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: 0028076

Facility Name: WATERFRONT TERRACE

Address: 7750 S SHORE DR (Number) CHICAGO (City) 60649 (Zip Code)

County: COOK

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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) MARSHALL MAUER
(Title) TREASURER

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 WATERFRONT TERRACE # 0028076 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	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	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			4,926	4,926	8
9	SNF/PED					9
10	ICF	32,131	709		32,840	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,131	709	4,926	37,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.45%

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 4,926

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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 WATERFRONT TERRACE # 0028076 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	206,025	28,232	9,843	244,100		244,100		244,100			1
2	Food Purchase		225,102		225,102		225,102	(1,184)	223,918			2
3	Housekeeping		18,866	152,531	171,397		171,397		171,397			3
4	Laundry		15,022	105,152	120,174		120,174		120,174			4
5	Heat and Other Utilities			95,976	95,976		95,976	1,075	97,051			5
6	Maintenance	99,621	65,572	17,492	182,685		182,685	15,645	198,330			6
7	Other (specify):*			18,645	18,645		18,645	867	19,512			7
8	**TOTAL General Services**	305,646	352,794	399,639	1,058,079		1,058,079	16,403	1,074,482			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,762,086	133,938	13,075	1,909,099		1,909,099		1,909,099			10
10a	Therapy	553,971	4,388	38,082	596,441		596,441		596,441			10a
11	Activities	121,287	19,474	2,275	143,036		143,036		143,036			11
12	Social Services	39,739		3,833	43,572		43,572		43,572			12
13	CNA Training											13
14	Program Transportation			3,160	3,160		3,160		3,160			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,477,083	157,800	66,425	2,701,308		2,701,308		2,701,308			16
	C. General Administration											
17	Administrative	149,145		87,000	236,145		236,145	53,845	289,990			17
18	Directors Fees											18
19	Professional Services			110,081	110,081		110,081	(798)	109,283			19
20	Dues, Fees, Subscriptions & Promotions			184,155	184,155		184,155	(162,678)	21,477			20
21	Clerical & General Office Expenses	175,927	43,181	448,852	667,960		667,960	(398,309)	269,651			21
22	Employee Benefits & Payroll Taxes			683,679	683,679		683,679		683,679			22
23	Inservice Training & Education			7,100	7,100		7,100		7,100			23
24	Travel and Seminar							2,485	2,485			24
25	Other Admin. Staff Transportation			24,534	24,534		24,534	(4,940)	19,594			25
26	Insurance-Prop.Liab.Malpractice			125,010	125,010		125,010		125,010			26
27	Other (specify):*			140,713	140,713		140,713	(102,204)	38,509			27
28	**TOTAL General Administration**	325,072	43,181	1,811,124	2,179,377		2,179,377	(612,599)	1,566,778			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,107,801	553,775	2,277,188	5,938,764		5,938,764	(596,196)	5,342,568			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WATERFRONT TERRACE **#0028076** **Report Period Beginning: 01/01/2012** **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	9,312	
	REPAIRS & MAINTENANCE		531	
			0	9,843
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SVC		152,531	
			0	152,531
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,015	
	CONTRACTED LAUNDRY SERVICES		102,137	105,152
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,995	
	ELECTRICITY		45,207	
	WATER		19,774	
	CABLE TV - LOBBY		0	
			0	95,976
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		873	
	PAINTING & DECORATING		2,303	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,754	
	ELEVATOR MAINTENANCE & REPAIR		3,362	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,200	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	17,492
7	**OTHER**			
	SCAVENGER		18,645	
	SECURITY SERVICE		0	
			0	
			0	18,645
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

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	7,174	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	5,901	
			0	
			0	13,075
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		38,082	
	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	
				38,082
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,275	
			0	2,275
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,833	
				3,833
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE **#0028076** **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		3,160	3,160
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	87,000	87,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,799	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	88,282	
			0	110,081
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	161,548	
	EMPLOYEE WANT ADS	XIX F	1,508	
	CONTRIBUTIONS	VI 20 XIX F	800	
	DUES & SUBSCRIPTIONS	XIX F	12,062	
	LICENSES & PERMITS	XIX F	5,407	
	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	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,830	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				184,155
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		528	
	EQUIPMENT REPAIR & MAINTENANCE		19,524	
	OUTSIDE CLERICAL SERVICES		411,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	490	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,110	
	MESSENGER SERVICE		0	
			0	448,852

