FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0038612

Facility Name: The Waterford Nursing & Rehabilitation

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: BOB KAGDA **Telephone Number:** (847) 675-3585
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 01/01/2010 to 12/31/2010 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) DAN SHABAT
(Title) OWNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 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	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	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	14,518	722	2,530	17,770	8
9	SNF/PED					9
10	ICF	26,057	1,266		27,323	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,575	1,988	2,530	45,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.62%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 37 and days of care provided 2,530

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	209,344	16,842	8,724	234,910		234,910		234,910			1
2	Food Purchase		204,662		204,662	(30,835)	173,827	(1,020)	172,807			2
3	Housekeeping	131,151	28,374		159,525		159,525		159,525			3
4	Laundry	54,970	9,979		64,949		64,949		64,949			4
5	Heat and Other Utilities			124,662	124,662		124,662		124,662			5
6	Maintenance	28,415	4,580	41,792	74,787		74,787	9,729	84,516			6
7	Other (specify):*			9,600	9,600		9,600		9,600			7
8	TOTAL General Services	423,880	264,437	184,778	873,095	(30,835)	842,260	8,709	850,969			8
	B. Health Care and Programs											
9	Medical Director			23,300	23,300		23,300		23,300			9
10	Nursing and Medical Records	1,889,783	74,520	29,921	1,994,224		1,994,224		1,994,224			10
10a	Therapy	51,422			51,422		51,422		51,422			10a
11	Activities	90,276	3,054	3,400	96,730		96,730		96,730			11
12	Social Services	30,951	1,000	5,646	37,597		37,597		37,597			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,062,432	78,574	62,267	2,203,273		2,203,273		2,203,273			16
	C. General Administration											
17	Administrative	73,751		300,000	373,751		373,751	(202,500)	171,251			17
18	Directors Fees											18
19	Professional Services			58,760	58,760		58,760	4,275	63,035			19
20	Dues, Fees, Subscriptions & Promotions			37,466	37,466		37,466	(26,349)	11,117			20
21	Clerical & General Office Expenses	221,187	7,778	22,831	251,796		251,796	(81,103)	170,693			21
22	Employee Benefits & Payroll Taxes			470,789	470,789	30,835	501,624		501,624			22
23	Inservice Training & Education			1,230	1,230		1,230		1,230			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,492	2,492		2,492	(2,492)				25
26	Insurance-Prop.Liab.Malpractice			34,128	34,128		34,128	109,757	143,885			26
27	Other (specify):*							7,429	7,429			27
28	TOTAL General Administration	294,938	7,778	927,696	1,230,412	30,835	1,261,247	(190,983)	1,070,264			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,781,250	350,789	1,174,741	4,306,780		4,306,780	(182,274)	4,124,506			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#: The Waterford Nursing & Rehabilitation #0038612 **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,724	
	REPAIRS & MAINTENANCE		0	
			0	8,724
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		47,990	
	ELECTRICITY		49,969	
	WATER		24,954	
	CABLE TV - LOBBY		1,749	
			0	124,662
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		31,776	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		7,144	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,872	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	41,792
7	**OTHER**			
	SCAVENGER		9,600	
	SECURITY SERVICE		0	
			0	
			0	9,600
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	23,300	23,300

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	22,366	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 46-2	1,350	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,568	
	PHARMACY CONSULTANT	XVIII B 39-2	4,637	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	29,921
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,400	
			0	3,400
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,646	
			0	5,646
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number The Waterford Nursing & Rehabilitation **#0038612** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	300,000	300,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,739	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	39,021	
			0	58,760
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	19,628	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	700	
	DUES & SUBSCRIPTIONS	XIX F	7,241	
	LICENSES & PERMITS	XIX F	2,776	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	515	
	CONTRIBUTIONS - POLITICAL - COPE	VI 20 XIX F	5,506	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,100	
	PATIENT BACKGROUND CHECKS	XIX F		
				37,466
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,061	
	EQUIPMENT REPAIR & MAINTENANCE		2,824	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	883	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,063	
	MESSENGER SERVICE		0	
			0	22,831

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	212,768	
	UNEMPLOYMENT COMPENSATION	XIX D	15,537	
	WORKERS COMPENSATION INSURANC	XIX D	50,331	
	HOSPITALIZATION INSURANCE	XIX D	162,118	
	EMPLOYEE BENEFITS - OTHER	XIX D	97	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	24,574	
	CHICAGO HEAD TAX	XIX D	5,364	
			0	470,789
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,230	
				1,230
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF - SEE PAGE 5A		2,492	
				2,492
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		923	
	INSURANCE SETTLEMENTS-ASSURECARE		33,205	
				34,128
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,174,741**

