

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre

0038612 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	16,303	286	2,121	18,710	8	
9	SNF/PED					9	
10	ICF	26,343	1,011		27,354	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	42,646	1,297	2,121	46,064	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.51%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 37 and days of care provided 2,121

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation Cent # 0038612 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	212,999	16,501	8,034	237,534		237,534		237,534		1
2	Food Purchase		218,266		218,266	(32,281)	185,985	(823)	185,162		2
3	Housekeeping	124,370	19,419		143,789		143,789		143,789		3
4	Laundry	54,002	8,855		62,857		62,857		62,857		4
5	Heat and Other Utilities			120,376	120,376		120,376		120,376		5
6	Maintenance	29,286	6,143	51,784	87,213		87,213		87,213		6
7	Other (specify):*			9,352	9,352		9,352		9,352		7
8	TOTAL General Services	420,657	269,184	189,546	879,387	(32,281)	847,106	(823)	846,283		8
	B. Health Care and Programs										
9	Medical Director			7,600	7,600		7,600		7,600		9
10	Nursing and Medical Records	1,772,102	63,608	26,384	1,862,094		1,862,094		1,862,094		10
10a	Therapy		1,728		1,728		1,728		1,728		10a
11	Activities	89,073	3,901	9,495	102,469		102,469		102,469		11
12	Social Services	80,212		3,951	84,163		84,163		84,163		12
13	CNA Training										13
14	Program Transportation			72	72		72		72		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,941,387	69,237	47,502	2,058,126		2,058,126		2,058,126		16
	C. General Administration										
17	Administrative	75,073		300,000	375,073		375,073	(199,240)	175,833		17
18	Directors Fees										18
19	Professional Services			57,553	57,553		57,553	6,700	64,253		19
20	Dues, Fees, Subscriptions & Promotions			40,970	40,970		40,970	(21,962)	19,008		20
21	Clerical & General Office Expenses	193,619	7,846	32,747	234,212		234,212	(93,324)	140,888		21
22	Employee Benefits & Payroll Taxes			451,865	451,865	32,281	484,146		484,146		22
23	Inservice Training & Education			1,405	1,405		1,405		1,405		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			2,167	2,167		2,167	(2,167)			25
26	Insurance-Prop.Liab.Malpractice			132,312	132,312		132,312	106,179	238,491		26
27	Other (specify):*							3,889	3,889		27
28	TOTAL General Administration	268,692	7,846	1,019,019	1,295,557	32,281	1,327,838	(199,925)	1,127,913		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,630,736	346,267	1,256,067	4,233,070		4,233,070	(200,748)	4,032,322		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,034
	REPAIRS & MAINTENANCE	0
		0
		8,034
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	48,852
	ELECTRICITY	46,404
	WATER	25,120
	CABLE TV - LOBBY	0
		0
		120,376
6	MAINTENANCE	
	GROUPS MAINTENANCE	2,357
	PAINTING & DECORATING	0
	BUILDING REPAIRS	4,000
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	34,427
	ELEVATOR MAINTENANCE & REPAIR	7,485
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,515
	FIRE SERVICE	0
		0
		0
		0
		0
		51,784
7	OTHER	
	SCAVENGER	9,352
	SECURITY SERVICE	0
		0
		0
		9,352
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,600
		7,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	19,470
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,568
	PHARMACY CONSULTANT XVIII B 39-2	5,346
	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
		26,384
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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	4,645
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,850
		0
		9,495
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,951
		3,951
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	72
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	300,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,714
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	37,839
		0
		57,553
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	17,467
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	800
	DUES & SUBSCRIPTIONS XIX F	12,539
	LICENSES & PERMITS XIX F	3,769
	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	3,695
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	60
	PATIENT FINGERPRINTS/BACKGROUND CHEC XIX F	2,640
		40,970
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	295
	EQUIPMENT REPAIR & MAINTENANCE	1,843
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	12,184
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,425
	MESSENGER SERVICE	0
		0
		32,747

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	201,252
	UNEMPLOYMENT COMPENSATION XIX D	17,307
	WORKERS COMPENSATION INSURANC XIX D	43,200
	HOSPITALIZATION INSURANCE XIX D	163,801
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	22,165
	CHICAGO HEAD TAX XIX D	4,140
		0
		451,865
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,405
		1,405
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,167
		2,167
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	132,312
		132,312
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,256,067