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	235,301	
	UNEMPLOYMENT COMPENSATION	XIX D	118,620	
	WORKERS COMPENSATION INSURANC	XIX D	91,591	
	HOSPITALIZATION INSURANCE	XIX D	217,877	
	EMPLOYEE BENEFITS - OTHER	XIX D	20,290	
	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	0	
			0	683,679
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		7,100	
				7,100
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		24,534	
				24,534
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		125,010	
				125,010
27	**OTHER**			
	BAD DEBTS	VI 24	140,713	
				140,713

GRAND TOTAL COLUMN 3 OTHER **2,277,188**

WATERFRONT TERRACE
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	225,102
LESS SALES TAX	(1,184)
NET FOOD	223,918
TOTAL PATIENT CENSUS	37,766
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	113,298
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	113,298
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	113,298
NET FOOD	223,918
DIVIDE TOTAL MEALS/YEAR	113,298
COST PER MEAL	1.98
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number WATERFRONT TERRACE #0028076 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			164,681	164,681		164,681	42,185	206,866			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,444	62,444		62,444	180,553	242,997			32
33	Real Estate Taxes			107,696	107,696		107,696	3,477	111,173			33
34	Rent-Facility & Grounds			624,000	624,000		624,000	(624,000)				34
35	Rent-Equipment & Vehicles			15,023	15,023		15,023	8,900	23,923			35
36	Other (specify):*											36
37	**TOTAL Ownership**			973,844	973,844		973,844	(388,885)	584,959			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,349	530	146,879		146,879		146,879			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			265,359	265,359		265,359		265,359			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		146,349	265,889	412,238		412,238		412,238			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,107,801	700,124	3,516,921	7,324,846		7,324,846	(985,081)	6,339,765			45

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	33,046	30		9
10	Interest and Other Investment Income	(244)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,184)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(490)	21		18
19	Entertainment		20		19
20	Contributions	(1,800)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,110)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(140,713)	27		24
25	Fund Raising, Advertising and Promotional	(161,548)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(54,060)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (329,103)		$	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)	(655,978)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (655,978)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (985,081)		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

ID# 0028076

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (49,053)	21	1
2	MARKETING TRAVEL	(5,007)	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**	(54,060)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE # 0028076 **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	(1,184)	0	0	0	0	0	0	0	0	0	0	(1,184)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,075	0	0	0	0	0	0	0	0	1,075	5
6	Maintenance	0	0	9,232	6,413	0	0	0	0	0	0	0	15,645	6
7	Other (specify):*	0	0	198	0	669	0	0	0	0	0	0	867	7
8	**TOTAL General Services**	(1,184)	0	10,505	6,413	669	0	0	0	0	0	0	16,403	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	(87,000)	0	140,845	0	0	0	0	0	0	0	53,845	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,110)	0	1,312	0	0	0	0	0	0	0	0	(798)	19
20	Fees, Subscriptions & Promotions	(163,348)	0	670	0	0	0	0	0	0	0	0	(162,678)	20
21	Clerical & General Office Expenses	(49,543)	(411,200)	54,086	8,348	0	0	0	0	0	0	0	(398,309)	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	2,485	0	0	0	0	0	0	0	0	2,485	24
25	Other Admin. Staff Transportation	(5,007)	0	67	0	0	0	0	0	0	0	0	(4,940)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(140,713)	0	10,433	0	28,076	0	0	0	0	0	0	(102,204)	27
28	**TOTAL General Administration**	(360,721)	(498,200)	69,053	149,193	28,076	0	0	0	0	0	0	(612,599)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(361,905)	(498,200)	79,558	155,606	28,745	0	0	0	0	0	0	(596,196)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	33,046	6,425	2,714	0	0	0	0	0	0	0	0	42,185	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(244)	177,612	3,185	0	0	0	0	0	0	0	0	180,553	32
33	Real Estate Taxes	0	0	3,477	0	0	0	0	0	0	0	0	3,477	33
34	Rent-Facility & Grounds	0	(624,000)	0	0	0	0	0	0	0	0	0	(624,000)	34
35	Rent-Equipment & Vehicles	0	0	8,900	0	0	0	0	0	0	0	0	8,900	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	32,802	(439,963)	18,276	0	0	0	0	0	0	0	0	(388,885)	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)**	(329,103)	(938,163)	97,834	155,606	28,745	0	0	0	0	0	0	(985,081)	45

