FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 28076

Facility Name: WATERFRONT TERRACE INC

Address: 7750 S SHORE DRIVE (Number) CHICAGO (City) 60645 (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 01/01/2011 to 12/31/2011 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 INC # 28076 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 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	7,497	37	5,644	13,178	8
9	SNF/PED					9
10	ICF	23,096	572	331	23,999	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,593	609	5,975	37,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.32%

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 5,400

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

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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	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	203,174	21,080	10,113	234,367		234,367		234,367			1
2	Food Purchase		213,602		213,602		213,602	(663)	212,939			2
3	Housekeeping		23,704	142,698	166,402		166,402		166,402			3
4	Laundry		23,719	102,710	126,429		126,429		126,429			4
5	Heat and Other Utilities			103,992	103,992		103,992	992	104,984			5
6	Maintenance	93,330	70,261	16,598	180,189		180,189	12,768	192,957			6
7	Other (specify):*			24,744	24,744		24,744	750	25,494			7
8	**TOTAL General Services**	296,504	352,366	400,855	1,049,725		1,049,725	13,847	1,063,572			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,838,579	128,239	6,672	1,973,490		1,973,490		1,973,490			10
10a	Therapy	531,849	3,014		534,863		534,863		534,863			10a
11	Activities	141,248	20,659	1,326	163,233		163,233		163,233			11
12	Social Services	45,284		4,603	49,887		49,887		49,887			12
13	CNA Training											13
14	Program Transportation			1,795	1,795		1,795		1,795			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,556,960	151,912	35,996	2,744,868		2,744,868		2,744,868			16
	C. General Administration											
17	Administrative	140,064		89,000	229,064		229,064	58,130	287,194			17
18	Directors Fees											18
19	Professional Services			152,708	152,708		152,708	612	153,320			19
20	Dues, Fees, Subscriptions & Promotions			214,417	214,417		214,417	(185,395)	29,022			20
21	Clerical & General Office Expenses	177,858	36,728	449,723	664,309		664,309	(393,516)	270,793			21
22	Employee Benefits & Payroll Taxes			691,134	691,134		691,134		691,134			22
23	Inservice Training & Education			4,891	4,891		4,891		4,891			23
24	Travel and Seminar							718	718			24
25	Other Admin. Staff Transportation			14,766	14,766		14,766	(2,931)	11,835			25
26	Insurance-Prop.Liab.Malpractice			102,377	102,377		102,377	420	102,797			26
27	Other (specify):*			39,568	39,568		39,568	3,474	43,042			27
28	**TOTAL General Administration**	317,922	36,728	1,758,584	2,113,234		2,113,234	(518,488)	1,594,746			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,171,386	541,006	2,195,435	5,907,827		5,907,827	(504,641)	5,403,186			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 INC **#28076** **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,953	
	REPAIRS & MAINTENANCE		160	
			0	10,113
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICE		142,698	
			0	142,698
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,578	
	CONTRACTED LAUNDRY SERVICE		95,132	102,710
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		43,723	
	ELECTRICITY		44,320	
	WATER		15,949	
	CABLE TV - LOBBY		0	
			0	103,992
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,318	
	PAINTING & DECORATING		1,294	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,897	
	ELEVATOR MAINTENANCE & REPAIR		3,414	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,675	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	16,598
7	**OTHER**			
	SCAVENGER		24,744	
	SECURITY SERVICE		0	
			0	
			0	24,744
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,600	21,600

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 CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,672	
	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	6,672
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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,326	
			0	1,326
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,603	
				4,603
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE INC **#28076** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,795	1,795
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	89,000	89,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,961	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	137,747	
			0	152,708
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	185,166	
	EMPLOYEE WANT ADS	XIX F	6,833	
	CONTRIBUTIONS	VI 20 XIX F	400	
	DUES & SUBSCRIPTIONS	XIX F	12,511	
	LICENSES & PERMITS	XIX F	4,011	
	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	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	4,996	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				214,417
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,533	
	EQUIPMENT REPAIR & MAINTENANCE		27,322	
	OUTSIDE CLERICAL SERVICES		400,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,070	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,598	
	MESSENGER SERVICE		0	
			0	449,723

