FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0028076

Facility Name: WATERFRONT TERRACE

Address: 7750 SOUTH SHORE DRIVE (Number) CHICAGO (City) 60649 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 04/01/1983

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) MARSHALL MAUER
(Title) TREASURER

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 WATERFRONT TERRACE # 0028076 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	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	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	7,559	263	5,396	13,218	8
9	SNF/PED					9
10	ICF	23,353	312		23,665	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,912	575	5,396	36,883	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.64%

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 04/01/1983

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1983 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 5,396

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

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 WATERFRONT TERRACE # 0028076 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	196,297	13,931	10,017	220,245		220,245		220,245			1
2	Food Purchase		191,482		191,482	(31,536)	159,946	(926)	159,020			2
3	Housekeeping		19,361	137,898	157,259		157,259		157,259			3
4	Laundry		29,342	101,594	130,936		130,936		130,936			4
5	Heat and Other Utilities			109,673	109,673		109,673	1,262	110,935			5
6	Maintenance	64,225	82,845	18,245	165,315		165,315	10,573	175,888			6
7	Other (specify):*			22,087	22,087		22,087	632	22,719			7
8	**TOTAL General Services**	260,522	336,961	399,514	996,997	(31,536)	965,461	11,541	977,002			8
	B. Health Care and Programs											
9	Medical Director			12,200	12,200		12,200		12,200			9
10	Nursing and Medical Records	1,809,474	119,897	6,388	1,935,759		1,935,759	(4,357)	1,931,402			10
10a	Therapy	580,891	1,615		582,506		582,506		582,506			10a
11	Activities	118,760	21,637	1,440	141,837		141,837		141,837			11
12	Social Services	46,109		6,394	52,503		52,503		52,503			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,555,234	143,149	26,422	2,724,805		2,724,805	(4,357)	2,720,448			16
	C. General Administration											
17	Administrative	130,470		67,000	197,470		197,470	86,195	283,665			17
18	Directors Fees											18
19	Professional Services			90,649	90,649		90,649	763	91,412			19
20	Dues, Fees, Subscriptions & Promotions			176,006	176,006		176,006	(125,114)	50,892			20
21	Clerical & General Office Expenses	180,170	32,523	430,261	642,954		642,954	(383,527)	259,427			21
22	Employee Benefits & Payroll Taxes			638,492	638,492	31,536	670,028		670,028			22
23	Inservice Training & Education			3,411	3,411		3,411		3,411			23
24	Travel and Seminar							330	330			24
25	Other Admin. Staff Transportation			12,997	12,997		12,997	(2,869)	10,128			25
26	Insurance-Prop.Liab.Malpractice			107,988	107,988		107,988	1,134	109,122			26
27	Other (specify):*			47,025	47,025		47,025	(7,193)	39,832			27
28	**TOTAL General Administration**	310,640	32,523	1,573,829	1,916,992	31,536	1,948,528	(430,281)	1,518,247			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,126,396	512,633	1,999,765	5,638,794		5,638,794	(423,097)	5,215,697			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#: WATERFRONT TERRACE **#0028076** **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	9,324	
	REPAIRS & MAINTENANCE		693	
			0	10,017
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICES		137,898	
			0	137,898
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		9,662	
	CONTRACTED LAUNDRY SERVICES		91,932	101,594
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		48,878	
	ELECTRICITY		44,715	
	WATER		16,080	
	CABLE TV - LOBBY		0	
			0	109,673
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,244	
	PAINTING & DECORATING		1,319	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,580	
	ELEVATOR MAINTENANCE & REPAIR		4,464	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,638	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	18,245
7	**OTHER**			
	SCAVENGER		22,087	
	SECURITY SERVICE		0	
			0	
			0	22,087
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,200	12,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,388	
	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	6,388
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	1,440	
			0	1,440
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,394	
			0	6,394
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE **#0028076** **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	67,000	67,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,159	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	77,490	
			0	90,649
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	116,231	
	EMPLOYEE WANT ADS	XIX F	35,370	
	CONTRIBUTIONS	VI 20 XIX F	2,600	
	DUES & SUBSCRIPTIONS	XIX F	8,024	
	LICENSES & PERMITS	XIX F	2,667	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	6,964	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	4,150	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				176,006
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,171	
	EQUIPMENT REPAIR & MAINTENANCE		19,163	
	OUTSIDE CLERICAL SERVICES		388,553	
	PENALTIES / OVERDRAFT CHARGES	VI 18	64	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,310	
	MESSENGER SERVICE		0	
			0	430,261