The Waterford Nursing & Rehabilitation Centre
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	218,266
LESS SALES TAX	<u>(823)</u>
NET FOOD	217,443
TOTAL PATIENT CENSUS	46,064
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	138,192
ADD # EMPLOYEE MEALS/DAY	<u>66</u>
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	24,090
PATIENT MEALS	138,192
ADD EMPLOYEE MEALS	<u>24,090</u>
TOTAL MEALS/YEAR	162,282
NET FOOD	217,443
DIVIDE TOTAL MEALS/YEAR	<u>162,282</u>
COST PER MEAL	1.34
TIME EMPLOYEE MEALS	<u>24,090</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>32,281</u>
	=====

PROFESSIONAL FEES
PAGE 21 XIX. C.

MEDIFAX EDI	DATA PROCESSING	206
MDI TECHNOLOGY	DATA PROCESSING	7,419
IVANS	DATA PROCESSING	1209
CURASPAN HEALTH GROUP	DATA PROCESSING	2700
LIFE CARE SOFTWARE SOLUTIONS	DATA PROCESSING	8179
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	14,020
OSTROW REISEN BERK ABRAMS	ACCOUNTING	2,322
STEVEN BRUEGGEMAN	ACCOUNTING	6,100
SKIDELSKY & ASSOCIATES	REAL ESTATE TAX LEGAL	185
MUCH SHELST	LEGAL	695
GUARDIANSHIP SERVICES	LEGAL	2,918
LAW OFFICES OF MARY RALEIGH	LEGAL	810
LAW OFFICES OF THOMAS BREWER	LEGAL	619
ASHMAN & STEIN	LEGAL	1,786
RICHARD PEELO	MEDICARE COST REPORT	4,200
ELDERLIFE DEVELOPMENT	FIRE CODE CONSULTANT	3,035
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	<u>1,150</u>
	 PROFESSIONAL FEES	 57,553
		=====

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre #0038612 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			51,871	51,871		51,871	117,312	169,183			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,556	4,556		4,556	264,645	269,201			32
33	Real Estate Taxes							163,873	163,873			33
34	Rent-Facility & Grounds			774,927	774,927		774,927	(774,927)				34
35	Rent-Equipment & Vehicles			537	537		537		537			35
36	Other (specify):*							21,624	21,624			36
37	TOTAL Ownership			831,891	831,891		831,891	(207,473)	624,418			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		88,235	309,915	398,150		398,150		398,150			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		88,235	387,113	475,348		475,348		475,348			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,630,736	434,502	2,475,071	5,540,309		5,540,309	(408,221)	5,132,088			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,130)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(823)	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	(12,184)	21		18
19	Entertainment				19
20	Contributions	(4,495)	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	(17,467)	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	(83,307)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,406)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(277,815)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (277,815)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (408,221)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		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

BHF USE ONLY

48		49		50		51		52	
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The Waterford Nursing & Rehabilitation Centre

ID# 0038612

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MARKETING SALARY	\$ (81,140)	21	1
2	MARKETING TRAVEL	(2,167)	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	(83,307)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre# 0038612

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(823)	0	0	0	0	0	0	0	0	0	0	(823)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(823)	0	0	0	0	0	0	0	0	0	0	(823)	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	(199,240)	0	0	0	0	0	0	0	0	(199,240)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,700	0	0	0	0	0	0	0	0	0	6,700	19
20	Fees, Subscriptions & Promotions	(21,962)	0	0	0	0	0	0	0	0	0	0	(21,962)	20
21	Clerical & General Office Expenses	(93,324)	0	0	0	0	0	0	0	0	0	0	(93,324)	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	(2,167)	0	0	0	0	0	0	0	0	0	0	(2,167)	25
26	Insurance-Prop.Liab.Malpractice	0	106,179	0	0	0	0	0	0	0	0	0	106,179	26
27	Other (specify):*	0	0	3,889	0	0	0	0	0	0	0	0	3,889	27
28	TOTAL General Administration	(117,453)	112,879	(195,351)	0	0	0	0	0	0	0	0	(199,925)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,276)	112,879	(195,351)	0	0	0	0	0	0	0	0	(200,748)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre# 0038612