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	241,497	
	UNEMPLOYMENT COMPENSATION	XIX D	80,293	
	WORKERS COMPENSATION INSURANC	XIX D	87,426	
	HOSPITALIZATION INSURANCE	XIX D	255,825	
	EMPLOYEE BENEFITS - OTHER	XIX D	21,837	
	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	4,256	
			0	691,134
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,891	
				4,891
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		14,766	
				14,766
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		102,377	
				102,377
27	**OTHER**			
	BAD DEBTS	VI 24	39,568	
				39,568

GRAND TOTAL COLUMN 3 OTHER **2,195,435**

WATERFRONT TERRACE INC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	213,602
LESS SALES TAX	(663)
NET FOOD	212,939
TOTAL PATIENT CENSUS	37,177
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	111,531
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	111,531
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	111,531
NET FOOD	212,939
DIVIDE TOTAL MEALS/YEAR	111,531
COST PER MEAL	1.91
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number WATERFRONT TERRACE INC #28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			272,075	272,075		272,075	(103,220)	168,855			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,584	36,584		36,584	159,338	195,922			32
33	Real Estate Taxes			112,146	112,146		112,146	4,365	116,511			33
34	Rent-Facility & Grounds			594,000	594,000		594,000	(594,000)				34
35	Rent-Equipment & Vehicles			13,354	13,354		13,354	8,401	21,755			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,028,159	1,028,159		1,028,159	(525,116)	503,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		218,525	64,169	282,694		282,694	4,291	286,985			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**		218,525	128,774	347,299		347,299	4,291	351,590			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,171,386	759,531	3,352,368	7,283,285		7,283,285	(1,025,466)	6,257,819			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 INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(111,641)	30		9
10	Interest and Other Investment Income	(133)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(663)	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	(1,070)	21		18
19	Entertainment				19
20	Contributions	(900)	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	(39,568)	27		24
25	Fund Raising, Advertising and Promotional	(185,166)	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	(53,880)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (393,021)		$	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)	(632,445)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (632,445)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,025,466)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WATERFRONT TERRACE INC

ID# 28076

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ -49698	21	1
2	MARKETING TRAVEL	(4,182)	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**	(53,880)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(663)	0	0	0	0	0	0	0	0	0	0	(663)	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	992	0	0	0	0	0	0	0	0	992	5
6	Maintenance	0	0	6,128	6,640	0	0	0	0	0	0	0	12,768	6
7	Other (specify):*	0	0	93	0	657	0	0	0	0	0	0	750	7
8	TOTAL General Services	(663)	0	7,213	6,640	657	0	0	0	0	0	0	13,847	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	(89,000)	0	147,130	0	0	0	0	0	0	0	58,130	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	612	0	0	0	0	0	0	0	0	612	19
20	Fees, Subscriptions & Promotions	(186,066)	0	671	0	0	0	0	0	0	0	0	(185,395)	20
21	Clerical & General Office Expenses	(50,768)	(400,200)	49,560	7,892	0	0	0	0	0	0	0	(393,516)	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	718	0	0	0	0	0	0	0	0	718	24
25	Other Admin. Staff Transportation	(4,182)	0	1,251	0	0	0	0	0	0	0	0	(2,931)	25
26	Insurance-Prop.Liab.Malpractice	0	0	420	0	0	0	0	0	0	0	0	420	26
27	Other (specify):*	(39,568)	0	10,344	0	32,698	0	0	0	0	0	0	3,474	27
28	TOTAL General Administration	(280,584)	(489,200)	63,576	155,022	32,698	0	0	0	0	0	0	(518,488)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(281,247)	(489,200)	70,789	161,662	33,355	0	0	0	0	0	0	(504,641)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 **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 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	(111,641)	6,425	1,996	0	0	0	0	0	0	0	0	(103,220)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(133)	155,945	3,526	0	0	0	0	0	0	0	0	159,338	32
33	Real Estate Taxes	0	0	4,365	0	0	0	0	0	0	0	0	4,365	33
34	Rent-Facility & Grounds	0	(594,000)	0	0	0	0	0	0	0	0	0	(594,000)	34
35	Rent-Equipment & Vehicles	0	0	8,401	0	0	0	0	0	0	0	0	8,401	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(111,774)	(431,630)	18,288	0	0	0	0	0	0	0	0	(525,116)	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	4,291	0	0	0	0	0	0	0	0	4,291	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	4,291	0	0	0	0	0	0	0	0	4,291	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(393,021)	(920,830)	93,368	161,662	33,355	0	0	0	0	0	0	(1,025,466)	45