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	230,140	
	UNEMPLOYMENT COMPENSATION	XIX D	78,388	
	WORKERS COMPENSATION INSURANC	XIX D	75,878	
	HOSPITALIZATION INSURANCE	XIX D	226,165	
	EMPLOYEE BENEFITS - OTHER	XIX D	22,821	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	5,100	
			0	638,492
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,411	
				3,411
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,997	
				12,997
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		107,988	
				107,988
27	**OTHER**			
	BAD DEBTS	VI 24	47,025	
				47,025

GRAND TOTAL COLUMN 3 OTHER **1,999,765**

WATERFRONT TERRACE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	191,482
LESS SALES TAX	(926)
NET FOOD	190,556
TOTAL PATIENT CENSUS	36,883
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	110,649
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	21,900
PATIENT MEALS	110,649
ADD EMPLOYEE MEALS	21,900
TOTAL MEALS/YEAR	132,549
NET FOOD	190,556
DIVIDE TOTAL MEALS/YEAR	132,549
COST PER MEAL	1.44
TIME EMPLOYEE MEALS	21,900
EMPLOYEE MEAL RECLASSIFICATION	**31,536**
	========

Facility Name & ID Number WATERFRONT TERRACE #0028076 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			127,379	127,379		127,379	33,778	161,157			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,421	55,421		55,421	3,502	58,923			32
33	Real Estate Taxes			95,696	95,696		95,696	2,151	97,847			33
34	Rent-Facility & Grounds			534,000	534,000		534,000	(534,000)				34
35	Rent-Equipment & Vehicles			24,409	24,409		24,409	6,404	30,813			35
36	Other (specify):*											36
37	**TOTAL Ownership**			836,905	836,905		836,905	(488,165)	348,740			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		214,673	3,015	217,688		217,688	(1,866)	215,822			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		214,673	67,620	282,293		282,293	(1,866)	280,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,126,396	727,306	2,904,290	6,757,992		6,757,992	(913,128)	5,844,864			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 WATERFRONT TERRACE # 0028076 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	24,603	30		9
10	Interest and Other Investment Income	(31)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(926)	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				17
18	Fines and Penalties	(64)	21		18
19	Entertainment				19
20	Contributions	(9,564)	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	(47,025)	27		24
25	Fund Raising, Advertising and Promotional	(116,231)	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 SEE PAGE 5A	(56,397)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (205,635)		$	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)	(707,493)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (707,493)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (913,128)		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

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ -52797	21	1
2	MARKETING TRAVEL	(3,600)	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**	(56,397)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE # 0028076 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(926)	0	0	0	0	0	0	0	0	0	0	(926)	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	1,262	0	0	0	0	0	0	0	0	1,262	5
6	Maintenance	0	0	4,122	6,451	0	0	0	0	0	0	0	10,573	6
7	Other (specify):*	0	0	0	0	632	0	0	0	0	0	0	632	7
8	**TOTAL General Services**	(926)	0	5,384	6,451	632	0	0	0	0	0	0	11,541	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	(4,357)	0	0	0	0	0	(4,357)	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	(4,357)	0	0	0	0	0	(4,357)	16
	C. General Administration													
17	Administrative	0	(67,000)	0	153,195	0	0	0	0	0	0	0	86,195	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	763	0	0	0	0	0	0	0	0	763	19
20	Fees, Subscriptions & Promotions	(125,795)	0	681	0	0	0	0	0	0	0	0	(125,114)	20
21	Clerical & General Office Expenses	(52,861)	(388,553)	49,944	7,943	0	0	0	0	0	0	0	(383,527)	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	330	0	0	0	0	0	0	0	0	330	24
25	Other Admin. Staff Transportation	(3,600)	0	731	0	0	0	0	0	0	0	0	(2,869)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,134	0	0	0	0	0	0	0	0	1,134	26
27	Other (specify):*	(47,025)	0	9,691	0	30,141	0	0	0	0	0	0	(7,193)	27
28	**TOTAL General Administration**	(229,281)	(455,553)	63,274	161,138	30,141	0	0	0	0	0	0	(430,281)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(230,207)	(455,553)	68,658	167,589	30,773	(4,357)	0	0	0	0	0	(423,097)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **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	24,603	6,425	2,750	0	0	0	0	0	0	0	0	33,778	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31)	0	3,533	0	0	0	0	0	0	0	0	3,502	32
33	Real Estate Taxes	0	0	2,151	0	0	0	0	0	0	0	0	2,151	33
34	Rent-Facility & Grounds	0	(534,000)	0	0	0	0	0	0	0	0	0	(534,000)	34
35	Rent-Equipment & Vehicles	0	0	6,404	0	0	0	0	0	0	0	0	6,404	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	24,572	(527,575)	14,838	0	0	0	0	0	0	0	0	(488,165)	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	(1,866)	0	0	0	0	0	(1,866)	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	(1,866)	0	0	0	0	0	(1,866)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(205,635)	(983,128)	83,496	167,589	30,773	(6,223)	0	0	0	0	0	(913,128)	45