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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
MARSHALL MAUER	25	SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		
FRANCES MAUER	25					
MAURICE AARON	25					
SUSAN STERN	25					

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	$ 87,000	DYNAMIC HEALTH CARE CONSULTANT		$	$ (87,000)	1
2	V	21	BOOKKEEPING SERVICE	411,200	" "			(411,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	624,000	WATERFRONT TERRACE ASSOCIATES			(624,000)	7
8	V	30	DEPRECIATION		" "		6,425	6,425	8
9	V	32	INTEREST		" "		177,612	177,612	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,122,200			$ 184,037	$ * (938,163)	14

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS		$ 1,075	$ 1,075	15
16	V	6	REPAIR & MAINT.		" "		9,232	9,232	16
17	V	7	EMP BEN-GEN SERV		" "		198	198	17
18	V	19	PROFESSIONAL FEES		" "		1,312	1,312	18
19	V	20	DUES AND SUBSCRIPTION		" "		670	670	19
20	V	21	CLERICAL & GENERAL		" "		54,086	54,086	20
21	V	24	SEMINARS AND TRAVEL		" "		2,485	2,485	21
22	V	25	AUTO EXPENSE		" "		67	67	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" "		10,433	10,433	23
24	V	30	DEPRECIATION		" "		2,714	2,714	24
25	V	32	INTEREST		" "		3,185	3,185	25
26	V	33	REAL ESTATE TAXES		" "		3,477	3,477	26
27	V	35	EQUIPMENT RENTAL		" "		8,588	8,588	27
28	V	35	EQUIPMENT RENTAL		" "		312	312	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			$			$ 97,834	$ * 97,834	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS		$ 6,413	$ 6,413	15
16	V	17	ADMIN COMP - M MAUER		" "		19,222	19,222	16
17	V	17	ADMIN COMP - M AARON		" "		21,836	21,836	17
18	V	17	ADMIN COMP - F AARON		" "		9,400	9,400	18
19	V	17	ADMIN COMP - D AARON		" "				19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "				20
21	V	17	ADMIN COMP - S HARAMARAS		" "		18,467	18,467	21
22	V	17	ADMIN COMP - D KUFTA		" "		16,617	16,617	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "		12,000	12,000	23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		5,885	5,885	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		20,115	20,115	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		17,303	17,303	26
27	V	21	CLERICAL COMP - S AARON		" "		8,195	8,195	27
28	V	21	CLERICAL COMP - E MARYLES		" "		153	153	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			$			$ 155,606	$ * 155,606	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS		$ 669	$ 669	15
16	V	27	EMP BEN - M MAUER		" "		1,042	1,042	16
17	V	27	EMP BEN - M AARON		" "		1,507	1,507	17
18	V	27	EMP BEN - F AARON		" "		7,237	7,237	18
19	V	27	EMP BEN - D AARON		" "				19
20	V	27	EMP BEN - S GOLDSTEIN		" "				20
21	V	27	EMP BEN - S HARAMARAS		" "		5,944	5,944	21
22	V	27	EMP BEN - D KUFTA		" "		1,165	1,165	22
23	V	27	EMP BEN - HOWARD ALTER		" "		1,076	1,076	23
24	V	27	EMP BEN - V DAVIS		" "		1,011	1,011	24
25	V	27	EMP BEN - NON OWNER		" "		5,391	5,391	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,167	2,167	26
27	V	27	EMP BEN - S AARON		" "		1,523	1,523	27
28	V	27	EMP BEN - E MARYLES		" "		13	13	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			$			$ 28,745	$ * 28,745	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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			BRIDGEVIEW HEALTH CARE CENTER	BRIDGEVIEW	WATERFRONT TERRACE ASSOCIATES		BUILDING CO	1
2			GROSS POINTE MANOR LLC	NILES	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3			OTTAWA PAVILION LTD	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4			PARK RIDGE CARE CENTER LTD	PARK RIDGE				4
5			STERLING PAVILION LTD	STERLING				5
6			WARREN PARK HEALTH AND LIVING CEN	CHICAGO				6
7			WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				7
8			WOODBRIDGE NURSING PAVILION LTD	CHICAGO				8
9			WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				9
10			WOODRIDGE SUPPORTING LIVING RESID	GENESEO				10
11			WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				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 WATERFRONT TERRACE # 0028076 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	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIC	25.00	180,778	3.84	9.61	SALARY	$ 19,222	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIC	25.00	178,164	4.37	10.92	SALARY	21,836	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATION		37,600	9		SALARY	9,400	17-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATION					SALARY	30,000	17-1	4
5	SHARON AARON	SHAREHOLDER	CLERICAL		77,191	3.84	9.61	SALARY	8,195	21-7	5
6	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR			40	100.00	SALARY	12,000	17-7	6
7	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR					SALARY	119,145	17-1	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL		15,112	0.28	1.00	SALARY	153	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 219,951		13