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(12,130)	129,442	0	0	0	0	0	0	0	0	0	117,312	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	264,645	0	0	0	0	0	0	0	0	0	264,645	32
33	Real Estate Taxes	0	163,873	0	0	0	0	0	0	0	0	0	163,873	33
34	Rent-Facility & Grounds	0	(774,927)	0	0	0	0	0	0	0	0	0	(774,927)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	21,624	0	0	0	0	0	0	0	0	0	21,624	36
37	TOTAL Ownership	(12,130)	(195,343)	0	0	0	0	0	0	0	0	0	(207,473)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(130,406)	(82,464)	(195,351)	0	0	0	0	0	0	0	0	(408,221)	45

VII. RELATED PARTIES

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

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		Real Estate Rental
				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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 774,927	Deauville Associates LLC	100.00%	\$	(774,927)	1
2	V	32 Interest		" "		259,514	259,514	2
3	V	19 Professional Fees		" "		6,700	6,700	3
4	V	26 Property Insurance		" "		106,179	106,179	4
5	V	33 R E Taxes		" "		163,873	163,873	5
6	V	30 SL Depreciation		" "		129,442	129,442	6
7	V	32 Amortization Loan Fees		" "		5,131	5,131	7
8	V	36 MIP Expense		" "		21,624	21,624	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 774,927			\$ 692,463	\$ * (82,464)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 294,000	SFMA, INC	100.00%	\$	\$ (294,000)
16	V	17 Dan Shabat Comp		" "		97,500	97,500
17	V	27 Admin Benefits		" "		3,729	3,729
18	V						
19	V						
20	V	17 Management Fees	6,000	Pro Health Care Inc	100.00%		(6,000)
21	V	17 Salary - Stan Aron		" "		3,260	3,260
22	V	27 Payroll Taxes		" "		160	160
23	V						
24	V						
25	V	10 In House Drugs	12,808	Pharmore Drugs LLC		12,808	
26	V	39 Exp - Drugs	77,492	" "		77,492	
27	V	10 Pharmacy Consultant	5,346	" "		5,346	
28	V						
29	V						
30	V	39 Exp - Laboratory	3,196	Lifescan Laboratory Inc		3,196	
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 398,842			\$ 203,491	\$ * (195,351)

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation Cer # 0038612 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dan Shabat	Owner	Administrative	100.00	See Attached	20	33.00	Alloc Salary	\$	17-7	1
2	Stan Aron		Administrative	0.00	See Attached	1	2.44	Alloc Salary		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	\$		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 Centre # 0038612 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Dan Shabat Comp	Avg Hours Worked	40	2	\$ 195,000	\$ 195,000	20	\$ 97,500	1
2	27	Admin Benefits	" "	40	2	7,458		20	3,729	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					\$ 202,458	\$ 195,000		\$ 101,229	25

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre # 0038612 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Salary - Stan Aron	Ave Hours Worked	41	4	\$ 133,640	\$ 133,640	1	\$ 3,260	1
2	27	Payroll Taxes	" "	41	4	6,566		1	160	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					\$ 140,206	\$ 133,640		\$ 3,420	25

Facility Name & ID Number The Waterford Nursing & Rehabilitation Cent # 0038612 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	RELATED PARTY-Deauville Associates, LLC				\$	\$			\$	1									
2	Heartland Bank	X	Mortgage	\$27,769.38	08/25/06	4,631,700	4,291,247	09/2036	6.0000	259,514									
3	Loan Fees	X	Amortized over life of loan			153,941	126,574			5,131									
4										4									
5	Lexus Financial	X	Auto Loan	\$800.00	08/25/11	27,057	24,964	08/25/14	3.9900	308									
Working Capital																			
6	Line of Credit	X	Working Capital	DEMAND		102,300	170,086		PRIME+	4,248									
7										7									
8										8									
9	TOTAL Facility Related			\$28,569.38		\$ 4,914,998	\$ 4,612,871			\$ 269,201									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$	\$			\$									
15	TOTALS (line 9+line14)					\$ 4,914,998	\$ 4,612,871			\$ 269,201									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,624 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	<u>155,102</u>	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.)		\$	<u>157,131</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,029</u>	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>161,844</u>	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.		\$	<u>163,873</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<u>153,961</u>	8	FOR BHF USE ONLY	
	2007	<u>144,746</u>	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2008	<u>146,198</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	<u>150,575</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2010	<u>157,131</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.					