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
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	$ 89,000	DYNAMIC HEALTH CARE CONSULTANT	100.00%	$	$ (89,000)	1
2	V	21	BOOKKEEPING SERVICE	400,200	" "			(400,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	594,000	WATERFRONT TERRACE ASSOCIATES	100.00%		(594,000)	7
8	V	30	DEPRECIATION		" "		6,425	6,425	8
9	V	32	INTEREST		" "		155,945	155,945	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,083,200			$ 162,370	$ * (920,830)	14

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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%	$ 992	$ 992	15
16	V	6	REPAIR & MAINT.		" " "		6,128	6,128	16
17	V	7	EMP. BEN. - GEN, SERV		" " "		93	93	17
18	V	19	PROFESSIONAL FEES		" " "		612	612	18
19	V	20	DUES AND SUBSCRIPTION		" " "		671	671	19
20	V	21	CLERICAL & GENERAL		" " "		49,560	49,560	20
21	V	24	SEMINARS AND TRAVEL		" " "		718	718	21
22	V	25	AUTO EXPENSE		" " "		1,251	1,251	22
23	V	26	INSURANCE		" " "		420	420	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" " "		10,344	10,344	24
25	V	30	DEPRECIATION		" " "		1,996	1,996	25
26	V	32	INTEREST		" " "		3,526	3,526	26
27	V	33	REAL ESTATE TAXES		" " "		3,712	3,712	27
28	V	33	RE TAX PROTEST FEES		" " "		653	653	28
29	V	35	EQUIPMENT RENTAL		" " "		8,401	8,401	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	39	ANCILLARY EXPENSE		LABPRO INC.		4,291	4,291	35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 93,368	$ * 93,368	39

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	100.00%	$ 6,640	$ 6,640	15
16	V	17	ADMIN COMP - M MAUER		" " "		18,829	18,829	16
17	V	17	ADMIN COMP - M AARON		" " "		21,340	21,340	17
18	V	17	ADMIN COMP - F AARON		" " "		13,600	13,600	18
19	V	17	ADMIN COMP - S GOLDSTEIN		" " "				19
20	V	17	ADMIN COMP - S HARAMARAS		" " "		18,526	18,526	20
21	V	17	ADMIN COMP - D KUFTA		" " "		16,256	16,256	21
22	V	17	ADMIN COMP - HOWARD ALTER		" " "		12,000	12,000	22
23	V	17	ADMIN COMP - NON OWNER - V DAVIS		" " "		4,992	4,992	23
24	V	17	ADMIN COMP - NON OWNER - VAR		" " "		21,207	21,207	24
25	V	17	ADMIN COMP - NON OWNER - CFO		" " "		20,380	20,380	25
26	V	21	CLERICAL COMP - S AARON		" " "		7,892	7,892	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			$			$ 161,662	$ * 161,662	39

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	100.00%	$ 657	$ 657	15
16	V	27	EMP BEN - M MAUER		" " "		1,034	1,034	16
17	V	27	EMP BEN - M AARON		" " "		1,198	1,198	17
18	V	27	EMP BEN - F AARON		" " "		8,783	8,783	18
19	V	27	EMP BEN - S GOLDSTEIN		" " "				19
20	V	27	EMP BEN - S HARAMARAS		" " "		7,548	7,548	20
21	V	27	EMP BEN - D KUFTA		" " "		1,142	1,142	21
22	V	27	EMP BEN - HOWARD ALTER		" " "		1,101	1,101	22
23	V	27	EMP BEN - V DAVIS		" " "		1,210	1,210	23
24	V	27	EMP BEN - NON OWNER		" " "		6,689	6,689	24
25	V	27	EMP BEN - NON OWNER - CFO		" " "		2,356	2,356	25
26	V	27	EMP BEN - S AARON		" " "		1,637	1,637	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			$			$ 33,355	$ * 33,355	39