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

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	17	MANAGEMENT FEE	$ 67,000	DYNAMIC HEALTH CARE CONSULTANT	100.00%	$	$ (67,000)	1
2	V	21	BOOKKEEPING SERVICE	388,553	" "			(388,553)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	534,000	WATERFRONT TERRACE ASSOCIATES	100.00%		(534,000)	7
8	V	30	DEPRECIATION		" "		6,425	6,425	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 989,553			$ 6,425	$ * (983,128)	14

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,262	$ 1,262	15
16	V	6	REPAIR & MAINT.		" " "		4,122	4,122	16
17	V	19	PROFESSIONAL FEES		" " "		763	763	17
18	V	20	DUES AND SUBSCRIPTION		" " "		681	681	18
19	V	21	CLERICAL & GENERAL		" " "		49,944	49,944	19
20	V	24	SEMINARS AND TRAVEL		" " "		330	330	20
21	V	25	AUTO EXPENSE		" " "		731	731	21
22	V	26	INSURANCE		" " "		1,134	1,134	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "		9,691	9,691	23
24	V	30	DEPRECIATION		" " "		2,750	2,750	24
25	V	32	INTEREST		" " "		3,533	3,533	25
26	V	33	REAL ESTATE TAXES		" " "		2,151	2,151	26
27	V	35	EQUIPMENT RENTAL		" " "		6,404	6,404	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			$			$ 83,496	$ * 83,496	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS		$ 6,451	$ 6,451	15
16	V	17	ADMIN COMP - M MAUER		" " "		18,620	18,620	16
17	V	17	ADMIN COMP - M AARON		" " "		21,113	21,113	17
18	V	17	ADMIN COMP - F AARON		" " "		17,200	17,200	18
19	V	17	ADMIN COMP - S GOLDSTEIN		" " "				19
20	V	17	ADMIN COMP - J AARON		" " "				20
21	V	17	ADMIN COMP - S KOPLIN		" " "		24,505	24,505	21
22	V	17	ADMIN COMP - D KUFTA		" " "		17,068	17,068	22
23	V	17	ADMIN COMP - HOWARD ALTER		" " "		12,000	12,000	23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" " "				24
25	V	17	ADMIN COMP - NON OWNER - VAR		" " "		24,067	24,067	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" " "		18,622	18,622	26
27	V	21	CLERICAL COMP - S AARON		" " "		7,943	7,943	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			$			$ 167,589	$ * 167,589	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS		$ 632	$ 632	15
16	V	27	EMP BEN - M MAUER		" " "		1,013	1,013	16
17	V	27	EMP BEN - M AARON		" " "		1,177	1,177	17
18	V	27	EMP BEN - F AARON		" " "		7,113	7,113	18
19	V	27	EMP BEN - S GOLDSTEIN		" " "				19
20	V	27	EMP BEN - J AARON		" " "				20
21	V	27	EMP BEN - S KOPLIN		" " "		8,373	8,373	21
22	V	27	EMP BEN - D MAGAFAS		" " "		1,128	1,128	22
23	V	27	EMP BEN - HOWARD ALTER		" " "		1,083	1,083	23
24	V	27	EMP BEN - V DAVIS		" " "				24
25	V	27	EMP BEN - NON OWNER		" " "		6,866	6,866	25
26	V	27	EMP BEN - NON OWNER - CFO		" " "		2,000	2,000	26
27	V	27	EMP BEN - S AARON		" " "		1,388	1,388	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			$			$ 30,773	$ * 30,773	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	MEDICAL SUPPLIES	$ 37,650	LINCOLN MEDICAL SUPPLIES INC		$ 33,293	$ (4,357)	15
16	V	39	ANCILLARY EXPENSE	16,128	" " "		14,262	(1,866)	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			$ 53,778			$ 47,555	$ * (6,223)	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	MARSHALL MAUER	ADMINISTRATION				SCHEDULE ATTACHED			$ 18,620	17-7	1
2	MAURICE AARON	ADMINISTRATION							21,113	17-7	2
3	FRED AARON	ADMINISTRATION							17,200	17-7	3
4	FRED AARON	ADMINISTRATION							30,000	17-1	4
5	SHARON AARON	CLERICAL							7,943	21-7	5
6	HOWARD ALTER	ADMINISTRATOR							12,000	17-7	6
7	HOWARD ALTER	ADMINISTRATOR							100,470	17-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 207,346		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 WATERFRONT TERRACE # 0028076 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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	400,612	11	$ 13,707	$	36,883	$ 1,262	1
2	6	REPAIR & MAINTENANCE	TOTAL PATIENT DAYS	400,612	11	44,776		36,883	4,122	2
3	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	400,612	11	8,291		36,883	763	3
4	20	DUES & SUBSCRIPTIONS	TOTAL PATIENT DAYS	400,612	11	7,402		36,883	681	4
5	21	CLERICAL & GENERAL	TOTAL PATIENT DAYS	400,612	11	542,482	382,381	36,883	49,944	5
6	24	SEMINARS & TRAVEL	TOTAL PATIENT DAYS	400,612	11	3,581		36,883	330	6
7	25	AUTO EXPENSE	TOTAL PATIENT DAYS	400,612	11	7,935		36,883	731	7