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.

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY - Deauville Associates, LLC</u>		<u>1984</u>	<u>\$ 195,934</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 195,934	3

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY-Deauville Associates, LLC:			\$	\$		\$	\$	\$	4
5	141	1994	1977	2,189,665	56,145	39	56,145		1,572,067	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	12,942	5	12,942		70,593	19
20	Nurses Station		2007	50,000	5,000	10	5,000		21,667	20
21	Window Replacement		2007	60,000	6,000	10	6,000		26,000	21
22	Physical Therapy Room		2007	29,808	2,981	10	2,981		13,166	22
23	Windows		2007	118,715	11,872	10	11,872		52,433	23
24	Boilers		2007	33,629	6,726	5	6,726		33,629	24
25	Door Handles, Locks		2007	13,243	2,649	5	2,649		11,699	25
26	Shower Room		2007	18,866	1,887	10	1,887		8,648	26
27	Nurses Call System 3rd Floor		2007	9,492	949	10	949		4,271	27
28	Shower Room		2007	23,046	2,305	10	2,305		10,564	28
29	Window Treatments		2007	10,090	1,009	10	1,009		4,541	29
30	Nurses Call System 2nd Floor		2007	4,746	475	10	475		2,136	30
31	Fire Alarm System & Sprinklers		2010	40,518	4,052	10	4,052		4,321	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 Centre# 0038612

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FACILITY:		\$	\$		\$	\$	\$	37
38	Various	1993	63,831	3,191	20	3,191		57,751	38
39	Various	1994	17,273	740	20	740		15,625	39
40	Various	1995	34,505	1,126	20	1,126		31,078	40
41	Various	1996	19,396	889	20	889		15,535	41
42	Various	1997	79,650	3,982	20	3,982		58,078	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		11,741	45
46	Various	2002	34,272	616	20	616		34,039	46
47	Various	2004	76,500	7,650	20	3,825	(3,825)	51,638	47
48	Cable Equipment & Installation	2007	7,500	750	20	375	(375)	2,531	48
49	Wall and Heater Removal	2007	45,287	4,528	20	2,264	(2,264)	16,227	49
50	1st and 2nd Floor Nurses Station and Corridor	2007	2,176	217	20	109	(108)	708	50
51	Resident Rooms - Doors & 2nd Floor Corr/Nurses Station	2008	1,524	153	20	76	(77)	393	51
52	Boilers	2008	14,924	1,493	20	746	(747)	4,103	52
53	Wiring for Cable - 30 Resident Rooms & 3 Dayrooms	2009	3,350	122	20	168	46	559	53
54	Wall & Door with Frame - 3rd Floor Dayroom	2009	2,948	107	20	147	40	508	54
55	6" Gate Valve on Air Conditioner	2009	3,225	117	20	161	44	439	55
56	Life Safety Upgradess Fire Alarm System	2009	2,400	87	20	120	33	327	56
57	Elevator Guide Shoes, Traveler & Rewire, Starter	2009	10,930	397	20	547	150	1,593	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	\$ 141,496		\$ 134,413	\$ (7,083)	\$ 2,471,197	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 141,617	\$ 14,307	\$ 15,688	\$ 1,381	5 - 10 Yrs	\$ 89,010	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	248,422					248,422	73
74	Deauville Health Care Center	498,071	14,450	14,450		5 - 10 Yrs	478,268	74
75	TOTALS	\$ 888,110	\$ 28,757	\$ 30,138	\$ 1,381		\$ 815,700	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	'11 Lexus	2011	\$ 37,057	\$ 11,060	\$ 4,632	\$ (6,428)	4 YRS	\$ 4,632	76
77										77
78										78
79										79
80	TOTALS			\$ 37,057	\$ 11,060	\$ 4,632	\$ (6,428)		\$ 4,632	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)	\$ 4,565,140	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 181,313	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,183	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,130)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,291,529	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-related partry

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: _____ *

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: \$ 537 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

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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 129,099	\$		\$ 129,099	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,026			6,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			166,963			166,963	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 prescripts				77,492		77,492	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39-3				7,827			7,827	12
13	Other (specify): <u>Lab, Med Supplies</u>	39-2					10,743		10,743	13
14	TOTAL			\$		\$ 309,915	\$ 88,235		\$ 398,150	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.