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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	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					SALARY	$ 18,829	17-7	1
2	MAURICE AARON	ADMINISTRATION						SALARY	21,340	17-7	2
3	FRED AARON	ADMINISTRATION						SALARY	30,000	17-1	3
4	FRED AARON	ADMINISTRATION						SALARY	13,600	17-7	4
5	SHARON AARON	CLERICAL						SALARY	7,892	21-7	5
6	HOWARD ALTER	ADMINISTRATOR						SALARY	110,064	17-1	6
7	HOWARD ALTER	ADMINISTRATOR						SALARY	12,000	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 213,725		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 INC # 28076 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 [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	416,329	14	$ 11,113	$	37,177	$ 992	1
2	6	REPAIR & MAINTENANCE	TOTAL PATIENT DAYS	416,329	14	68,628	12,499	37,177	6,128	2
3	7	EMP BEN - GEN SERV	TOTAL PATIENT DAYS	416,329	14	1,044		37,177	93	3
4	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	416,329	14	6,858		37,177	612	4
5	20	DUES & SUBSCRIPTIONS	TOTAL PATIENT DAYS	416,329	14	7,513		37,177	671	5
6	21	CLERICAL & GENERAL	TOTAL PATIENT DAYS	416,329	14	555,005	401,070	37,177	49,560	6
7	24	SEMINARS & TRAVEL	TOTAL PATIENT DAYS	416,329	14	8,041		37,177	718	7
8	25	AUTO EXPENSE	TOTAL PATIENT DAYS	416,329	14	14,007		37,177	1,251	8
9	26	INSURANCE	TOTAL PATIENT DAYS	416,329	14	4,707		37,177	420	9
10	27	EMP BEN - GEN ADMIN	TOTAL PATIENT DAYS	416,329	14	115,833		37,177	10,344	10
11	30	DEPRECIATION	TOTAL PATIENT DAYS	416,329	14	22,348		37,177	1,996	11
12	32	INTEREST	TOTAL PATIENT DAYS	416,329	14	39,492		37,177	3,526	12
13	33	REAL ESTATE TAXES	TOTAL PATIENT DAYS	416,329	14	41,569		37,177	3,712	13
14	33	RE TAX PROTEST FEES	TOTAL PATIENT DAYS	416,329	14	7,315		37,177	653	14
15	35	EQUIPMENT RENTAL	TOTAL PATIENT DAYS	416,329	14	94,081		37,177	8,401	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 997,554	$ 413,569		$ 89,077	25

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 [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	$ 62,231	$ 62,231	4	$ 6,640	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG. HOURS	40	10	200,000	200,000	4	18,829	2
3	17	ADMIN COMP - M AARON	WGHTD AVG. HOURS	40	8	200,000	200,000	4	21,340	3
4	17	ADMIN COMP - F AARON	WGHTD AVG. HOURS	45	5	68,000	68,000	9	13,600	4
5	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG. HOURS	40	2	121,602	121,602			5
6	17	ADMIN COMP - S HARAMARA	WGHTD AVG. HOURS	40	4	74,106	74,106	8	18,526	6
7	17	ADMIN COMP - D KUFTA	WGHTD AVG. HOURS	50	8	152,525	152,525	5	16,256	7
8	17	ADMIN COMP - H ALTER	WGHTD AVG. HOURS	50	1	12,000	12,000	40	12,000	8
9	17	ADMIN COMP - NON OWNER	WGHTD AVG. HOURS	40	8	74,874	74,874	3	4,992	9
10	17	ADMIN COMP - NON OWNER	WGHTD AVG. HOURS	45	8	198,817	198,817	5	21,207	10
11	17	ADMIN COMP - NON OWNER	WGHTD AVG. HOURS	45	10	216,469	216,469	4	20,380	11
12	21	CLERICAL COMP - S AARON	WGHTD AVG. HOURS	40	10	83,751	83,751	4	7,892	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,464,375	$ 1,464,375		$ 161,662	25

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 [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	$ 6,161	$	4	$ 657	1
2	27	EMP BEN - M MAUER	WGHTD AVG. HOURS	40	10	10,982		4	1,034	2
3	27	EMP BEN - M AARON	WGHTD AVG. HOURS	40	8	11,224		4	1,198	3
4	27	EMP BEN - F AARON	WGHTD AVG. HOURS	45	5	43,917		9	8,783	4
5	27	EMP BEN - S GOLDSTEIN	WGHTD AVG. HOURS	40	2	44,352				5
6	27	EMP BEN - S HARAMARAS	WGHTD AVG. HOURS	40	4	30,190		8	7,548	6
7	27	EMP BEN - D KUFTA	WGHTD AVG. HOURS	50	8	10,718		5	1,142	7
8	27	EMP BEN - H ALTER	WGHTD AVG. HOURS	50	1	1,101		40	1,101	8
9	27	EMP BEN - V DAVIS	WGHTD AVG. HOURS	40	8	18,154		3	1,210	9
10	27	EMP BEN - NON OWNER	WGHTD AVG. HOURS	45	8	62,705		5	6,689	10
11	27	EMP BEN - NON OWNER CFO	WGHTD AVG. HOURS	45	10	25,019		4	2,356	11
12	27	EMP BEN - S AARON	WGHTD AVG. HOURS	40	10	17,376		4	1,637	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					$ 281,899	$		$ 33,355	25