8	26	INSURANCE	TOTAL PATIENT DAYS	400,612	11	12,320		36,883	1,134	8
9	27	EMP BEN - GEN ADMIN	TOTAL PATIENT DAYS	400,612	11	105,262		36,883	9,691	9
10	30	DEPRECIATION	TOTAL PATIENT DAYS	400,612	11	29,871		36,883	2,750	10
11	32	INTEREST	TOTAL PATIENT DAYS	400,612	11	38,376		36,883	3,533	11
12	33	REAL ESTATE TAXES	TOTAL PATIENT DAYS	400,612	11	23,364		36,883	2,151	12
13	35	EQUIPMENT RENTAL	TOTAL PATIENT DAYS	400,612	11	69,556		36,883	6,404	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					$ 906,923	$ 382,381		$ 83,496	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	6	MAINT COMP - D NEHMER	WGHTD AVG. HOURS	40	8	$ 61,112	$ 61,112	4	$ 6,451	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG. HOURS	40	10	200,000	200,000	4	18,620	2
3	17	ADMIN COMP - M AARON	WGHTD AVG. HOURS	40	8	200,000	200,000	4	21,113	3
4	17	ADMIN COMP - F AARON	WGHTD AVG. HOURS	45	5	86,000	86,000	9	17,200	4
5	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG. HOURS	40	2	89,700	89,700			5
6	17	ADMIN COMP - J AARON	WGHTD AVG. HOURS	40	1	3,386	3,386			6
7	17	ADMIN COMP - S KOPLIN	WGHTD AVG. HOURS	30	3	73,516	73,516	10	24,505	7
8	17	ADMIN COMP - D MAGAFAS	WGHTD AVG. HOURS	50	8	161,659	161,659	5	17,068	8
9	17	ADMIN COMP - H ALTER	WGHTD AVG. HOURS	40	1	12,000	12,000	40	12,000	9
10	17	ADMIN COMP - NON OWNER	WGHTD AVG. HOURS	40	1	74,483	74,483			10
11	17	ADMIN COMP - NON OWNER	WGHTD AVG. HOURS	45	8	228,000	228,000	5	24,067	11
12	17	ADMIN COMP - NON OWNER	WGHTD AVG. HOURS	45	10	200,022	200,022	4	18,622	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG. HOURS	40	10	85,429	85,429	4	7,943	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,475,307	$ 1,475,307		$ 167,589	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	7	EMP BEN - D NEHMER	WGHTD AVG. HOURS	40	8	$ 5,988	$	4	$ 632	1
2	27	EMP BEN - M MAUER	WGHTD AVG. HOURS	40	10	10,884		4	1,013	2
3	27	EMP BEN - M AARON	WGHTD AVG. HOURS	40	8	11,145		4	1,177	3
4	27	EMP BEN - F AARON	WGHTD AVG. HOURS	45	5	35,563		9	7,113	4
5	27	EMP BEN - S GOLDSTEIN	WGHTD AVG. HOURS	40	2	35,796				5
6	27	EMP BEN - J AARON	WGHTD AVG. HOURS	40	1					6
7	27	EMP BEN - S KOPLIN	WGHTD AVG. HOURS	30	3	25,120		10	8,373	7
8	27	EMP BEN - D MAGAFAS	WGHTD AVG. HOURS	50	8	10,687		5	1,128	8
9	27	EMP BEN - H ALTER	WGHTD AVG. HOURS	40	1	1,083		40	1,083	9
10	27	EMP BEN - V DAVIS	WGHTD AVG. HOURS	40	1	16,762				10
11	27	EMP BEN - NON OWNER	WGHTD AVG. HOURS	45	8	65,051		5	6,866	11
12	27	EMP BEN - NON OWNER CFO	WGHTD AVG. HOURS	45	10	21,483		4	2,000	12
13	27	EMP BEN - S AARON	WGHTD AVG. HOURS	40	10	14,927		4	1,388	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					$ 254,489	$		$ 30,773	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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: LINCOLN MEDICAL SUPPLIES
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 33,293	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						14,262	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					$	$		$ 47,555	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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							$	$			$	1
2												2
3												3
4												4
5	RELATED PARTY										3,533	5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				83,591			39,347	6
7	WOODBRIDGE NURSING	X		WORKING CAPITAL							14,062	7
8			X	INSURANCE FINANCING							2,012	8
9	TOTAL Facility Related						$	$ 83,591			$ 58,954	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 83,591			$ 58,954	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **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 WATERFRONT TERRACE **#** 0028076 **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.**	$ 114,000	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.)		$ 103,696	2
3. Under or (over) accrual (line 2 minus line 1).		$ (10,304)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 106,000	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.		$ 95,696	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	110,653	8
	2006	111,687	9
	2007	110,495	10
	2008	111,603	11
	2009	103,696	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% 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 WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

