,548		604	104,152		104,152		104,152			12
13	CNA Training											13
14	Program Transportation			13,835	13,835		13,835	(2,503)	11,332			14
15	Other (specify):*							23,215	23,215			15
16	TOTAL Health Care and Programs	3,459,330	349,998	103,098	3,912,426		3,912,426	28	3,912,454			16
	C. General Administration											
17	Administrative	105,730		598,462	704,192		704,192	(508,691)	195,501			17
18	Directors Fees											18
19	Professional Services			332,269	332,269	(1,554)	330,715	(154,726)	175,989			19
20	Dues, Fees, Subscriptions & Promotions			56,732	56,732		56,732	(15,792)	40,940			20
21	Clerical & General Office Expenses	176,103	990	533,258	710,351		710,351	(322,703)	387,648			21
22	Employee Benefits & Payroll Taxes			739,670	739,670		739,670		739,670			22
23	Inservice Training & Education											23
24	Travel and Seminar			723	723		723	50	773			24
25	Other Admin. Staff Transportation			8,200	8,200		8,200	2,967	11,167			25
26	Insurance-Prop.Liab.Malpractice			461,154	461,154		461,154	3,726	464,880			26
27	Other (specify):*							43,113	43,113			27
28	TOTAL General Administration	281,833	990	2,730,468	3,013,291	(1,554)	3,011,737	(952,056)	2,059,681			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,447,426	698,015	3,131,823	8,277,264	(1,554)	8,275,710	(968,433)	7,307,277			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			39,026	39,026		39,026	205,805	244,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,643	14,643		14,643	742,949	757,592			32
33	Real Estate Taxes					1,554	1,554	255,404	256,958			33
34	Rent-Facility & Grounds			1,292,691	1,292,691		1,292,691	(1,276,109)	16,582			34
35	Rent-Equipment & Vehicles			18,937	18,937		18,937	11,086	30,023			35
36	Other (specify):*											36
37	TOTAL Ownership			1,365,297	1,365,297	1,554	1,366,851	(60,866)	1,305,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,187	984,062	1,103,249		1,103,249	(1,065)	1,102,184			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			325,162	325,162		325,162		325,162			42
43	Other (specify):*	85,254		78,827	164,081		164,081	(164,081)	0			43
44	TOTAL Special Cost Centers	85,254	119,187	1,388,051	1,592,492		1,592,492	(165,146)	1,427,346			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,532,680	817,202	5,885,171	11,235,053		11,235,053	(1,194,445)	10,040,608			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(11,730)	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	(572,379)	30		9
10	Interest and Other Investment Income	(4,392)	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	(1,227)	21		18
19	Entertainment				19
20	Contributions	(3,100)	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	(359,077)	21		24
25	Fund Raising, Advertising and Promotional	(1,800)	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	(415,605)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,369,439)		\$	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)	174,994		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 174,994		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,194,445)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bldg Co - Accounting	\$ (4,902)	19	1
2	Bldg Co - Bank Charges	(772)	21	2
3	PAC Dues	(12,549)	20	3
4	Bldg Co - Office Supplies	(2,683)	21	4
5	Bank Charges	(5,949)	21	5
6	Misc Income	(28)	21	6
7	Sequestration	(18,881)	21	7
8	Patient Needs	(859)	10	8
9	Marketing Salary	(85,254)	43	9
10	Marketing Expense	(78,572)	43	10
11	Credit Card/Pymt Process Fees	(215)	21	11
12	Refinance Proceeds to Real Estate Taxes	(181,630)	33	12
13	Additional R&M	2,812	06	13
14	Capitalized R&M	(7,717)	06	14
15	Non Allowable Auto Lease	(5,963)	35	15
16	Promotion Fees	(255)	43	16
17	Non Allowable Legal	(3,566)	19	17
18	Appraisal Fees for refinance	(8,621)	19	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(415,605)		49

Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(572,379)	773,583	2,735	1,866								205,805	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,392)	738,978	2,749	5,614								742,949	32
33	Real Estate Taxes	(181,630)	430,489		6,545								255,404	33
34	Rent-Facility & Grounds		(1,292,691)	25,047	(8,465)								(1,276,109)	34
35	Rent-Equipment & Vehicles	(5,963)		17,049									11,086	35
36	Other (specify):*													36
37	TOTAL Ownership	(764,365)	650,359	47,580	5,560								(60,866)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,065)						(1,065)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(164,081)											(164,081)	43
44	TOTAL Special Cost Centers	(164,081)					(1,065)						(165,146)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,369,439)	658,716	(486,515)	6,944		(1,648)	(2,503)					(1,194,445)	45

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.