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 [X] NO [ ]

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

Name of Related Organization: LABPRO INC.
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	39	ANCILLARY EXPENSE	DIRECT ALLOCATION			$ 4,291	$		$ 4,291	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291	$		$ 4,291	25

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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	
	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	BANK FINANCIAL		X	MORTGAGE	INTEREST	01/01/11	$ 5,310,000	$ 5,310,000	06/06/13	3.2900	$ 155,945	1
2												2
3												3
4	PHARMACY		X	AP FINANCING	$3,778.79	11/10/11	126,161	122,382	10/10/14	5.2500	535	4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				1,337,940			25,655	6
7	WILLOW CREST	X		WORKING CAPITAL							8,958	7
8			X	INSURANCE FINANCING							1,436	8
9	TOTAL Facility Related				$3,778.79		$ 5,436,161	$ 6,770,322			$ 192,529	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,436,161	$ 6,770,322			$ 192,529	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 INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 106,000	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.)		$ 108,146	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,146	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 110,000	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.		$ 112,146	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	111,687	8
	2007	110,495	9
	2008	111,603	10
	2009	103,696	11
	2010	108,146	12

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 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE INC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 28076

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-412-038-0000	NURSING HOME	$ 1,497.05	$ 1,497.05
2.	21-30-412-045-0000	NURSING HOME	$ 106,648.65	$ 106,648.65
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,145.70	$ 108,145.70

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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).

N/A

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 INC # 28076 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 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	$ 1,238,723	4
5											5
6											6
7											7
8	RELATED PARTY				39,612	1,016	35	1,132	116	20,749	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)	1,438	16
17	LEASEHOLD IMPROVEMENT			1992	18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT			1992	1,097	35	15	11	(24)	1,097	18
19	LEASEHOLD IMPROVEMENT			1993	7,742	246	31.5	246		4,602	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		1,624	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		11,207	21
22	ELEVATOR REPAIR			1995	1,500	38	39	38		644	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		1,796	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		2,420	24
25	FENCING			1996	756	31	15	31		756	25
26	NURSE STATION			1996	5,300	136	39	136		2,057	26
27	HANDRAILS			1996	3,735	96	39	96		1,444	27
28	PARKING LOT REPAVING			1997	14,968	998	15	998		13,568	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		9,516	29
30	DRAPERY			1997	14,754	378	39	378		5,426	30
31	DOORS & SIGNS			1997	8,428	216	39	216		3,105	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		6,268	32
33	REMODELING			1997	59,133	1,517	39	1,517		21,965	33
34	NURSE STATION			1997	5,106	131	39	131		1,883	34
35										1,752	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 INC # 28076 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 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	$	$ 15,440	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNETS	1998	6,419	165	39	165		2,223	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,256	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		2,759	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		692	41
42	REMODELING	1998	21,934	562	39	562		7,540	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		4,576	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,321	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		7,234	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		5,959	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		3,467	47
48	FIRE ALARM	1999	10,286	264	39	264		3,352	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		11,558	49
50	BOILER WORK	1999	7,345	189	39	189		2,391	50
51	CABLE WORK	1999	433	11	39	11		141	51
52	CARPET	1999	18,828	483	39	483		6,082	52
53	ELEVATOR WORK	1999	2,017	52	39	52		659	53
54	AIR CONDITIONING	1999	7,350	189	39	189		2,419	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		2,910	55
56	ROOF WORK	1999	2,187	56	39	56		702	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		18,820	57
58	WINDOWS	1999	5,513	142	39	142		1,784	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		10,370	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		6,284	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		56,365	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		7,028	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		1,168	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		4,264	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,341	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		4,325	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		33,517	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		1,128	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		1,106	69
70	TOTAL (lines 4 thru 69)		$ 2,504,980	$ 27,317		$ 68,530	$ 41,213	$ 1,670,162	70