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

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
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	PATIENT DAYS	413,728	13	$ 11,773	$	37,766	$ 1,075	1
2	6	REPAIR & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	37,766	9,232	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	413,728	13	2,165		37,766	198	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		37,766	1,312	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	413,728	13	7,338		37,766	670	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	37,766	54,086	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		37,766	2,485	7
8	25	AUTO EXPENSE	PATIENT DAYS	413,728	13	736		37,766	67	8
9	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	413,728	13	114,290		37,766	10,433	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		37,766	2,714	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		37,766	3,185	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		37,766	3,477	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	94,085		37,766	8,588	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		37,766	312	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,071,756	$ 456,183		$ 97,834	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
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	$ 58,740	$ 58,740	4	$ 6,413	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	4	19,222	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	200,000	200,000	4	21,836	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	47,000	47,000	9	9,400	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	52,765	52,765			5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	102,086	102,086			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	73,867	73,867	8	18,467	7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	152,170	152,170	5	16,617	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000	40	12,000	9
10	17	ADMIN COMP - NON OWNER - V I	WGHTD AVG HOURS	40	8	117,701	117,701	2	5,885	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	8	184,393	184,393	5	20,115	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	45	10	180,028	180,028	4	17,303	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	85,386	85,386	4	8,195	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	15,265	15,265	0	153	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,481,401	$ 1,481,401		$ 155,606	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
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	$ 6,127	$	4	$ 669	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	10,847		4	1,042	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	13,801		4	1,507	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	36,183		9	7,237	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,278				5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,829				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	23,776		8	5,944	7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,672		5	1,165	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,076		40	1,076	9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	8	20,219		2	1,011	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	49,423		5	5,391	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,545		4	2,167	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	15,870		4	1,523	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	1,340		0	13	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,986	$		$ 28,745	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	BANK FINANCIAL		X	MORTGAGE	INTEREST	01/01/11	$ 5,310,000	$ 5,310,000	06/06/13	3.2900	$ 177,612	1
2												2
3												3
4												4
5	PHARMACY		X	AP FINANCING	$3,778.79	11/10/11	126,161	79,093			5,646	5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				961,164			54,545	6
7	WILLOW CREST	X		WORKING CAPITAL							1,771	7
8			X	INSURANCE FINANCING							482	8
9	TOTAL Facility Related				$3,778.79		$ 5,436,161	$ 6,350,257			$ 240,056	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	$ 6,350,257			$ 240,056	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

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

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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.**	$ 110,000	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.)		$ 107,696	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,304)	3
4. Real Estate Tax accrual used for 2012 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.		$ 107,696	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	110,495	8
	2008	111,603	9
	2009	103,696	10
	2010	108,146	11
	2011	107,696	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.