The Waterford Nursing & Rehabilitation
SCHEDULES
12/31/2010

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	204,662
LESS SALES TAX	(1,020)
NET FOOD	203,642
TOTAL PATIENT CENSUS	45,093
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	135,279
ADD # EMPLOYEE MEALS/DAY	66
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	24,090
PATIENT MEALS	135,279
ADD EMPLOYEE MEALS	24,090
TOTAL MEALS/YEAR	159,369
NET FOOD	203,642
DIVIDE TOTAL MEALS/YEAR	159,369
COST PER MEAL	1.28
TIME EMPLOYEE MEALS	24,090
EMPLOYEE MEAL RECLASSIFICATION	**30,835**

PROFESSIONAL FEES
PAGE 21 XIX. C.

MEDIFAX EDI	DATA PROCESSING	302
MDI TECHNOLOGY	DATA PROCESSING	10,058
IVANS	DATA PROCESSING	1051
CURASPAN HEALTH GROUP	DATA PROCESSING	2700
LIFE CARE SOFTWARE SOLUTIONS	DATA PROCESSING	5628
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	16,360
OSTROW REISEN BERK ABRAMS	ACCOUNTING	2,224
STEVEN BRUEGGEMAN	ACCOUNTING	9,200
SKIDELSKY & ASSOCIATES	REAL ESTATE TAX LEGAL	6,039
MUCH SHELIST	LEGAL	953
RICHARD PEELO	MEDICARE COST REPORT	2,100
ELDERLIFE DEVELOPMENT	FIRE CODE CONSULTANT	1,515
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	630
	PROFESSIONAL FEES	**58,760**

Facility Name & ID Number The Waterford Nursing & Rehabilitation #0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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			46,207	46,207		46,207	118,844	165,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,415	5,415		5,415	268,349	273,764			32
33	Real Estate Taxes							155,093	155,093			33
34	Rent-Facility & Grounds			745,933	745,933		745,933	(745,933)				34
35	Rent-Equipment & Vehicles			427	427		427		427			35
36	Other (specify):*							21,981	21,981			36
37	**TOTAL Ownership**			797,982	797,982		797,982	(181,666)	616,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,611	382,976	501,587		501,587		501,587			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,198	77,198		77,198		77,198			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		118,611	460,174	578,785		578,785		578,785			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,781,250	469,400	2,432,897	5,683,547		5,683,547	(363,940)	5,319,607			45

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,992)	30		9
10	Interest and Other Investment Income	(106)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,020)	2		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	(515)	20		17
18	Fines and Penalties	(883)	21		18
19	Entertainment	(19,628)	20		19
20	Contributions	(6,206)	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				24
25	Fund Raising, Advertising and Promotional				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	(82,712)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (119,062)		$	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)	(244,878)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (244,878)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (363,940)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Waterford Nursing & Rehabilitation

ID# **0038612**

Report Period Beginning: **01/01/2010**

Ending: **12/31/2010**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (80,220)	21	1
2	MARKETING TRAVEL	(2,492)	25	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				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**	(82,712)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,020)	0	0	0	0	0	0	0	0	0	0	(1,020)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	9,729	0	0	0	0	0	0	0	0	0	9,729	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,020)	9,729	0	0	0	0	0	0	0	0	0	8,709	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(196,500)	(6,000)	0	0	0	0	0	0	0	(202,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,275	0	0	0	0	0	0	0	0	0	4,275	19
20	Fees, Subscriptions & Promotions	(26,349)	0	0	0	0	0	0	0	0	0	0	(26,349)	20
21	Clerical & General Office Expenses	(81,103)	0	0	0	0	0	0	0	0	0	0	(81,103)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,492)	0	0	0	0	0	0	0	0	0	0	(2,492)	25
26	Insurance-Prop.Liab.Malpractice	0	109,757	0	0	0	0	0	0	0	0	0	109,757	26
27	Other (specify):*	0	0	4,793	2,636	0	0	0	0	0	0	0	7,429	27
28	**TOTAL General Administration**	(109,944)	114,032	(191,707)	(3,364)	0	0	0	0	0	0	0	(190,983)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,964)	123,761	(191,707)	(3,364)	0	0	0	0	0	0	0	(182,274)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(7,992)	126,836	0	0	0	0	0	0	0	0	0	118,844	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(106)	268,455	0	0	0	0	0	0	0	0	0	268,349	32
33	Real Estate Taxes	0	155,093	0	0	0	0	0	0	0	0	0	155,093	33
34	Rent-Facility & Grounds	0	(745,933)	0	0	0	0	0	0	0	0	0	(745,933)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	21,981	0	0	0	0	0	0	0	0	0	21,981	36
37	**TOTAL Ownership**	(8,098)	(173,568)	0	0	0	0	0	0	0	0	0	(181,666)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(119,062)	(49,807)	(191,707)	(3,364)	0	0	0	0	0	0	0	(363,940)	45

