FOR BHF USE

LL1

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

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0038612

Facility Name: Waterford Nursing & Rehab

Address: 7445 N Sheridan Rd (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 338-3300 **Fax #** (773) 338-5868

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1982

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **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 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) DAN SHABAT
(Title) OWNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, 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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,738	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	141	TOTALS	141	51,606	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			2,374	2,374	8
9	SNF/PED					9
10	ICF	42,054	776	153	42,983	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,054	776	2,527	45,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.89%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 37 and days of care provided 2,374

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,731	19,912	7,823	240,466		240,466		240,466			1
2	Food Purchase		226,395		226,395	(34,060)	192,335	(432)	191,903			2
3	Housekeeping	129,246	22,311		151,557		151,557		151,557			3
4	Laundry	54,880	11,877		66,757		66,757		66,757			4
5	Heat and Other Utilities			121,143	121,143		121,143		121,143			5
6	Maintenance	29,414	8,481	45,415	83,310		83,310		83,310			6
7	Other (specify):*			9,119	9,119		9,119		9,119			7
8	TOTAL General Services	426,271	288,976	183,500	898,747	(34,060)	864,687	(432)	864,255			8
	B. Health Care and Programs											
9	Medical Director			5,300	5,300		5,300		5,300			9
10	Nursing and Medical Records	1,735,949	90,325	43,260	1,869,534		1,869,534		1,869,534			10
10a	Therapy		1,878	270	2,148		2,148		2,148			10a
11	Activities	84,436	4,003	4,800	93,239		93,239		93,239			11
12	Social Services	81,892		3,412	85,304		85,304		85,304			12
13	CNA Training											13
14	Program Transportation			2,245	2,245		2,245		2,245			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,902,277	96,206	59,287	2,057,770		2,057,770		2,057,770			16
	C. General Administration											
17	Administrative	224,288		299,500	523,788		523,788	(196,500)	327,288			17
18	Directors Fees											18
19	Professional Services			46,246	46,246		46,246	5,050	51,296			19
20	Dues, Fees, Subscriptions & Promotions			40,425	40,425		40,425	(28,265)	12,160			20
21	Clerical & General Office Expenses	202,023	10,019	21,011	233,053		233,053	(80,960)	152,093			21
22	Employee Benefits & Payroll Taxes			431,947	431,947	34,060	466,007		466,007			22
23	Inservice Training & Education			2,080	2,080		2,080		2,080			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,282	2,282		2,282	(2,210)	72			25
26	Insurance-Prop.Liab.Malpractice			89,374	89,374		89,374	47,780	137,154			26
27	Other (specify):*			39,525	39,525		39,525	(34,625)	4,900			27
28	TOTAL General Administration	426,311	10,019	972,390	1,408,720	34,060	1,442,780	(289,730)	1,153,050			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,754,859	395,201	1,215,177	4,365,237		4,365,237	(290,162)	4,075,075			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#: Waterford Nursing & Rehab **#0038612** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,823	
	REPAIRS & MAINTENANCE		0	
			0	7,823
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		48,180	
	ELECTRICITY		42,487	
	WATER		28,661	
	CABLE TV - LOBBY		1,815	
			0	121,143
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,800	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		1,000	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		33,079	
	ELEVATOR MAINTENANCE & REPAIR		6,776	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,760	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	45,415
7	**OTHER**			
	SCAVENGER		9,119	
	SECURITY SERVICE		0	
			0	
			0	9,119
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,300	5,300

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	35,488	
	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	1,568	
	PHARMACY CONSULTANT	XVIII B 39-2	6,204	
	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	43,260
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		270	
	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	
				270
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,800	
			0	4,800
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,412	
				3,412
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number Waterford Nursing & Rehab #0038612 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,245	2,245
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	299,500	299,500
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,960	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	30,286	
			0	46,246
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	19,182	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS	XIX F	5,865	
	LICENSES & PERMITS	XIX F	4,305	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	515	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	7,568	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	650	
	PATIENT BACKGROUND CHECKS	XIX F	1,340	
				40,425
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		287	
	EQUIPMENT REPAIR & MAINTENANCE		1,087	
	OUTSIDE CLERICAL SERVICES		43	
	PENALTIES / OVERDRAFT CHARGES	VI 18	523	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,071	
	MESSENGER SERVICE		0	
			0	21,011