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 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		$ 2,504,980	$ 27,317		$ 68,530	$ 41,213	$ 1,670,162	1
2	EXHAUST FAN	2000	890	32	27.5	32		377	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		467	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,308	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		2,920	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		2,402	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		2,207	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		2,382	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		948	10
11	AC UNIT	2001	786	28	27.5	28		296	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		2,070	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		1,812	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		761	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		1,226	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		593	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		14,630	17
18	DECK & FENCE	2004	10,197	680	15	680		5,100	18
19	A/C REPAIR	2004	2,200	80	27.5	80		596	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		1,216	20
21	WATER HEATER	2004	6,937	252	27.5	252		1,880	21
22	NURSE CALL STATION	2004	585	21	27.5	21		157	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		342	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		8,848	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		3,933	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		4,566	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		3,029	27
28	ROOF REPAIRS	2005	726	26	27.5	26		168	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		1,033	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		239	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		1,703	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		617	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		6,545	33
34	TOTAL (lines 1 thru 33)		$ 2,763,806	$ 36,629		$ 77,842	$ 41,213	$ 1,755,780	34

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 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		$ 2,763,806	$ 36,629		$ 77,842	$ 41,213	$ 1,755,780	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		404	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		1,408	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		13,335	4
5	DOORS	2006	15,104	549	27.5	549		2,997	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		1,097	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		14,410	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		737	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		327	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		491	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		295	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		589	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		595	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		2,461	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		3,937	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		2,256	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		15,814	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		12,497	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		3,063	19
20	SIGNAGE	2007	2,403	87	27.5	87		388	20
21	BOILER WORK	2007	1,835	67	27.5	67		298	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		3,763	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		767	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		446	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		3,080	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		1,418	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		7,460	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		1,082	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		1,273	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		2,932	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		498	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		654	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		1,311	33
34	TOTAL (lines 1 thru 33)		$ 3,381,669	$ 59,097		$ 100,310	$ 41,213	$ 1,857,863	34

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 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		$ 3,381,669	$ 59,097		$ 100,310	$ 41,213	$ 1,857,863	1
2	REFRIGERATOR REPAIRS	2008	1,721	63	27.5	63		218	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	55	27.5	55		190	3
4	RFIRE ALARM SYSTEM REPAIRS	2009	12,907	469	27.5	469		1,153	4
5	ELECTRICAL WORK	2009	53,455	1,944	27.5	1,944		4,779	5
6	ELEVATOR REPAIRS	2009	23,314	847	27.5	847		2,083	6
7	CARPET, TILE & VINYL	2009	5,857	213	27.5	213		524	7
8	AIR CONDITIONERS & SLEEVES	2009	6,183	225	27.5	225		553	8
9	DOORS	2009	3,967	144	27.5	144		354	9
10	PLUMBING REPAIRS	2009	15,124	550	27.5	550		1,352	10
11	DISH NETWORK EQUIPMENT	2009	1,575	58	27.5	58		142	11
12	EMERGENCY ALARM CONTROL PANEL	2009	1,175	43	27.5	43		105	12
13	DOORS AND ACCESSORIES, DOOR ALARM & KEY PAD	2010	17,232	627	27.5	627		914	13
14	REPLACE WATER TUBES AND GASKET	2010	1,992	72	27.5	72		105	14
15	AIR CONDITIONERS, REPLACE AIR HANDLER MOTOR	2010	13,721	499	27.5	499		728	15
16	ROOF REPAIR	2010	4,135	150	27.5	150		219	16
17	CEILING PIPING REPAIRS- FRONT OFFICE	2010	4,850	176	27.5	176		257	17
18	INSTALL FIRE DAMPERS,FIRE,CIRCULATING,BRONZ PUMI	2010	5,689	207	27.5	207		302	18
19	BASEMENT REPAIRS	2010	2,600	95	27.5	95		138	19
20	REPLACE PRIMARY PUMP IN BASEMENT	2010	2,400	87	27.5	87		127	20
21	2ND FLOOR PATIENTS BATHROOMS AND ROOMS:	2010	54,081	1,967	27.5	1,967		2,868	21
22	INSTALL NEW WALLS, CERAMIC TILE,CALL LIGHT								22
23	LIGHTING ACCESSORIES, FIXTURES, LAMPS	2010	12,135	441	27.5	441		643	23
24	UTILITYU ROOM SINK, REPAIR SPRINKLER SYSTEM	2010	3,299	120	27.5	120		175	24
25	WALL PROTECTION HANDRAILS	2010	9,634	350	27.5	350		511	25
26	BUMBERS AROUND GARBAGE AREA	2010	4,766	173	27.5	173		252	26
27	WALLCOVERING, CUBICLE CURTAINS	2010	5,711	208	27.5	208		303	27
28	INSTALL STAIN & RAMP RAILINGS, SECURITY SYSTEM	2010	3,175	115	27.5	115		168	28
29	REPLACE ELECTRIC FOR TV ABOVE CEILING	2010	2,700	98	27.5	98		143	29
30	3RD FLOOR-REPLACE LIGHTS, INSTALL WATT FIXTURE	2010	3,328	121	27.5	121		176	30
31	NORTH SIDE EAST END-PERLACE BUILDING LIGHTS	2010	3,052	111	27.5	111		162	31
32	INSTALL OUTDOOR LIGHTING	2010	7,250	264	27.5	264		385	32
33	PATIO ROOMS-NEW DOOR, TILE, FLOOR, LIGHTING	2010	13,417	488	27.5	488		712	33
34	TOTAL (lines 1 thru 33)		$ 3,683,635	$ 70,077		$ 111,290	$ 41,213	$ 1,878,604	34