	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 WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 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.	21-30-412-038-0000	NURSING HOME	$ 1,490.85	$ 1,490.85
2.	21-30-412-045-0000	NURSING HOME	$ 106,205.09	$ 106,205.09
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 107,695.94	$ 107,695.94

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 WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,824 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRET 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 # 0028076 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	118		1983		$ 1,508,000	$	35	$ 43,086	$ 43,086	$ 1,281,809	4
5											5
6											6
7											7
8	RELATED PARTY				40,493	1,038		1,157	119	22,367	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		(35)	1,097	18
19	LEASEHOLD IMPROVEMENT			1993	7,742	246	31.5	246		4,848	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		1,712	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		11,849	21
22	ELEVATOR REPAIR			1995	1,500	38	39	38		682	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		1,903	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		2,574	24
25	FENCING			1996	756		15			756	25
26	NURSE STATION			1996	5,300	136	39	136		2,193	26
27	HANDRAILS			1996	3,735	96	39	96		1,540	27
28	PARKING LOT REPAVING			1997	14,968	998	15	998		14,566	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		10,178	29
30	DRAPERY			1997	14,754	378	39	378		5,804	30
31	DOORS & SIGNS			1997	8,428	216	39	216		3,321	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		6,704	32
33	REMODELING			1997	59,133	1,517	39	1,517		23,482	33
34	NURSE STATION			1997	5,106	131	39	131		2,014	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	$ 44,786	$ 1,148	39	$ 1,148	$	$ 16,588	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		2,388	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,349	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		2,964	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		744	41
42	REMODELING	1998	21,934	562	39	562		8,102	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		4,915	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,419	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		7,773	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		6,403	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		3,725	47
48	FIRE ALARM	1999	10,286	264	39	264		3,616	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		12,472	49
50	BOILER WORK	1999	7,345	189	39	189		2,580	50
51	CABLE WORK	1999	433	11	39	11		152	51
52	CARPET	1999	18,828	483	39	483		6,565	52
53	ELEVATOR WORK	1999	2,017	52	39	52		711	53
54	AIR CONDITIONING	1999	7,350	189	39	189		2,608	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		3,143	55
56	ROOF WORK	1999	2,187	56	39	56		758	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		20,343	57
58	WINDOWS	1999	5,513	142	39	142		1,926	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		11,202	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		6,789	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		60,889	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		7,592	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		1,269	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		4,631	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,456	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		4,698	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		36,408	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		1,226	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		1,202	69
70	TOTAL (lines 4 thru 69)		$ 2,505,861	$ 27,308		$ 68,513	$ 41,205	$ 1,737,384	70