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dan Shabat	100%	Heritage Nursing Home Inc	Chicago	Deauville Associates LLC		Building Co
				Pharmore Drugs LLC		Drug Co
				Lifescan Laboratory Inc		Lab Co
				Pro Health Care Inc		Mgmt Co
				SFMA Inc		Mgmt Co

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 745,933	Deauville Associates LLC	100.00%	$	$ (745,933)	1
2	V	32	Interest	472	" "		263,796	263,324	2
3	V	19	Professional Fees		" "		4,275	4,275	3
4	V	6	Repairs & Maintenance		" "		9,729	9,729	4
5	V	26	Property Insurance		" "		109,757	109,757	5
6	V	33	R E Taxes		" "		155,093	155,093	6
7	V	30	Depreciation		" "		126,836	126,836	7
8	V	32	Amortization Loan Fees		" "		5,131	5,131	8
9	V	36	MIP Expense		" "		21,981	21,981	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 746,405			$ 696,598	$ * (49,807)	14

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 294,000	SFMA, INC		$	$ (294,000)	15
16	V	17	Dan Shabat Comp		" "		97,500	97,500	16
17	V	27	Admin Benefits		" "		4,793	4,793	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			$ 294,000			$ 102,293	$ * (191,707)	39

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 6,000	Pro Health Care Inc		$	$ (6,000)	15
16	V	27	Salary - Stan Aron		" "		2,439	2,439	16
17	V	27	Payroll Taxes		" "		197	197	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			$ 6,000			$ 2,636	$ * (3,364)	39

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	10	In House Drugs	$ 5,865	Pharmore Drugs LLC		$ 5,865	$	15
16	V	39	Exp - Drugs	98,507	" "		98,507		16
17	V	10	Pharmacy Consultant	4,637	" "		4,637		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			$ 109,009			$ 109,009	$ *	39

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Exp - Laboratory	$ 4,283	Lifescan Laboratory Inc		$ 4,283	$	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			$ 4,283			$ 4,283	$ *	39

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Dan Shabat	Owner	Administrative	100.00	See Attached	20	33.00	Alloc Salary	$ 97,500	17-7	1
2	Stan Aron		Administrative	0.00	See Attached	1	2.44	Alloc Salary	2,439	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 99,939		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Dan Shabat Comp	Avg Hours Worked	40	2	$ 195,000	$ 195,000	20	$ 97,500	1
2	27	Admin Benefits	" "	40	2	9,586		20	4,793	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					$ 204,586	$ 195,000		$ 102,293	25

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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: Pro Health Care Inc C/O FR & R
Street Address: 111 Pfingsten Road
City / State / Zip Code: Deerfield, IL 60115
Phone Number: (847) 236-1111
Fax Number: (847) 236-1155

	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	Salary - Stan Aron	Ave Hours Worked	41	4	$ 100,000	$ 100,000	1	$ 2,439	1
2	27	Payroll Taxes	" "	41	4	8,087		1	197	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					$ 108,087	$ 100,000		$ 2,636	25

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	RELATED PARTY-Deauville Associates, LLC						$	$			$	1
2	Heartland Bank		X	Mortgage	$27,769.38	08/25/06	4,631,700	4,364,599	09/2036	6.0000	263,796	2
3	Loan Fees		X	Amortized over life of loan			153,941	126,575			5,131	3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital			102,300				5,415	6
7												7
8												8
9	TOTAL Facility Related				$27,769.38		$ 4,887,941	$ 4,491,174			$ 274,342	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,887,941	$ 4,491,174			$ 274,342	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 21,981 **Line #** 36

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

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation **#** 0038612 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 150,584	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.)		$ 150,575	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 155,102	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.**		$	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.		$ 155,093	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	157,355	8
	2006	153,961	9
	2007	144,746	10
	2008	146,198	11
	2009	150,575	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Waterford Nursing & Rehabilitation COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038612

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-308-005-0000	NURSING HOME	$ 150,575.35	$ 150,575.35
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 150,575.35	$ 150,575.35

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,216 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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	RELATED PARTY - Deauville Associates, LLC		1984	$ 195,934	1
2					2
3	TOTALS			$ 195,934	3