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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 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		$ 3,683,635	$ 70,077		$ 111,290	$ 41,213	$ 1,878,604	1
2	AIR COMPRESSOR COIL REPAIR	2010	1,850	68	27.5	68		99	2
3	RECEPTION DESK/CABINETS	2011	16,284	271			(271)		3
4	WALLCOVERING/WINDOW TREATMENTS/ARTWORK/COR	2011	35,692	595			(595)		4
5	FLOORING/WINDOW TREATMENTS	2011	96,290	1,605			(1,605)		5
6	DOORS/KICK PLATES	2011	22,647	377			(377)		6
7	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	57,913	965			(965)		7
8	PLUMBING/ELECTRIC WORK	2011	45,941	766			(766)		8
9	WINDOWS	2011	72,160	1,203			(1,203)		9
10	ROOD REPAIRS/AIR HANDLER	2011	11,093	185			(185)		10
11	STAIRWELL CRASH RAILS	2011	5,242	87			(87)		11
12	LOBBY HEAT/COOL/FLOORING	2011	29,666	494			(494)		12
13	WINDOW TREATMENT LIGHTING WALL PLASTERING	2011	26,424	440			(440)		13
14	CAPRET, CORNER GUARDS	2011	5,247	87			(87)		14
15	DOORS	2011	3,370	56			(56)		15
16	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	149,510	2,494			(2,494)		16
17	ELECTRIC REPAIR/REPLACE	2011	54,666	911			(911)		17
18	HOT WATER HEATERS/PLUMBING WORK	2011	18,765	313			(313)		18
19	RECEPTION DESK	2011	21,772	363			(363)		19
20	ROOF REPAIR	2011	2,310	38			(38)		20
21	SECURITY/FIRE SYSTEM REPAIR	2011	19,325	322			(322)		21
22	HEATERS/AC UNIT	2011	17,028	284			(284)		22
23	SCANNERS/COMPUTER CABLING	2011	35,424	590			(590)		23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,432,254	$ 82,591		$ 111,358	$ 28,767	$ 1,878,703	34