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.	21-30-412-038-0000	NURSING HOME	$ 1,496.97	$ 1,496.97
2.	21-30-412-045-0000	NURSING HOME	$ 102,199.51	$ 102,199.51
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 103,696.48	$ 103,696.48

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 WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,824 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETI 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 [ ] (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).

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	NURSING HOME	37,824	1983	$ 100,000	1
2					2
3	TOTALS	37,824		$ 100,000	3

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	118		1983		$ 1,508,000	$	35	$ 43,086	$ 43,086	$ 1,195,637	4
5											5
6											6
7											7
8	RELATED PARTY				40,841	1,047	35	1,167	120	20,226	8
	Improvement Type**										
9	ROOF			1983	21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT			1985	950		15			950	10
11	LEASEHOLD IMPROVEMENT			1986	3,800		10			3,800	11
12	LEASEHOLD IMPROVEMENT			1986	1,005		15			1,005	12
13	ROOF			1990	13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING			1990	20,776	660	15		(660)	20,776	14
15	LEASEHOLD IMPROVEMENT			1991	7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT			1991	1,491	47	15	47		1,485	16
17	LEASEHOLD IMPROVEMENT			1992	18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT			1992	1,097	35	15	74	39	1,086	18
19	LEASEHOLD IMPROVEMENT			1993	7,742	246	31.5	246		4,356	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		1,536	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		10,565	21
22	ELEVATOR REPAIR			1995	1,500	38	39	38		606	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		1,689	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		2,266	24
25	FENCING			1996	756	50	15	50		725	25
26	NURSE STATION			1996	5,300	136	39	136		1,921	26
27	HANDRAILS			1996	3,735	96	39	96		1,348	27
28	PARKING LOT REPAVING			1997	14,968	998	15	998		12,570	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		8,854	29
30	DRAPERY			1997	14,754	378	39	378		5,048	30
31	DOORS & SIGNS			1997	8,428	216	39	216		2,889	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		5,832	32
33	REMODELING			1997	59,133	1,517	39	1,517		20,448	33
34	NURSE STATION			1997	5,106	131	39	131		1,752	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 WATERFRONT TERRACE # 0028076 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	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	$ 44,786	$ 1,148	39	$ 1,148	$	$ 14,292	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		2,058	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,163	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		2,554	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		640	41
42	REMODELING	1998	21,934	562	39	562		6,978	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		4,237	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,223	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		6,695	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		5,515	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		3,209	47
48	FIRE ALARM	1999	10,286	264	39	264		3,088	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		10,644	49
50	BOILER WORK	1999	7,345	189	39	189		2,202	50
51	CABLE WORK	1999	433	11	39	11		130	51
52	CARPET	1999	18,828	483	39	483		5,599	52
53	ELEVATOR WORK	1999	2,017	52	39	52		607	53
54	AIR CONDITIONING	1999	7,350	189	39	189		2,230	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		2,677	55
56	ROOF WORK	1999	2,187	56	39	56		646	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		17,297	57
58	WINDOWS	1999	5,513	142	39	142		1,642	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		9,538	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		5,779	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		51,841	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		6,464	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		1,067	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		3,897	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,226	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		3,952	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		30,626	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		1,030	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		1,010	69
70	TOTAL (lines 4 thru 69)		$ 2,506,209	$ 27,367		$ 68,694	$ 41,327	$ 1,600,536	70