[illegible]

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,292,691	7445 Sheridan Road LLC		\$	\$ (1,292,691)	1
2	V	32	Interest		7445 Sheridan Road LLC		738,978	738,978	2
3	V	33	Real Estate Taxes		7445 Sheridan Road LLC		430,489	430,489	3
4	V	19	Accounting		7445 Sheridan Road LLC		4,902	4,902	4
5	V	21	Bank Charges		7445 Sheridan Road LLC		772	772	5
6	V	21	Office Supplies & Software		7445 Sheridan Road LLC		2,683	2,683	6
7	V	30	Depreciation		7445 Sheridan Road LLC		773,583	773,583	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,292,691			\$ 1,951,407	\$ * 658,716	14

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

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 CO	1
2	Kenneth Ripstein	25.50%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3	Ari Shabat Investment Trust u/a/d October 18, 2016	15.00%	CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4	Chaim Yitzchak Shabat Investment Trust u/a/d October 18, 2016	15.00%	CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5	Raphaela Stern	4.95%	CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	5
6	Stern Family Investment Trust u/a/d June 11, 2015	4.95%	CITADEL CARE CENTER-STERLING LLC	STERLING, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7	Illana Teller	4.00%	THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL				7
8	Marcella Graf	3.00%	PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				8
9	Yakov Kohen	2.00%	SKOKIE MEADOWS LLC	SKOKIE, IL				9
10			THE CITADEL OF SKOKIE LLC	SKOKIE, IL				10
11			THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				11
12			THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				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

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
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	\$	Damen Healthcare Group, LLC		\$ 1,659	\$ 1,659	15
16	V	5	Utilities		Damen Healthcare Group, LLC		1,372	1,372	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		12,979	12,979	17
18	V	6	Maintenance	20,346	Damen Healthcare Group, LLC		1,707	(18,639)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		2,759	2,759	19
20	V	10	Nursing	130,968	Damen Healthcare Group, LLC		111,726	(19,242)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		23,215	23,215	21
22	V	17	Administrative	598,462	Damen Healthcare Group, LLC		28,794	(569,669)	22
23	V	19	Professional Fees	144,000	Damen Healthcare Group, LLC		307	(143,693)	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		1,657	1,657	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		161,572	161,572	25
26	V	21	Office Expense - Other	110,645	Damen Healthcare Group, LLC		11,747	(98,898)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		50	50	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		2,967	2,967	28
29	V	26	Insurance		Damen Healthcare Group, LLC		3,726	3,726	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		43,113	43,113	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		2,735	2,735	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		2,749	2,749	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		16,582	16,582	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		8,465	8,465	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		916	916	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		16,133	16,133	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		32,184	32,184	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		28,794	28,794	38
39	Total			\$ 1,004,422			\$ 517,906	\$ * (486,515)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	3755 W Chase, LLC		\$ 230	\$ 230	15
16	V	30	Depreciation		3755 W Chase, LLC		1,866	1,866	16
17	V	32	Interest Expense		3755 W Chase, LLC		5,614	5,614	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		6,545	6,545	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		1,154	1,154	19
20	V								20
21	V	34	Rent	8,465	3755 W Chase, LLC			(8,465)	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			\$ 8,465			\$ 15,409	\$ * 6,944	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	\$ 437,400	Biltmore Incorporated Cell		\$ 437,400	\$	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			\$ 437,400			\$ 437,400	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies/DME	\$ 3,761	Integra Healthcare Equipment		\$ 3,178	\$ (583)	15
16	V	39	Ancillary Expense	6,873	Integra Healthcare Equipment		5,808	(1,065)	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			\$ 10,634			\$ 8,986	\$ * (1,648)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Patient Transportation	\$ 13,243	Lifeline Ambulance		\$ 10,740	\$ (2,503)	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			\$ 13,243			\$ 10,740	\$ * (2,503)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