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 486,766	$ 24,763	$ 44,834	$ 20,071	5-10 YRS	$ 287,118	71
72	Current Year Purchases	172,162	172,162	8,608	(163,554)	10 YRS	8,608	72
73	Fully Depreciated Assets	676,162					676,162	73
74	RELATED PARTY	20,372		660	660		17,751	74
75	TOTALS	$ 1,355,462	$ 196,925	$ 54,102	$ (142,823)		$ 989,639	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	RELATED PARTY			$ 20,555	$ 980	$ 3,395	$ 2,415		$ 9,701	76
77										77
78										78
79										79
80	TOTALS			$ 20,555	$ 980	$ 3,395	$ 2,415		$ 9,701	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)	$ 5,908,271	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 280,496	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,855	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (111,641)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,878,043	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 INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 7,151 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		2010 BUICK ENCLAVE	$ 578.56	$ 6,942	17
18		2010 TOYOTA CAMRY	342.93	4,115	18
19		PAYROLL ADJ		(4,854)	19
20					20
21	TOTAL		$ 921.49	$ 6,203	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 INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			530			530	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			63,639			63,639	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				184,381		184,381	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): SUP/LAB/XRAY						34,144		34,144	13
14	TOTAL			$		$ 64,169	$ 218,525		$ 282,694	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 INC # 28076 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 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 416,000)	2,007,959		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,066		6
7	Other Prepaid Expenses	44,713		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	206,435		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,349,173	$	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	2,634,075		15
16	Equipment, at Historical Cost	1,350,014		16
17	Accumulated Depreciation (book methods)	(1,847,973)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,136,116	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,485,289	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,485,308	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,460,322		29
30	Accrued Salaries Payable	258,806		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,641		31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,000		32
33	Accrued Interest Payable	7,851		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)**	$ 3,351,928	$	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)**	$ 3,351,928	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,133,361	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,485,289	$	48

***(See instructions.)**

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,316,157	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,316,157	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	57,204	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)**	$ (182,796)	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)**	$ 1,133,361	24 *

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,053,036	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,053,036	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	303,221	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 303,221	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***	133	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 133	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)**	$ 7,356,390	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,049,725	31
32	Health Care	2,744,868	32
33	General Administration	2,113,234	33
	B. Capital Expense		
34	Ownership	1,028,159	34
	C. Ancillary Expense		
35	Special Cost Centers	282,694	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,283,285	40
41	**Income before Income Taxes (line 30 minus line 40)****	73,105	41
42	**Income Taxes**	(15,901)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 57,204	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 INC # 28076 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,277	2,630	$ 108,525	$ 41.26	1
2	Assistant Director of Nursing	967	994	42,976	43.24	2
3	Registered Nurses	2,308	2,327	112,544	48.36	3
4	Licensed Practical Nurses	35,549	39,809	976,787	24.54	4
5	CNAs & Orderlies	57,587	61,584	580,449	9.43	5
6	CNA Trainees					6
7	Licensed Therapist	12,648	13,176	531,849	40.36	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,092	2,192	34,408	15.70	9
10	Activity Assistants	9,410	10,532	106,840	10.14	10
11	Social Service Workers	2,509	2,587	45,284	17.50	11
12	Dietician					12
13	Food Service Supervisor	2,173	2,396	44,157	18.43	13
14	Head Cook	5,972	6,632	77,590	11.70	14
15	Cook Helpers/Assistants	7,679	8,437	81,427	9.65	15
16	Dishwashers					16
17	Maintenance Workers	5,292	5,449	93,330	17.13	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,901	2,086	110,064	52.76	20
21	Assistant Administrator					21
22	Other Administrative	450	450	30,000	66.67	22
23	Office Manager					23
24	Clerical	7,874	8,175	177,858	21.76	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	1,203	1,420	17,298	12.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,891	170,876	$ 3,171,386 *	$ 18.56	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	$ 9,953	1-3	35
36	Medical Director	O	21,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,672	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	1,326	11-3	44
45	Social Service Consultant	E	4,603	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,154		49

C. CONTRACT NURSES

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMINISTRATOR		$ 110,064
			0
FRED AARON	OTHER ADMIN		30,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 140,064

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 89,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 89,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		152,708
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 152,708

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,426
Unemployment Compensation Insurance	80,293
FICA Taxes	241,497
Employee Health Insurance	255,825
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	21,837
CHICAGO HEAD TAX	4,256
TOTAL (agree to Schedule V, line 22, col.8)	$ 691,134

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,833
Health Care Worker Background Check	4,996
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	900
MARKETING/ADV/PROMO	185,166
LICENSES/DUES/SUBSCRIPTIONS	16,522
MGMT CO ALLOC	671
TRUST/FRANCHISE/CONTRIB/ETC	(900)
Less: Public Relations Expense	(0)
Non-allowable advertising	(185,166)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,022

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	718
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 718

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number WATERFRONT TERRACE INC # 28076 Report 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 $12,036**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **3,176** 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 fo
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 Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **0** 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 fo
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 othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

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

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

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