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	208,725	
	UNEMPLOYMENT COMPENSATION	XIX D	13,754	
	WORKERS COMPENSATION INSURANC	XIX D	39,660	
	HOSPITALIZATION INSURANCE	XIX D	148,099	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	20	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	18,545	
	CHICAGO HEAD TAX	XIX D	3,144	
			0	431,947
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,080	
				2,080
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,282	
				2,282
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		89,374	
				89,374
27	**OTHER**			
	BAD DEBTS	VI 24	39,525	
				39,525

GRAND TOTAL COLUMN 3 OTHER **1,215,177**

Waterford Nursing & Rehab
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	226,395
LESS SALES TAX	(432)
NET FOOD	225,963
TOTAL PATIENT CENSUS	45,357
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	136,071
ADD # EMPLOYEE MEALS/DAY	66
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	24,156
PATIENT MEALS	136,071
ADD EMPLOYEE MEALS	24,156
TOTAL MEALS/YEAR	160,227
NET FOOD	225,963
DIVIDE TOTAL MEALS/YEAR	160,227
COST PER MEAL	1.41
TIMES EMPLOYEE MEALS	24,156
EMPLOYEE MEAL RECLASSIFICATION	**34,060**

SEMINARS
PAGE 3 SCHEDULE V COLUMN 3 LINES 23

DATE	SPONSOR	TOPIC	PERSONNEL ATTENDING	DEPT	LOC	COST OF SEMINAR
2.22.12	ICLTC	In-Depth Training for Wound Care Nurses	L.Villareal	DON	IL	390.00
			R.Siapno	Bkkp		
3.21.12	ICLTC	Reducing Hospital Readmissions	L.Villareal	DON	IL	105.00
5.01.12	ICLTC	Coming	K.Donohue	Admin	IL	315.00
			L.Villareal	DON		
			A.Shabat			
6.06.12	ICLTC	Behavior De-escalation	K.Heinze	PsychoSoc	IL	105.00
7.09.12	WPS Medicare	Skilled Nursing Facility Billing Seminar	S.Flannery	Bkkp	IL	110.00
9.07.12	ICLTC	Antipsychotic Drug Quality Management	K.Donohue	Admin	IL	315.00
			L.Villareal	DON		
			M.Rienton	MDS		
			N. Matin			
10.19.12	C CHOW & ASSOC	Food service Seminar	M.Zahiruddin		IL	110.00
11.14.12	ICLTC	New OBRA Standards	K.Donohue	Admin	IL	210.00
			L.Villareal	DON		
12.13.12	ICLTC	Medicaid Intergrated Care Program -Phase II	S. Herlihy	Director	IL	420.00
			M.Flores	Bkkp		
			K. Donohue	Admin		
Total			A.Shabat			2,080.00

Facility Name & ID Number Waterford Nursing & Rehab #0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			16,496	16,496		16,496	144,394	160,890			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,052	11,052		11,052	317,917	328,969			32
33	Real Estate Taxes							138,695	138,695			33
34	Rent-Facility & Grounds			616,784	616,784		616,784	(616,784)				34
35	Rent-Equipment & Vehicles			1,854	1,854		1,854		1,854			35
36	Other (specify):*							22,915	22,915			36
37	**TOTAL Ownership**			646,186	646,186		646,186	7,137	653,323			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,657	416,464	518,121		518,121		518,121			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			473,484	473,484		473,484		473,484			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		101,657	889,948	991,605		991,605		991,605			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,754,859	496,858	2,751,311	6,003,028		6,003,028	(283,025)	5,720,003			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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	25,420	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	(432)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(515)	20		17
18	Fines and Penalties	(523)	21		18
19	Entertainment				19
20	Contributions	(8,568)	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	(39,525)	27		24
25	Fund Raising, Advertising and Promotional	(19,182)	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	(82,647)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (125,972)		$	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)	(157,053)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (157,053)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (283,025)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Waterford Nursing & Rehab