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	RELATED PARTY-Deauville Associates, LLC:				$	$		$	$	$	4
5	141		1994	1977	2,189,665	56,145	39	56,145		1,515,922	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY-Deauville Associates, LLC:										9
10	Deauville Associates			1982	3,174		15			3,174	10
11	Deauville Associates			1983	22,000		15			22,000	11
12	Deauville Associates			1984	78,473		15			78,473	12
13	Deauville Associates			1985	65,697		19			65,697	13
14	Deauville Associates			1986	11,600		19			11,600	14
15	Deauville Associates			1987	17,548		10			17,548	15
16	Deauville Associates			1990	16,762		10			16,762	16
17	Deauville Associates			1991	36,643		10			36,643	17
18	Deauville Associates			1992	27,806		10			27,806	18
19	Boilers			2006	70,593	14,119	5	14,119		57,651	19
20	Nurses Station			2007	50,000	5,000	10	5,000		16,667	20
21	Window Replacement			2007	60,000	6,000	10	6,000		20,000	21
22	Physical Therapy Room			2007	29,808	2,981	10	2,981		10,185	22
23	Windows			2007	118,715	11,872	10	11,872		40,561	23
24	Boilers			2007	33,629	6,726	5	6,726		26,903	24
25	Door Handles, Locks			2007	13,243	2,649	5	2,649		9,050	25
26	Shower Room			2007	18,866	1,887	10	1,887		6,761	26
27	Nurses Call System 3rd Floor			2007	9,492	949	10	949		3,322	27
28	Shower Room			2007	23,046	2,305	10	2,305		8,259	28
29	Window Treatments			2007	10,090	1,009	10	1,009		3,532	29
30	Nurses Call System 2nd Floor			2007	4,746	475	10	475		1,661	30
31	Fire Alarm System & Sprinklers			2010	40,518	269	10	269		269	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	FACILITY:		$	$		$	$	$	37
38	Various	1993	63,831	3,191	20	3,191		54,560	38
39	Various	1994	17,273	740	20	740		14,885	39
40	Various	1995	34,505	1,126	20	1,126		29,952	40
41	Various	1996	19,396	889	20	889		14,646	41
42	Various	1997	79,650	3,982	20	3,982		54,096	42
43	Various	1999	35,500		3			35,500	43
44	Various	2000	17,386		5			17,386	44
45	Various	2001	19,348	339	20	339		11,402	45
46	Various	2002	34,272	616	20	616		33,423	46
47	Various	2004	76,500	7,650	20	3,825	(3,825)	47,813	47
48	Cable Equipment & Installation	2007	7,500	750	20	375	(375)	2,156	48
49	Wall and Heater Removal	2007	45,287	4,528	20	2,264	(2,264)	13,963	49
50	1st and 2nd Floor Nurses Station and Corridor	2007	2,176	217	20	109	(108)	599	50
51	Resident Rooms - Doors & 2nd Floor Corr/Nurses Station	2008	1,524	153	20	76	(77)	317	51
52	Boilers	2008	14,924	1,493	20	746	(747)	3,357	52
53	Wiring for Cable - 30 Resident Rooms & 3 Dayrooms	2009	3,350	122	20	168	46	391	53
54	Wall & Door with Frame	2009	2,948	107	20	147	40	361	54
55	6" Gate Value	2009	3,225	117	20	161	44	278	55
56	Smoke Detectors	2009	2,400	87	20	120	33	207	56
57	Elevator Repairs	2009	10,930	397	20	547	150	1,046	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,444,039	$ 138,890		$ 131,807	$ (7,083)	$ 2,336,784	70