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	
1	Totals from Page 12A, Carried Forward		$ 2,505,861	$ 27,308		$ 68,513	$ 41,205	$ 1,737,384	1
2	EXHAUST FAN	2000	890	32	27.5	32		409	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		507	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,420	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		3,191	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		2,627	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		2,414	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		2,605	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		1,037	10
11	AC UNIT	2001	786	28	27.5	28		324	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		2,254	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		2,039	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		851	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		1,371	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		663	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		15,755	17
18	DECK & FENCE	2004	10,197	680	15	680		5,780	18
19	A/C REPAIR	2004	2,200	80	27.5	80		676	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		1,379	20
21	WATER HEATER	2004	6,937	252	27.5	252		2,132	21
22	NURSE CALL STATION	2004	585	21	27.5	21		178	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		388	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		10,218	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		4,542	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		5,273	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		3,498	27
28	ROOF REPAIRS	2005	726	26	27.5	26		194	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		1,193	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		276	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		2,015	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		730	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		7,744	33
34	TOTAL (lines 1 thru 33)		$ 2,764,687	$ 36,620		$ 77,825	$ 41,205	$ 1,832,314	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	
1	Totals from Page 12B, Carried Forward		$ 2,764,687	$ 36,620		$ 77,825	$ 41,205	$ 1,832,314	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		478	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		1,666	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		15,778	4
5	DOORS	2006	15,104	549	27.5	549		3,546	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		1,298	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		17,050	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		872	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		387	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		581	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		349	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		697	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		704	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		3,013	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		4,820	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		2,762	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		19,361	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		15,300	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		3,750	19
20	SIGNAGE	2007	2,403	87	27.5	87		475	20
21	BOILER WORK	2007	1,835	67	27.5	67		365	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		4,607	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		939	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		546	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		3,771	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		1,828	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		9,617	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		1,395	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		1,641	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		3,780	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		642	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		843	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		1,690	33
34	TOTAL (lines 1 thru 33)		$ 3,382,550	$ 59,088		$ 100,293	$ 41,205	$ 1,956,865	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	
1	Totals from Page 12C, Carried Forward		$ 3,382,550	$ 59,088		$ 100,293	$ 41,205	$ 1,956,865	1
2	REFRIGERATOR REPAIRS	2008	1,721	63	27.5	63		281	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	55	27.5	55		245	3
4	RFIRE ALARM SYSTEM REPAIRS	2009	12,907	469	27.5	469		1,622	4
5	ELECTRICAL WORK	2009	53,455	1,944	27.5	1,944		6,723	5
6	ELEVATOR REPAIRS	2009	23,314	847	27.5	847		2,930	6
7	CARPET, TILE & VINYL	2009	5,857	213	27.5	213		737	7
8	AIR CONDITIONERS & SLEEVES	2009	6,183	225	27.5	225		778	8
9	DOORS	2009	3,967	144	27.5	144		498	9
10	PLUMBING REPAIRS	2009	15,124	550	27.5	550		1,902	10
11	DISH NETWORK EQUIPMENT	2009	1,575	58	27.5	58		200	11
12	EMERGENCY ALARM CONTROL PANEL	2009	1,175	43	27.5	43		148	12
13	DOORS AND ACCESSORIES, DOOR ALARM & KEY PAD	2010	17,232	627	27.5	627		1,541	13
14	REPLACE WATER TUBES AND GASKET	2010	1,992	72	27.5	72		177	14
15	AIR CONDITIONERS, REPLACE AIR HANDLER MOTOR	2010	13,721	499	27.5	499		1,227	15
16	ROOF REPAIR	2010	4,135	150	27.5	150		369	16
17	CEILING PIPING REPAIRS- FRONT OFFICE	2010	4,850	176	27.5	176		433	17