ID# **0038612**

Report Period Beginning: **01/01/2012**

Ending: **12/31/2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (80,437)	21	1
2	MARKETING TRAVEL	(2,210)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(82,647)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(432)	0	0	0	0	0	0	0	0	0	0	(432)	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**	(432)	0	0	0	0	0	0	0	0	0	0	(432)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(196,500)	0	0	0	0	0	0	0	0	(196,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,050	0	0	0	0	0	0	0	0	0	5,050	19
20	Fees, Subscriptions & Promotions	(28,265)	0	0	0	0	0	0	0	0	0	0	(28,265)	20
21	Clerical & General Office Expenses	(80,960)	0	0	0	0	0	0	0	0	0	0	(80,960)	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	(2,210)	0	0	0	0	0	0	0	0	0	0	(2,210)	25
26	Insurance-Prop.Liab.Malpractice	0	47,780	0	0	0	0	0	0	0	0	0	47,780	26
27	Other (specify):*	(39,525)	0	4,900	0	0	0	0	0	0	0	0	(34,625)	27
28	**TOTAL General Administration**	(150,960)	52,830	(191,600)	0	0	0	0	0	0	0	0	(289,730)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(151,392)	52,830	(191,600)	0	0	0	0	0	0	0	0	(290,162)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Waterford Nursing & Rehab **#** 0038612 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	25,420	118,974	0	0	0	0	0	0	0	0	0	144,394	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	317,917	0	0	0	0	0	0	0	0	0	317,917	32
33	Real Estate Taxes	0	138,695	0	0	0	0	0	0	0	0	0	138,695	33
34	Rent-Facility & Grounds	0	(616,784)	0	0	0	0	0	0	0	0	0	(616,784)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	22,915	0	0	0	0	0	0	0	0	0	22,915	36
37	**TOTAL Ownership**	25,420	(18,283)	0	0	0	0	0	0	0	0	0	7,137	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(125,972)	34,547	(191,600)	0	0	0	0	0	0	0	0	(283,025)	45

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 616,784	Deauville Associates LLC	100.00%	$	$ (616,784)	1
2	V	32	Interest	1,797	" "		191,716	189,919	2
3	V	19	Accounting Fees		" "		5,050	5,050	3
4	V	26	Property Insurance		" "		47,780	47,780	4
5	V	33	R E Taxes		" "		138,695	138,695	5
6	V	30	SL Depreciation		" "		118,974	118,974	6
7	V	32	Amortization Loan Fees		" "		127,998	127,998	7
8	V	36	MIP Expense		" "		22,915	22,915	8
9	V						1,431	1,431	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 618,581			$ 654,559	$ * 35,978	14

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 294,000	SFMA, INC	100.00%	$	$ (294,000)	15
16	V	17	Dan Shabat Comp		" "		97,500	97,500	16
17	V	27	Admin Benefits		" "		4,900	4,900	17
18	V								18
19	V								19
20	V	17	Management Fees-Stan Aron	5,500	Pro Health Care Inc	100.00%	5,500		20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	10	In House Drugs	7,015	Pharmore Drugs LLC		7,015		25
26	V	39	Exp - Drugs	91,232	" "		91,232		26
27	V	10	Pharmacy Consultant	6,204	" "		6,204		27
28	V								28
29	V								29
30	V	39	Exp - Laboratory	3,561	Lifescan Laboratory Inc		3,561		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			$ 407,512			$ 215,912	$ * (191,600)	39