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	
1	Totals from Page 12A, Carried Forward		$ 2,506,209	$ 27,367		$ 68,694	$ 41,327	$ 1,600,536	1
2	EXHAUST FAN	2000	890	32	27.5	32		345	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		427	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,196	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		2,649	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		2,177	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		2,000	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		2,159	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		859	10
11	AC UNIT	2001	786	28	27.5	28		268	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		1,886	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		1,585	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		671	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		1,081	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		523	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		13,505	17
18	DECK & FENCE	2004	10,197	680	15	680		4,420	18
19	A/C REPAIR	2004	2,200	80	27.5	80		516	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		1,053	20
21	WATER HEATER	2004	6,937	252	27.5	252		1,628	21
22	NURSE CALL STATION	2004	585	21	27.5	21		136	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		296	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		7,478	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		3,324	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		3,859	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		2,560	27
28	ROOF REPAIRS	2005	726	26	27.5	26		142	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		873	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		202	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		1,391	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		504	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		5,346	33
34	TOTAL (lines 1 thru 33)		$ 2,765,035	$ 36,679		$ 78,006	$ 41,327	$ 1,676,842	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	
1	Totals from Page 12B, Carried Forward		$ 2,765,035	$ 36,679		$ 78,006	$ 41,327	$ 1,676,842	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		330	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		1,150	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		10,892	4
5	DOORS	2006	15,104	549	27.5	549		2,448	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		896	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		11,770	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		602	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		267	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		401	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		241	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		481	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		486	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		1,909	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		3,054	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		1,750	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		12,267	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		9,694	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		2,376	19
20	SIGNAGE	2007	2,403	87	27.5	87		301	20
21	BOILER WORK	2007	1,835	67	27.5	67		231	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		2,919	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		595	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		346	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		2,389	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		1,008	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		5,303	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		769	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		905	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		2,084	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		354	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		465	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		932	33
34	TOTAL (lines 1 thru 33)		$ 3,382,898	$ 59,147		$ 100,474	$ 41,327	$ 1,756,457	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	
1	Totals from Page 12C, Carried Forward		$ 3,382,898	$ 59,147		$ 100,474	$ 41,327	$ 1,756,457	1
2	REFRIGERATOR REPAIRS	2008	1,721	63	27.5	63		155	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	55	27.5	55		135	3
4	RFIRE ALARM SYSTEM REPAIRS	2009	12,907	469	27.5	469		684	4
5	ELECTRICAL WORK	2009	53,455	1,944	27.5	1,944		2,835	5
6	ELEVATOR REPAIRS	2009	23,314	847	27.5	847		1,236	6
7	CARPET, TILE & VINYL	2009	5,857	213	27.5	213		311	7
8	AIR CONDITIONERS & SLEEVES	2009	6,183	225	27.5	225		328	8
9	DOORS	2009	3,967	144	27.5	144		210	9
10	PLUMBING REPAIRS	2009	15,124	550	27.5	550		802	10
11	DISH NETWORK EQUIPMENT	2009	1,575	58	27.5	58		84	11
12	EMERGENCY ALARM CONTROL PANEL	2009	1,175	43	27.5	43		62	12
13	DOORS AND ACCESSORIES, DOOR ALARM & KEY PAD	2010	17,232	287	27.5	287		287	13
14	REPLACE WATER TUBES AND GASKET	2010	1,992	33	27.5	33		33	14
15	AIR CONDITIONERS, REPLACE AIR HANDLER MOTOR	2010	13,721	229	27.5	229		229	15
16	ROOF REPAIR	2010	4,135	69	27.5	69		69	16
17	CEILING PIPING REPAIRS- FRONT OFFICE	2010	4,850	81	27.5	81		81	17
18	INSTALL FIRE DAMPERS,FIRE,CIRCULATING,BRONZ PUM	2010	5,689	95	27.5	95		95	18
19	BASEMENT REPAIRS	2010	2,600	43	27.5	43		43	19
20	REPLACE PRIMARY PUMP IN BASEMENT	2010	2,400	40	27.5	40		40	20
21	2ND FLOOR PATIENTS BATHROOMS AND ROOMS:	2010	54,081	901	27.5	901		901	21
22	INSTALL NEW WALLS, CERAMIC TILE,CALL LIGHT								22
23	LIGHTING ACCESSORIES, FIXTURES, LAMPS	2010	12,135	202	27.5	202		202	23
24	UTILITYU ROOM SINK, REPAIR SPRINKLER SYSTEM	2010	3,299	55	27.5	55		55	24
25	WALL PROTECTION HANDRAILS	2010	9,634	161	27.5	161		161	25
26	BUMBERS AROUND GARBAGE AREA	2010	4,766	79	27.5	79		79	26
27	WALLCOVERING, CUBICLE CURTAINS	2010	5,711	95	27.5	95		95	27
28	INSTALL STAIN & RAMP RAILINGS, SECURITY SYSTEM	2010	3,175	53	27.5	53		53	28
29	REPLACE ELECTRIC FOR TV ABOVE CEILING	2010	2,700	45	27.5	45		45	29
30	3RD FLOOR-REPLACE LIGHTS, INSTALL WATT FIXTURE	2010	3,328	55	27.5	55		55	30
31	NORTH SIDE EAST END-PERLACE BUILDING LIGHTS	2010	3,052	51	27.5	51		51	31
32	INSTALL OUTDOOR LIGHTING	2010	7,250	121	27.5	121		121	32
33	PATIO ROOMS-NEW DOOR, TILE, FLOOR, LIGHTING	2010	13,417	224	27.5	224		224	33
34	TOTAL (lines 1 thru 33)		$ 3,684,864	$ 66,677		$ 108,004	$ 41,327	$ 1,766,218	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	
1	Totals from Page 12D, Carried Forward		$ 3,684,864	$ 66,677		$ 108,004	$ 41,327	$ 1,766,218	1
2	AIR COMPRESSOR COIL REPAIR	2010	1,850	31	27.5	31		31	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)		$ 3,686,714	$ 66,708		$ 108,035	$ 41,327	$ 1,766,249	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	$ 506,929	$ 23,222	$ 43,650	$ 20,428	7-20	$ 327,238	71
72	Current Year Purchases	68,201	44,921	3,410	(41,511)	10	3,410	72
73	Fully Depreciated Assets	587,798					587,798	73
74	RELATED PARTY	42,008		1,548	1,548		35,240	74
75	TOTALS	$ 1,204,936	$ 68,143	$ 48,608	$ (19,535)		$ 953,686	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	RELATED PARTY			21,192	1,703	4,514	2,811		6,502	77
78										78
79										79
80	TOTALS			$ 21,192	$ 1,703	$ 4,514	$ 2,811		$ 6,502	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,012,842	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 136,554	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 161,157	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,603	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,726,437	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 WATERFRONT TERRACE # 0028076 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 - RELATED PARTY
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.		$
13.		$
14.		$