Facility Name & ID Number The Waterford Care Center # 0054452 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jonathan Aaron	Owner	Administrative	25.60%	See Attached	5.15	12.88%	Alloc Mgt Fee	\$ 32,184	17-7	1
2	Kenneth Ripstein	Owner	Administrative	25.50%	See Attached	4.61	11.53%	Alloc Mgt Fee	28,794	17-7	2
3	Yakov Kohen	Owner	Clerical	2.00%	See Attached	4.61	11.53%	Alloc Salary	15,791	21-7	3
4	Marcella Graf	Owner	Administrative	3.00%	See Attached	4.61	11.53%	Alloc Salary	28,794	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 105,563		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

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number The Waterford Care Center# 0054452

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Damen Healthcare Group, LLC

Street Address

3755 W. Chase Ave.

City / State / Zip Code

Skokie, IL 60076

Phone Number

(224) 470-2044

Fax Number

(224) 470-2952

	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	396,623	14	\$ 14,400	\$	45,681	\$ 1,659	1
2	5	Utilities	Patient Days	396,623	14	11,913		45,681	1,372	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	112,690	45,681	12,979	3
4	6	Maintenance	Patient Days	396,623	14	14,821		45,681	1,707	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951		45,681	2,759	5
6	10	Nursing	Patient Days	396,623	14	970,057	948,342	45,681	111,726	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561		45,681	23,215	7
8	17	Administrative	Patient Days	396,623	14	250,000	250,000	45,681	28,794	8
9	19	Professional Fees	Patient Days	396,623	14	2,669		45,681	307	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390		45,681	1,657	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	1,402,841	45,681	161,572	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995		45,681	11,747	12
13	24	Seminars & Education	Patient Days	396,623	14	431		45,681	50	13
14	25	Auto Expense	Patient Days	396,623	14	25,762		45,681	2,967	14
15	26	Insurance	Patient Days	396,623	14	32,350		45,681	3,726	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325		45,681	43,113	16
17	30	Depreciation	Patient Days	396,623	14	23,745		45,681	2,735	17
18	32	Interest Expense	Patient Days	396,623	14	23,867		45,681	2,749	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975		45,681	16,582	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500		45,681	8,465	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954		45,681	916	21
22	35	Auto Lease	Patient Days	396,623	14	140,073		45,681	16,133	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000		45,681	32,184	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000		45,681	28,794	24
25	TOTALS					\$ 4,467,270	\$ 2,713,873		\$ 517,906	25

Ending: 12/31/20

(224) 470-2952

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

(630) 834-1500

IL478-2471

Ending: 12/31/20

(312) 949-9262

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Midwest Bank		X	Mortgage Payable			\$	15,297,983			\$	738,978	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				393,509				14,643	6
7													7
8													8
9	TOTAL Facility Related						\$	15,691,492			\$	753,621	9
	B. Non-Facility Related*												
10	Interest Income		X									(4,392)	10
11	Allocated from Damen HC	X										2,749	11
12	Allocated from 3755 Chase	X										5,614	12
13													13
14	TOTAL Non-Facility Related						\$				\$	3,971	14
15	TOTALS (line 9+line14)						\$	15,691,492			\$	757,592	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	252,449	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.)			\$	251,085	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,364)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	256,767	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.)			\$	1,554	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.			\$	256,957	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	209,858	8	
		2016	229,376	9	
		2017	246,532	10	
		2018	240,428	11	
		2019	244,540	12	
2020 Accrual = \$244,540 x 1.05 = \$256,767					
Allocated from 3755 Chase \$6,545					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>The Waterford Care Center</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Waterford Care Center COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0054452
CONTACT PERSON REGARDING THIS REPORT Steven Lavenda
TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