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 188,592	$ 18,158	$ 18,279	$ 121	5 - 10 Yrs	$ 122,872	71
72	Current Year Purchases	2,575	1,545	515	(1,030)	5 Yrs	515	72
73	Fully Depreciated Assets	198,872					198,872	73
74	Deauville Health Care Center	498,071	14,450	14,450		5 - 10 Yrs	463,818	74
75	TOTALS	$ 888,110	$ 34,153	$ 33,244	$ (909)		$ 786,077	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 4,528,083	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,043	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 165,051	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,992)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,122,861	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 The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 427 Description: POSTAGE METER RENTAL
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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 The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	39-3	hrs	$		$ 160,558	$		$ 160,558	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			26,762			26,762	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			189,700			189,700	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				98,507		98,507	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39-3				5,956			5,956	12
13	Other (specify): Lab, Med Supplies	39-2					20,104		20,104	13
14	TOTAL			$		$ 382,976	$ 118,611		$ 501,587	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 The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 5,708	$ 58,361	1
2	Cash-Patient Deposits	4,860	4,860	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 597,438)	1,014,292	1,014,292	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,394	83,277	6
7	Other Prepaid Expenses	1,974	1,974	7
8	Accounts Receivable (owners or related parties)	230,251	644,142	8
9	Other(specify): Employee Loans & Advances	3,307	3,307	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,280,786	$ 1,810,213	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,934	13
14	Buildings, at Historical Cost		2,189,665	14
15	Leasehold Improvements, at Historical Cost	491,925	1,089,903	15
16	Equipment, at Historical Cost	390,038	1,059,001	16
17	Accumulated Depreciation (book methods)	(669,609)	(3,138,051)	17
18	Deferred Charges		145,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		489,966	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSIT	5,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 217,354	$ 2,031,533	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,498,140	$ 3,841,746	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 494,906	$ 531,045	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,772	56,772	28
29	Short-Term Notes Payable		73,352	29
30	Accrued Salaries Payable	119,954	119,954	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,451	3,451	31
32	Accrued Real Estate Taxes(Sch.IX-B)		155,102	32
33	Accrued Interest Payable		21,823	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	510,155		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,185,238	$ 961,499	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,291,247	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)**	$	$ 4,291,247	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,185,238	$ 5,252,746	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 312,902	$ (1,411,000)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,498,140	$ 3,841,746	48

*(See instructions.)

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 551,498	1
2	Restatements (describe):		2
3	**PRIOR YEAR ROUTINE SERVICE INCOME ADJUSTMENT**	58,474	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 609,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(297,070)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (297,070)	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)**	$ 312,902	24 *

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,299,033	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,299,033	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	87,038	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 87,038	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	106	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 106	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COOK COUNTY BOARD OF ELECTIONS	300	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 300	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,386,477	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	873,095	31
32	Health Care	2,203,273	32
33	General Administration	1,230,412	33
	B. Capital Expense		
34	Ownership	797,982	34
	C. Ancillary Expense		
35	Special Cost Centers	501,587	35
36	Provider Participation Fee	77,198	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,683,547	40
41	**Income before Income Taxes (line 30 minus line 40)****	(297,070)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (297,070)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **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 The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2,007	2,248	$ 96,821	$ 43.07	1
2	Assistant Director of Nursing	1,928	2,129	66,046	31.02	2
3	Registered Nurses	16,185	17,646	449,380	25.47	3
4	Licensed Practical Nurses	17,147	19,450	437,231	22.48	4
5	CNAs & Orderlies	66,051	94,378	760,085	8.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,059	6,104	51,422	8.42	8
9	Activity Director					9
10	Activity Assistants	7,241	8,516	90,276	10.60	10
11	Social Service Workers	1,779	1,990	30,951	15.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,917	28,112	209,344	7.45	15
16	Dishwashers					16
17	Maintenance Workers	1,978	2,266	28,415	12.54	17
18	Housekeepers	11,712	16,929	131,151	7.75	18
19	Laundry	5,775	7,707	54,970	7.13	19
20	Administrator	1,944	2,129	73,751	34.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,937	15,822	221,187	13.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: ADMITTING	1,853	2,086	80,220	38.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,513	227,512	$ 2,781,250 *	$ 12.22	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	M	$ 8,724	1-3	35
36	Medical Director	O	23,300	9-3	36
37	Medical Records Consultant	N	1,568	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,637	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,400	11-3	44
45	Social Service Consultant	E	5,646	12-3	45
46	Other(specify) Psycho-social	S	1,350	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 48,625		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 714	10-3	50
51	Licensed Practical Nurses	578	21,652	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	594	$ 22,366		53

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Donahue	ADMINISTRATOR		$ 73,751
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,751

B. Administrative - Other

Description	Amount
Management Fees - SFMA	$ 294,000
Management Fees - Pro Health	6,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 300,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		58,760
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 58,760

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,331
Unemployment Compensation Insurance	15,537
FICA Taxes	212,768
Employee Health Insurance	162,118
Employee Meals	30,835
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	97
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	24,574
CHICAGO HEAD TAX	5,364
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 501,624

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	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	1,100
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	6,721
MARKETING/ADV/PROMO	19,628
LICENSES/DUES/SUBSCRIPTIONS	8,027
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(6,721)
Less: Public Relations Expense	(19,628)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,117

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Waterford Nursing & Rehabilitation # 0038612 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $6,527 IAHC $564**

(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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,126** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Deauville Healthcare Center, License #38612 11/01/1992

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **77,198**
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. $ **30,835** 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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.