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: $ 18,576 Description: SEE SCHEDULE 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		2007 TOYOTA	$ 424.88	$ 1,700	17
18		2010 TOYOTA CAMRY	342.93	3,429	18
19		2010 BUICK ENCLAVE	578.56	5,207	19
20				(4,503)	20
21	TOTAL		$ #######	$ 5,833	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 WATERFRONT TERRACE # 0028076 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 WATERFRONT TERRACE STATE OF ILLINOIS # 0028076 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	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,015			3,015	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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				176,838		176,838	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, Laboratory,Ambulance, Other (specify): Medical Supplies	39-2					37,835		37,835	13
14	TOTAL			$		$ 3,015	$ 214,673		$ 217,688	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 WATERFRONT TERRACE # 0028076 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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 493,000)	957,069		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,595		6
7	Other Prepaid Expenses	21,028		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Tax Escrow	200,581		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,256,273	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,887,307		15
16	Equipment, at Historical Cost	1,177,851		16
17	Accumulated Depreciation (book methods)	(1,575,898)		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): Deposit on Fixed Assets	21,380		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,510,640	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,766,913	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 971,735	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	83,591		29
30	Accrued Salaries Payable	255,511		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,857		31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,000		32
33	Accrued Interest Payable	3,063		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,450,757	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,450,757	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,316,156	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,766,913	$	48