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

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1984	\$ 195,934	1
2	Allocated from 3755 W Chase		2019	77,420	2
3	TOTALS			\$ 273,354	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	141		1994	1977	\$ 2,183,500	\$ 773,583	39	\$ 55,987	\$ (717,596)	\$ 2,076,266	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		63,831		20			63,831	9
10	Various		1994		33,446		20	7	7	33,446	10
11	Various		1995		40,581		20	10	10	40,581	11
12	Various		1996		19,396		20	1	1	19,396	12
13	Various		1997		99,588		20	7	7	99,588	13
14	Various		1998		26,433		20	4	4	26,433	14
15	Various		1999		80,052		20	3	3	80,052	15
16	Various		2000		87,666		20	2,082	2,082	87,666	16
17	Various		2001		59,253		20	2,827	2,827	57,299	17
18	Various		2002		46,347		20			46,347	18
19	Various		2003		55,449		20	2,773	2,773	48,860	19
20	Various		2004		91,388		20	745	745	89,031	20
21	Various		2005		9,567		20	363	363	7,999	21
22	Various		2006		14,506		20	725	725	10,386	22
23	Various		2007		279,182		20	11,084	11,084	202,814	23
24	Various		2008		33,896		20	1,478	1,478	23,542	24
25	Various		2009		22,853		20	1,143	1,143	13,713	25
26	Various		2014		6,183		20	309	309	1,929	26
27	Various		2015		37,082		20	1,855	1,855	15,593	27
28	Various		2016		6,196		20	310	310	1,403	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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,209,105			46,466	46,466	712,142	67
68	Related Party Allocations (Pages 12H & 12I)		438,716	2,858		2,500	(358)	19,324	68
69	Financial Statement Depreciation			39,026			(39,026)		69
70	TOTAL (lines 4 thru 69)		\$ 4,944,216	\$ 815,467		\$ 130,679	\$ (684,788)	\$ 3,777,641	70

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

Facility Name & ID Number The Waterford Care Center

0054452

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,944,216	\$ 815,467		\$ 130,679	\$ (684,788)	\$ 3,777,641	1
2	Installed Galvanized Steel Door - Basement Stairwell	2017	5,613		20	281	281	3,088	2
3	Installed 4 New Wander Systems - 3Rd Floor Elevators	2017	8,980		20	449	449	1,796	3
4	Tuckpointed Lintel - Outer Walls	2017	7,200		20	360	360	1,080	4
5	Redrilled Holes And Recased - Elevator	2017	26,790		20	1,340	1,340	3,014	5
6	Installed 4 New Wanderguards System - Elevator	2017	4,469		20	223	223	670	6
7	Install 100 Amp 3 Phase Fusible Disconnet - Elevator	2017	2,685		20	134	134	436	7
8	Replaced Bad Raveler, Added Junction Box - Elevator	2017	4,900		20	245	245	796	8
9	Installed 11 Exhaust Fans - Roof	2017	16,500		20	825	825	2,063	9
10	Drained Old And Installed New A/C Piping - Elevator/Employee I	2017	4,859		20	243	243	972	10
11	Removed Faulty Draft Inducer - Chimney	2017	2,535		20	127	127	508	11
12	Installed Brone Recirculating Pump - Basement Valve Room	2017	3,800		20	190	190	760	12
13	4 New Alarms W/Keypads And Push Buttons On 1St & 2Nd Fl	2017	3,166		20	158	158	844	13
14	Bedrooms Entry Door Lighting, Window Cornices, Electric Outlet	2018	18,943		20	947	947	4,735	14
15	New A/C Chiller Compressors	2018	9,347		20	467	467	1,713	15
16	Repair Walls, Install Lvt, Paint In Corridors, Conf Rm, Day Rm	2018	15,958		20	798	798	1,330	16
17	Repair Boiler & Ah Heating Coils	2018	4,705		20	235	235	706	17
18	Repair Main Circulating Pump	2018	2,722		20	136	136	408	18
19	1St, 2Nd & 3Rd Floor Window Replacements	2019	3,065		20	153	153	306	19
20	Kitchen & Hallway Ah Fresh Air Replacement - Dampers	2019	5,450		20	273	273	546	20
21	Electrical Room Pipe Repair	2019	4,353		20	218	218	436	21
22	Provide And Install New Heating Boiler	2020	14,193		20	710	710	710	22
23	New 45 Ton Carrier 2-Stage Chiller (Net Of Insurance)	2020	34,785		20	1,739	1,739	1,739	23
24	Installed Closed Loop Inline Filtration System	2020	6,740		20	337	337	337	24
25	Installed Horizontal Water Line-Basement Ceiling	2020	15,275		20	764	764	764	25
26	Roof Patching	2020	4,950		20	248	248	248	26
27	Repair Basement Water Leak	2020	2,767		20	138	138	138	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	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)		\$ 5,178,966	\$ 815,467		\$ 142,417	\$ (673,050)	\$ 3,807,784	34