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dan Shabat	Owner	Administrative	100.00	97,500	20	33.00	Alloc Salary	$ 97,500	17-7	1
2	ProHealth-Stan Aron		Administrative	0.00		1	2.44	Mgt Fee	5,500	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 103,000		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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Dan Shabat Comp	Avg Hours Worked	40	2	$ 195,000	$ 195,000	20	$ 97,500	1
2	27	Admin Benefits	" "	40	2	9,799		20	4,900	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 204,799	$ 195,000		$ 102,400	25

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY-Deauville Associates, LLC						$	$			$	1
2	Heartland Bank		X	Mortgage	$27,769.38	08/25/06	4,631,700		09/2036	6.0000	129,143	2
3	Loan Fees		X	Amortized over life of loan			153,941				126,574	3
4	Beech St		X	Mortgage	$21,629.36	06/28/12	4,578,700	4,522,761	09/2036	2.7500	62,573	4
5	Loan Fees		X	Amortized over life of loan			85,441	84,017			1,424	5
	Working Capital											
6	Line of Credit		X	Working Capital	DEMAND		102,300			PRIME+	10,215	6
7	Lexus Financial		X	Auto Loan	$800.00	08/25/11	27,057	15,401	08/25/14	3.9900	837	7
8												8
9	TOTAL Facility Related				$50,198.74		$ 9,579,139	$ 4,622,179			$ 330,766	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,579,139	$ 4,622,179			$ 330,766	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 22,915 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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 161,844	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.)		$ 156,477	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,367)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 161,223	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.)**		$ 9,100	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 $ 26,261 For 2008&2009 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (26,261)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 138,695	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	144,746	8
	2008	146,198	9
	2009	150,575	10
	2010	157,131	11
	2011	156,477	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 2011 TAX BILL.
Skidelsky & Assoc invoices and 2008 & 2009 Real Estate Tax refunds attached

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Waterford Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038612

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-308-005-0000	NURSING HOME	$ 156,477.00	$ 156,477.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 156,477.00	$ 156,477.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATED PARTY-Deauville Associates, LLC:				$	$		$	$	$	4
5	141		1994	1977	2,189,665	56,145	39	56,145		1,628,212	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		5			70,593	19
20	Nurses Station			2007	50,000	5,000	10	5,000		26,667	20
21	Window Replacement			2007	60,000	6,000	10	6,000		32,000	21
22	Physical Therapy Room			2007	29,808	2,981	10	2,981		16,147	22
23	Windows			2007	118,715	11,872	10	11,872		64,305	23
24	Boilers			2007	33,629	6,726	5	6,726		40,355	24
25	Door Handles, Locks			2007	13,243	2,649	5	2,649		14,348	25
26	Shower Room			2007	18,866	1,887	10	1,887		10,535	26
27	Nurses Call System 3rd Floor			2007	9,492	949	10	949		5,220	27
28	Shower Room			2007	23,046	2,305	10	2,305		12,869	28
29	Window Treatments			2007	10,090	1,009	10	1,009		5,550	29
30	Nurses Call System 2nd Floor			2007	4,746	475	10	475		2,611	30
31	Fire Alarm System & Sprinklers			2010	40,518	4,052	10	4,052		8,373	31
32	Fire Dampers/Injector Pump			2012	4,790	123	39	123		123	32
33	Boiler/Piping/Air vent/Asbestos insulation abatement			2012	37,160	476	39	476		476	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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	FACILITY:		$	$		$	$	$	37
38	Various	1993	63,831	1,637	20	3,191	1,554	60,942	38
39	Various	1994	17,273	379	20	740	361	16,365	39
40	Various	1995	34,505	697	20	1,126	429	32,204	40
41	Various	1996	19,396	497	20	889	392	16,424	41
42	Various	1997	79,650	2,042	20	3,982	1,940	62,060	42
43	Various	1999	35,500	910	3		(910)	35,500	43
44	Various	2000	17,386	446	5		(446)	17,386	44
45	Various	2001	19,348	284	20	339	55	12,080	45
46	Various	2002	34,272	879	20	233	(646)	34,272	46
47	Various	2004	76,500		20	3,825	3,825	55,463	47
48	Cable Equipment & Installation	2007	7,500	60	20	375	315	2,906	48
49	Wall and Heater Removal	2007	45,287	1,000	20	2,264	1,264	18,491	49
50	1st and 2nd Floor Nurses Station and Corridor	2007	2,176	217	20	109	(108)	817	50
51	Resident Rooms - Doors & 2nd Floor Corr/Nurses Station	2008	1,524	222	20	76	(146)	469	51
52	Boilers	2008	14,924	1,493	20	746	(747)	4,849	52
53	Wiring for Cable - 30 Resident Rooms & 3 Dayrooms	2009	3,350	86	20	168	82	727	53
54	Wall & Door with Frame - 3rd Floor Dayroom	2009	2,948	76	20	147	71	655	54
55	6" Gate Valve on Air Conditioner	2009	3,225	83	20	161	78	600	55
56	Life Safety Upgradess Fire Alarm System	2009	2,400	61	20	120	59	447	56
57	Elevator Guide Shoes, Traveler & Rewire, Starter	2009	10,930	280	20	547	267	2,140	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)		$ 3,485,989	$ 113,998		$ 121,687	$ 7,689	$ 2,592,884	70