***(See instructions.)**

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **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**	$ 1,591,538	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,591,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,382)	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	(240,000)	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)**	$ (275,382)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,316,156	24 *

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	$ 6,747,317	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,747,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	325,907	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 325,907	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***	31	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,073,255	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	996,997	31
32	Health Care	2,724,805	32
33	General Administration	1,916,992	33
	B. Capital Expense		
34	Ownership	836,905	34
	C. Ancillary Expense		
35	Special Cost Centers	217,688	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	350,645	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,108,637	40
41	**Income before Income Taxes (line 30 minus line 40)****	(35,382)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (35,382)	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 WATERFRONT TERRACE # 0028076 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	1,981	2,279	$ 85,748	$ 37.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,207	1,223	70,914	57.98	3
4	Licensed Practical Nurses	36,980	41,735	1,008,528	24.17	4
5	CNAs & Orderlies	56,726	61,729	625,148	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,620	14,836	580,891	39.15	8
9	Activity Director	2,626	2,604	36,172	13.89	9
10	Activity Assistants	7,747	8,720	82,588	9.47	10
11	Social Service Workers	3,222	3,398	46,109	13.57	11
12	Dietician					12
13	Food Service Supervisor	2,166	2,331	39,925	17.13	13
14	Head Cook	5,818	6,544	74,484	11.38	14
15	Cook Helpers/Assistants	7,909	8,824	81,888	9.28	15
16	Dishwashers					16
17	Maintenance Workers	4,183	4,439	64,225	14.47	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,301	1,851	130,470	70.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,618	8,069	180,170	22.33	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	1,344	1,552	19,136	12.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,448	170,134	$ 3,126,396 *	$ 18.38	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	$ 9,324	1-3	35
36	Medical Director	O	12,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,388	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	1,440	11-3	44
45	Social Service Consultant	E	6,394	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 35,746		49

C. CONTRACT NURSES

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMINISTRATOR		$ 100,470
FRED AARON	OTHER ADMIN		30,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,470

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 67,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 67,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEM	DATA PROCESSING	$ 4,557
E-HEALTH DATA SOLUTIONS	DATA PROCESSING	5,002
CASAMBA	DATA PROCESSING	3,600
MUCH SHELIST	LEGAL	36,991
SIDNEY BERGER	LEGAL	15,156
PERSONNEL PLANNERS	UC CONSULTANT	3,192
PROSPECT RESOURCES	UTILITY PROCUREMENT	1,500
FIRST REAL ESTATE SERVICES	APPRAISAL	2,750
S-E-A	DISPOSAL,RETENTION	470
KRUPNICK BOKOR	ACCOUNTING	12,431
FROST RUTTENBERG	ACCOUNTING	5,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 90,649

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,878
Unemployment Compensation Insurance	78,388
FICA Taxes	230,140
Employee Health Insurance	226,165
Employee Meals	31,536
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	22,821
	0
	0
CHICAGO HEAD TAX	5,100
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 670,028

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,095
Advertising: Employee Recruitment	35,370
Health Care Worker Background Check	4,150
(Indicate # of checks performed 415)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	9,564
MARKETING/ADV/PROMO	116,231
LICENSES/DUES/SUBSCRIPTIONS	8,596
MGMT CO ALLOC	681
TRUST/FRANCHISE/CONTRIB/ETC	(9,564)
Less: Public Relations Expense	(0)
Non-allowable advertising	(116,231)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,892

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	330
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 330

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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-$6068 IL ASSOC OF HC-$1416**

(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. $ **5,722** 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 NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **64,605**
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. $ **31,536** 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? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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