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre

0038612

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 25,531	\$ 92,042	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>(375,000)</u>)	1,982,799	1,982,799	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,950	82,518	6
7	Other Prepaid Expenses	870	870	7
8	Accounts Receivable (owners or related parties)		779,039	8
9	Other(specify): <u>Employee Loans & Advances</u>	3,174	3,174	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,036,324	\$ 2,940,442	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		2,787,643	14
15	Leasehold Improvements, at Historical Cost	491,925	491,925	15
16	Equipment, at Historical Cost	427,095	1,096,058	16
17	Accumulated Depreciation (book methods)	(721,480)	(3,320,436)	17
18	Deferred Charges		126,574	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		587,601	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Security Deposit</u>	5,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 202,540	\$ 1,965,299	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,238,864	\$ 4,905,741	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 437,973	\$ 482,004	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	61,632	61,632	28
29	Short-Term Notes Payable	178,849	256,725	29
30	Accrued Salaries Payable	128,191	128,191	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,319	15,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)		161,844	32
33	Accrued Interest Payable		21,456	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Parties</u>	145,007		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 966,971	\$ 1,127,171	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	16,201	16,201	39
40	Mortgage Payable		4,213,371	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)	\$ 16,201	\$ 4,229,572	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 983,172	\$ 5,356,743	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,255,692	\$ (451,002)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,238,864	\$ 4,905,741	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 312,902	1
2	Restatements (describe):		2
3	POST-CLOSING INCOME ADJUSTMENT	251,673	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 564,575	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	691,117	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)	\$ 691,117	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)	\$ 1,255,692	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre # 0038612 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,097,136	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,097,136	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	134,140	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 134,140	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Cook County Board of Elections</u>	150	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 150	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,231,426	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	879,387	31
32	Health Care	2,058,126	32
33	General Administration	1,295,557	33
B. Capital Expense			
34	Ownership	831,891	34
C. Ancillary Expense			
35	Special Cost Centers	398,150	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)*	\$ 5,540,309	40
41	Income before Income Taxes (line 30 minus line 40)**	691,117	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 691,117	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 Centre

0038612

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,013	2,246	\$ 97,711	\$ 43.50	1
2	Assistant Director of Nursing	1,805	2,086	65,700	31.50	2
3	Registered Nurses	12,713	13,639	350,120	25.67	3
4	Licensed Practical Nurses	16,724	18,010	400,126	22.22	4
5	CNAs & Orderlies	58,385	65,591	712,575	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,922	7,933	89,073	11.23	10
11	Social Service Workers	5,358	6,032	80,212	13.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,965	18,779	212,999	11.34	15
16	Dishwashers					16
17	Maintenance Workers	1,972	2,210	29,286	13.25	17
18	Housekeepers	10,963	12,535	124,370	9.92	18
19	Laundry	5,461	5,933	54,002	9.10	19
20	Administrator	1,941	2,134	75,073	35.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,281	7,399	193,619	26.17	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	1,819	1,898	17,178	9.05	31
32	Other Health C: <u>MDS/NS/CPC</u>	7,664	9,513	128,692	13.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,986	175,938	\$ 2,630,736 *	\$ 14.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 8,034	1-3	35
36	Medical Director	O	7,600	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	5,346	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	4,850	11-3	44
45	Social Service Consultant	E	3,951	12-3	45
46	Other(specify) <u>Psycho-social</u>	S	3,951	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,300		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 948	10-3	50
51	Licensed Practical Nurses	454	18,177	10-3	51
52	Certified Nurse Assistants/Aides	16	345	10-3	52
53	TOTAL (lines 50 - 52)	486	\$ 19,470		53

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre# 0038612Report Period Beginning: 01/01/2011 Ending: 12/31/2011**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. \$ 1,066 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. \$ 32,281 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.