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

Facility Name & ID Number The Waterford Care Center

0054452

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	62,720	18
19	Various	2007	288,006		20	14,400	14,400	200,604	19
20	Various	2010	40,518		20	2,026	2,026	22,285	20
21	Various	2012	38,100		20	1,906	1,906	17,150	21
22	Various	2013	45,016		20	2,251	2,251	18,009	22
23	Various	2014	210,216		20	10,511	10,511	73,579	23
24	Light Fixtures, Wall Vinyl & Flooring in Corridors, Nrs Station, D	2017	94,839		20	4,742	4,742	18,968	24
25	Bedrooms & Window Cornices	2018	55,023		20	2,751	2,751	8,253	25
26	Repair Walls, Install LVT, Paint in Corridors, Conf Rm, Day Rm	2018	73,957		20	3,698	3,698	10,773	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,209,105	\$		\$ 46,466	\$ 46,466	\$ 712,142	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,209,105	\$		\$ 46,466	\$ 46,466	\$ 712,142	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,209,105	\$		\$ 46,466	\$ 46,466	\$ 712,142	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 3737 Chase	2019	438,716	1,866	35	2,500	634	19,324	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Management	2015		992			(992)		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)		\$ 438,716	\$ 2,858		\$ 2,500	\$ (358)	\$ 19,324	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 438,716	\$ 2,858		\$ 2,500	\$ (358)	\$ 19,324	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
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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)		\$ 438,716	\$ 2,858		\$ 2,500	\$ (358)	\$ 19,324	34

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

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	\$ 987,916	\$ 947	\$ 92,493	\$ 91,546	10	\$ 907,674	71
72	Current Year Purchases	23,827	643	1,442	799	10	1,442	72
73	Fully Depreciated Assets	993,570	153	8,479	8,326	10	993,570	73
74								74
75	TOTALS	\$ 2,005,314	\$ 1,743	\$ 102,414	\$ 100,671		\$ 1,902,686	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)	\$ 7,494,691	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 817,210	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 244,831	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (572,379)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,747,527	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Damen HC				16,582			5
6								6
7	TOTAL				\$16,582			7

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$1,619
- Description: See Attached

(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 Bus	2013 Ford F450	\$1,023	\$12,271	17
18	Allocated from Damen HC			16,133	18
19					19
20					20
21	TOTAL		\$1,023	\$28,404	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 334,814	\$		\$ 334,814	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			118,578			118,578	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			471,995			471,995	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				119,085		119,085	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					58,675	102		58,777	13
14	TOTAL			\$		\$ 984,062	\$ 119,187		\$ 1,103,249	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,861,518	\$ 2,007,723	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,486,687	2,486,687	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	492,860	492,860	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	24,987	103,097	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,866,052	\$ 5,090,367	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,586,250	13
14	Buildings, at Historical Cost		5,968,441	14
15	Leasehold Improvements, at Historical Cost	188,627	734,603	15
16	Equipment, at Historical Cost	123,027	3,069,690	16
17	Accumulated Depreciation (book methods)	(108,436)	(3,317,752)	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	580,385	5,593,264	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 783,603	\$ 13,634,496	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,649,655	\$ 18,724,863	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 752,429	\$ 752,429	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	393,509	5,197,037	29
30	Accrued Salaries Payable	346,559	346,559	30
31	Accrued Taxes Payable (excluding real estate taxes)	219,118	219,118	31
32	Accrued Real Estate Taxes(Sch.IX-B)		256,767	32
33	Accrued Interest Payable	1,525	1,525	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,303,371	1,304,537	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,016,511	\$ 8,077,972	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,494,455	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,494,455	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,016,511	\$ 18,572,427	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,633,144	\$ 152,436	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,649,655	\$ 18,724,863	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,964,119	1
2	Restatements (describe):		2
3	Depreciation	3,107	3
4	Repairs & Maintenance	53	4
5	Rounding	6	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,967,285	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,740,859	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	(1,075,000)	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)	\$ 665,859	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)	\$ 2,633,144	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Waterford Care Center# 0054452Report Period Beginning: 01/01/20Ending: 12/31/20