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 126,949	$ 247	$ 13,614	$ 13,367	5-10 Yrs	$ 87,441	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	263,090					263,090	73
74	Deauville Health Care Center	408,969	16,325	16,325		5-10 Yrs	376,777	74
75	TOTALS	$ 799,008	$ 16,572	$ 29,939	$ 13,367		$ 727,308	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	$ 4,900	$ 9,264	$ 4,364	4 Yrs	$ 13,896	76
77										77
78										78
79										79
80	TOTALS			$ 37,057	$ 4,900	$ 9,264	$ 4,364		$ 13,896	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)	$ 4,517,988	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,470	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 160,890	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,420	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,334,088	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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 1,854 Description: 330 Postage Meter Rental/1,524 Nursing Equipment Rental
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$		$ 199,607	$		$ 199,607	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,918			10,918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			201,950			201,950	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				91,232		91,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39-3				3,989			3,989	12
13	Other (specify): Lab, Med Supplies	39-2					10,425		10,425	13
14	TOTAL			$		$ 416,464	$ 101,657		$ 518,121	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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 222,441	$ 315,709	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (375,000))	716,082	716,082	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,401	70,117	6
7	Other Prepaid Expenses	3,956	16,287	7
8	Accounts Receivable (owners or related parties)	1,078,437	1,968,945	8
9	Other(specify): Escrow Deposits/Replacement Reserve		624,447	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,043,317	$ 3,711,587	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		2,829,593	14
15	Leasehold Improvements, at Historical Cost	491,925	491,925	15
16	Equipment, at Historical Cost	427,095	1,098,578	16
17	Accumulated Depreciation (book methods)	(737,976)	(3,442,509)	17
18	Deferred Charges		84,017	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): Security Deposit	5,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 186,044	$ 1,257,538	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,229,361	$ 4,969,125	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 407,039	$ 442,898	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	9,119	146,012	29
30	Accrued Salaries Payable	110,639	110,639	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,673	32,673	31
32	Accrued Real Estate Taxes(Sch.IX-B)		161,223	32
33	Accrued Interest Payable		10,365	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)**	$ 559,470	$ 903,810	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,282	6,282	39
40	Mortgage Payable		4,385,868	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)**	$ 6,282	$ 4,392,150	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 565,752	$ 5,295,960	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,663,609	$ (326,835)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,229,361	$ 4,969,125	48

***(See instructions.)**

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,255,692	1
2	Restatements (describe):		2
3			3
4	ROUNDING	5	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,255,697	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	407,912	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)**	$ 407,912	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)**	$ 1,663,609	24 *