18	INSTALL FIRE DAMPERS,FIRE,CIRCULATING,BRONZ PUM	2010	5,689	207	27.5	207		509	18
19	BASEMENT REPAIRS	2010	2,600	95	27.5	95		233	19
20	REPLACE PRIMARY PUMP IN BASEMENT	2010	2,400	87	27.5	87		214	20
21	2ND FLOOR PATIENTS BATHROOMS AND ROOMS:	2010	54,081	1,967	27.5	1,967		4,835	21
22	INSTALL NEW WALLS, CERAMIC TILE,CALL LIGHT								22
23	LIGHTING ACCESSORIES, FIXTURES, LAMPS	2010	12,135	441	27.5	441		1,084	23
24	UTILITYU ROOM SINK, REPAIR SPRINKLER SYSTEM	2010	3,299	120	27.5	120		295	24
25	WALL PROTECTION HANDRAILS	2010	9,634	350	27.5	350		861	25
26	BUMBERS AROUND GARBAGE AREA	2010	4,766	173	27.5	173		425	26
27	WALLCOVERING, CUBICLE CURTAINS	2010	5,711	208	27.5	208		511	27
28	INSTALL STAIN & RAMP RAILINGS, SECURITY SYSTEM	2010	3,175	115	27.5	115		283	28
29	REPLACE ELECTRIC FOR TV ABOVE CEILING	2010	2,700	98	27.5	98		241	29
30	3RD FLOOR-REPLACE LIGHTS, INSTALL WATT FIXTURE	2010	3,328	121	27.5	121		297	30
31	NORTH SIDE EAST END-PERLACE BUILDING LIGHTS	2010	3,052	111	27.5	111		273	31
32	INSTALL OUTDOOR LIGHTING	2010	7,250	264	27.5	264		649	32
33	PATIO ROOMS-NEW DOOR, TILE, FLOOR, LIGHTING	2010	13,417	488	27.5	488		1,200	33
34	TOTAL (lines 1 thru 33)		$ 3,684,516	$ 70,068		$ 111,273	$ 41,205	$ 1,988,586	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	
1	Totals from Page 12D, Carried Forward		$ 3,684,516	$ 70,068		$ 111,273	$ 41,205	$ 1,988,586	1
2	AIR COMPRESSOR COIL REPAIR	2010	1,850	68	27.5	68		167	2
3	RECEPTION DESK/CABINETS	2011	16,284	592	27.5	592		863	3
4	WALLCOVERING/WINDOW TREATMENTS/ARTWORK/COI	2011	35,692	1,298	27.5	1,298		1,893	4
5	FLOORING/WINDOW TREATMENTS	2011	96,290	3,501	27.5	3,501		5,106	5
6	DOORS/KICK PLATES	2011	22,647	824	27.5	824		1,201	6
7	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	57,913	2,106	27.5	2,106		3,071	7
8	SEE PAGE 12 F LINES 3-5								8
9	WINDOWS	2011	72,160	2,624	27.5	2,624		3,827	9
10	ROOD REPAIRS/AIR HANDLER	2011	11,093	403	27.5	403		588	10
11	STAIRWELL CRASH RAILS	2011	5,242	191	27.5	191		278	11
12	LOBBY HEAT/COOL/FLOORING	2011	29,666	1,079	27.5	1,079		1,573	12
13	SEE PAGE 12 F LINES 7-13								13
14	CAPRET, CORNER GUARDS-OFFICE, RECEPTION	2011	5,247	191	27.5	191		278	14
15	DOORS - RESIDENT RMS,TUB ROOM FRONT LOBBY	2011	3,370	122	27.5	122		178	15
16	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	149,510	5,437	27.5	5,437		7,931	16
17	SEE PAGE 12 F LINES 15-22								17
18	HOT WATER HEATERS/PLUMBING WORK	2011	18,765	682	27.5	682		995	18
19	RECEPTION DESK	2011	21,772	792	27.5	792		1,155	19
20	ROOF REPAIR	2011	2,310	84	27.5	84		122	20
21	SECURITY/FIRE SYSTEM REPAIR	2011	19,325	703	27.5	703		1,025	21
22	HEATERS/AC UNIT	2011	17,028	619	27.5	619		903	22
23	SCANNERS/COMPUTER CABLING	2011	35,424	1,288	27.5	1,288		1,878	23
24	SEE PAGE 12 F LINES 24-27								24
25	SECURITY/FIRE SYSTEM REPAIR	2012	12,807	214	27.5	214		214	25
26	HEATING & AIR CONDITIONING	2012	7,695	128	27.5	128		128	26
27	LAUNDRY ROOM PIPING & REPAIR	2012	27,596	461	27.5	461		461	27
28	WINDOW TRTMTS, CABINETS, PICTURES-OFFICE,NURSES	2012	7,820	131	27.5	131		131	28
29	ELEVATOR REPAIR	2012	10,300	172	27.5	172		172	29
30	DOORS, TILE - TUB, RESIDENT, MEDICATION RM	2012	4,215	70	27.5	70		70	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,376,537	$ 93,848		$ 135,053	$ 41,205	$ 2,022,794	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	
1	Totals from Page 12E, Carried Forward		$ 4,376,537	$ 93,848		$ 135,053	$ 41,205	$ 2,022,794	1
2	PAGE 12 E LINE 8								2
3	PLUMBING/ELECTRIC- KITCHEN	2011	11,675	418	27.5	418		609	3
4	PLUMBING/ELECTRIC - BOILER/MECHANICAL ROOMS	2011	27,323	986	27.5	986		1,438	4
5	PLUMBING/ELECTRIC - BASEMENT	2011	6,944	267	27.5	267		390	5
6	PAGE 12 E LINE 13								6
7	CUBICLE CURTAINS - SPA AREA	2011	1,380	48	27.5	48		70	7
8	PLASTER & PAINT - BACK STAIRWAY	2011	3,227	115	27.5	115		168	8
9	PLASTER & PRIME FLOORS - BASEMENT TO 4TH FL	2011	2,750	96	27.5	96		140	9
10	WALLPAPER,PAINT,WINDOW TRTMTS OFFICES	2011	11,466	413	27.5	413		602	10
11	MIRRORS & LIGHT FIXTURES - BATHROOM	2011	1,615	58	27.5	58		84	11
12	LIGHT FIXTURES INTSL - DINING ROOM	2011	3,600	135	27.5	135		196	12
13	WINDOW TRTMTS & LIGHTING - RESIDENT ROOMS	2011	2,387	96	27.5	96		141	13
14	PAGE 12 E LINE 17								14
15	ELECTRIC REPAIR/REPLACE - ELEVATOR ROOM	2011	1,860	60	27.5	60		87	15
16	ELECTRIC REPAIR/REPLACE - BATHROOMS	2011	8,200	298	27.5	298		435	16
17	ELECTRIC REPAIR/REPLACE - FIRE ALARMS 1,2,3 FLOOR	2011	4,800	179	27.5	179		261	17
18	ELECTRIC REPAIR/REPLACE - OXYGEN ROOM	2011	2,080	80	27.5	80		116	18
19	ELECTRIC REPAIR/REPLACE - NURSE CALL	2011	630	20	27.5	20		29	19
20	ELECTRIC REPAIR/REPLACE - KITCHEN & OFFICE	2011	19,471	716	27.5	716		1,044	20
21	ELECTRIC REPAIR/REPLACE - 2 & 3 FLOOR	2011	13,725	497	27.5	497		725	21
22	ELECTRIC REPAIR/REPLACE - TV ROOMS	2011	3,900	138	27.5	138		202	22
23	PAGE 12 E LINE 24								23
24	PLUMBING/ELECTRIC WORK - NURSE STATION	2012	1,040	15	27.5	15		15	24
25	PLUMBING/ELECTRIC WORK - TUB ROOM	2012	9,020	147	27.5	147		147	25
26	PLUMBING/ELECTRIC WORK - KITCHEN, HALL, RESIDEN'	2012	27,757	455	27.5	455		455	26
27	PLUMBING/ELECTRIC WORK - LAUNDRY, BOILER ROOM	2012	8,416	155	27.5	155		155	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,549,803	$ 99,240		$ 140,445	$ 41,205	$ 2,030,303	34