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,790,917	1
2	Discounts and Allowances for all Levels	(3,062,412)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,728,505	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,225,333	6
7	Oxygen	1	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,225,334	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	15,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,410	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,392	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,392	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	1,002,271	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,002,271	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,975,912	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,351,547	31
32	Health Care	3,912,426	32
33	General Administration	3,013,291	33
	B. Capital Expense		
34	Ownership	1,365,297	34
	C. Ancillary Expense		
35	Special Cost Centers	1,267,330	35
36	Provider Participation Fee	325,162	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,235,053	40
41	Income before Income Taxes (line 30 minus line 40)**	1,740,859	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,740,859	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,654,647	44
45	Private Pay - Net Inpatient Revenue	498,405	45
46	Medicare - Net Inpatient Revenue	2,425,019	46
47	Other-(specify) <u>Managed Care</u>	96,988	47
48	Other-(specify) <u>Hospice</u>	53,446	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,728,505	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,976	2,080	\$ 101,318	\$ 48.71	1
2	Assistant Director of Nursing	2,006	2,112	85,324	40.40	2
3	Registered Nurses	20,814	21,909	722,585	32.98	3
4	Licensed Practical Nurses	27,574	29,026	865,475	29.82	4
5	CNAs & Orderlies	82,194	86,520	1,396,937	16.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,034	2,141	41,072	19.19	8
9	Activity Director	1,386	1,459	24,184	16.58	9
10	Activity Assistants	5,969	6,283	99,138	15.78	10
11	Social Service Workers	6,045	6,363	103,548	16.27	11
12	Dietician					12
13	Food Service Supervisor	2,014	2,120	54,510	25.71	13
14	Head Cook	6,556	6,901	119,380	17.30	14
15	Cook Helpers/Assistants	10,158	10,692	165,630	15.49	15
16	Dishwashers					16
17	Maintenance Workers	2,976	3,132	52,204	16.67	17
18	Housekeepers	12,590	13,253	211,221	15.94	18
19	Laundry	6,292	6,623	103,318	15.60	19
20	Administrator	2,158	2,272	105,730	46.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,961	2,064	56,395	27.32	23
24	Clerical	6,454	6,793	119,708	17.62	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	1,100	1,158	16,657	14.38	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,181	2,296	88,346	38.47	33
34	TOTAL (lines 1 - 33)	204,438	215,197	\$ 4,532,680 *	\$ 21.06	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	161	\$ 8,580	01-03	35
36	Medical Director	Monthly	36,600	09-03	36
37	Medical Records Consultant	Quarterly	1,600	10-03	37
38	Nurse Consultant	Per Visit	2,000	10-03	38
39	Pharmacist Consultant	Monthly	21,021	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	50	2,663	11-03	44
45	Social Service Consultant	9	604	12-03	45
46	Other(specify) MDS Consultant	Monthly	24,775	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	220	\$ 97,843		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description	Amount		
Kathy Donohue	Administrator	0	\$ 105,730	Workers' Compensation Insurance		\$ 66,349	IDPH License Fee	\$ 3,980		
				Unemployment Compensation Insurance		17,668	Advertising: Employee Recruitment	1,914		
				FICA Taxes		346,750	Health Care Worker Background Check			
				Employee Health Insurance		230,056	(Indicate # of checks performed 35)	2,865		
				Employee Meals			Patient Background Checks 22	220		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	23,022		
				Life Insurance - Involuntary		9,362	Licenses & Fees	7,282		
				Dental / Vision Insurance		432				
				Employee Benefits - Other		16,645				
				Holiday Expense		1,884				
				401K Employer Match Expense		5,804				
				Pension Expense		44,720				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 105,730	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 40,940	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Management Fees - Damen Healthcare Group, LLC			\$ 598,462			\$	Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee	Type		Amount							
Marcum LLP	Accounting		\$ 29,137							
ProPay HR	Payroll Services		25,838							
Damen Healthcare Group, LLC	Bookkeeping Services		144,000							
Achieve Accreditation	Accreditation		4,860							
Correll Co	401K Planning		1,093							
MTS Consulting	Tax Consulting		360							
Personnel Planners	Unemployment Consultant		840							
Plante Moran	Field Audit		5,325							
CIBC	Appraisal Fee		8,621							
eSolutions Inc.	Data Processing		2,345							
See Attached	Legal		31,148							
See Supplemental Schedule			78,701							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			\$			
			\$ 332,268				TOTAL (agree to Sch. V, line 24, col. 8)			\$ 773

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>Yes</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>HCCI \$25,098</u>
(3)	Did the nursing home make political contributions or payments to a political organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 Years</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>32,031</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>325,162</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? (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.	<u>No</u>
(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?	\$ <u>N/A</u> Indicate the amount. \$ <u></u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>N/A</u> <u>N/A</u> <u>100% Ln 14</u> <u>No</u> <u>N/A</u> <u>N/A</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees	<u>Yes</u>