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

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,263,324	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,263,324	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	147,466	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 147,466	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	Cook County Board of Elections	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)**	$ 6,410,940	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	898,747	31
32	Health Care	2,057,770	32
33	General Administration	1,408,720	33
	B. Capital Expense		
34	Ownership	646,186	34
	C. Ancillary Expense		
35	Special Cost Centers	518,121	35
36	Provider Participation Fee	473,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,003,028	40
41	**Income before Income Taxes (line 30 minus line 40)****	407,912	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 407,912	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,161,368	44
45	Private Pay - Net Inpatient Revenue	107,992	45
46	Medicare - Net Inpatient Revenue	966,338	46
47	Other-(specify) HOSPICE,ETC	27,626	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,263,324	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,978	2,211	$ 96,218	$ 43.52	1
2	Assistant Director of Nursing	1,842	2,099	65,880	31.39	2
3	Registered Nurses	11,745	12,945	343,092	26.50	3
4	Licensed Practical Nurses	16,284	17,709	376,129	21.24	4
5	CNAs & Orderlies	58,519	65,771	719,046	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,233	7,908	84,436	10.68	10
11	Social Service Workers	5,625	2,090	81,892	39.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,565	18,750	212,731	11.35	15
16	Dishwashers					16
17	Maintenance Workers	1,995	2,220	29,414	13.25	17
18	Housekeepers	11,386	12,766	129,246	10.12	18
19	Laundry	5,361	4,892	54,880	11.22	19
20	Administrator	1,923	2,203	77,486	35.17	20
21	Assistant Administrator					21
22	Other Administrative	1,944	2,080	146,802	70.58	22
23	Office Manager					23
24	Clerical	10,211	11,070	202,023	18.25	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	689	732	6,990	9.55	31
32	Other Health C: MDS/NS/CPC	4,776	5,393	128,594	23.84	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,076	170,839	$ 2,754,859 *	$ 16.13	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	$ 7,823	1-3	35
36	Medical Director	O	5,300	9-3	36
37	Medical Records Consultant	N	1,568	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,204	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	4,800	11-3	44
45	Social Service Consultant	E	3,412	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,107		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 588	10-3	50
51	Licensed Practical Nurses	905	34,900	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	913	$ 35,488		53

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Donahue	ADMINISTRATOR	0	$ 77,486
Sylvia Herlihy	EXEC DIRECTOR	0	146,802
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 224,288

B. Administrative - Other

Description	Amount
Management Fees - SFMA	$ 294,000
Management Fees - Pro Health	5,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 299,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medifax-Edi	Data Processing	$ 429
MDI Technologies	Data Processing	7,419
MDI Achieve SDS-12-2905	Data Processing	1,000
Ivans	Data Processing	1,484
Lifecare Software Solutions	Data Processing	5,628
Richard Peelo	Medicare Cost Report	3,850
Steven Brueggeman	Accounting	9,563
Krupnick Bokor Kagda & Brooks	Accounting	15,540
Personnel Planners	UCConsultant	965
Much Shelist	Legal	368
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 46,246

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,660
Unemployment Compensation Insurance	13,754
FICA Taxes	208,725
Employee Health Insurance	148,099
Employee Meals	34,060
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	20
PENSION/PROFIT SHARING PLANS	18,545
CHICAGO HEAD TAX	3,144
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 466,007

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	650
(Indicate # of checks performed 20)	
Patient Background Checks 19	1,340
TRUST/FRANCHISE/CONTRIB/ETC	9,083
MARKETING/ADV/PROMO	19,182
LICENSES/DUES/SUBSCRIPTIONS	8,180
TRUST/FRANCHISE/CONTRIB/ETC	(9,083)
Less: Public Relations Expense	(0)
Non-allowable advertising	(19,182)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,160

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Waterford Nursing & Rehab # 0038612 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 $5,545**

(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. $ **1,708** 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. $ **473,484**
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. $ **34,060** 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.