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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	$ 657,454	$ 13,945	$ 57,442	$ 43,497	10 YRS	$ 351,693	71
72	Current Year Purchases	98,263	58,959	4,913	(54,046)	10 YRS	4,913	72
73	Fully Depreciated Assets	677,636					677,636	73
74	RELATED PARTY	21,119	294	663	369		18,808	74
75	TOTALS	$ 1,454,472	$ 73,198	$ 63,018	$ (10,180)		$ 1,053,050	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			$ 22,905	$ 1,382	$ 3,403	$ 2,021		$ 6,462	76
77										77
78										78
79										79
80	TOTALS			$ 22,905	$ 1,382	$ 3,403	$ 2,021		$ 6,462	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)	$ 6,127,180	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,820	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 206,866	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,046	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,089,815	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.	/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: $ 7,674 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	ADMINISTRATOR	2010 BUICK ENCLAVE	$ 578.56	$ 6,943	17
18	MARKETING	2010 TOYOTA CAMRY	489.27	5,336	18
19		PAYROLL ADJ		(4,930)	19
20					20
21	TOTAL		$ #######	$ 7,349	21

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

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 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 WATERFRONT TERRACE # 0028076 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			530			530	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				116,621		116,621	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): SUPPLIES, XRAY,EKG,LAB						29,728		29,728	13
14	TOTAL			$		$ 530	$ 146,349		$ 146,879	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 WATERFRONT TERRACE # 0028076 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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 290,000)	1,260,590		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,311		6
7	Other Prepaid Expenses	26,974		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	212,739		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,604,614	$	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	2,750,744		15
16	Equipment, at Historical Cost	1,433,352		16
17	Accumulated Depreciation (book methods)	(1,997,729)		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): DEPOSITS	23,589		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,209,956	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,814,570	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 886,188	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,040,257		29
30	Accrued Salaries Payable	266,974		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,145		31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,000		32
33	Accrued Interest Payable	3,149		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)**	$ 2,342,713	$	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)**	$ 2,342,713	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,471,857	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,814,570	$	48

***(See instructions.)**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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**	$ 1,133,357	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,133,357	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	578,500	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)**	$ 338,500	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)**	$ 1,471,857	24	*

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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	$ 7,535,474	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,535,474	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,346	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 362,346	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***	244	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 244	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	GAIN ON SALE OF ASSET	5,282	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,282	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,903,346	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,058,079	31
32	Health Care	2,701,308	32
33	General Administration	2,179,377	33
	B. Capital Expense		
34	Ownership	973,844	34
	C. Ancillary Expense		
35	Special Cost Centers	146,879	35
36	Provider Participation Fee	265,359	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,324,846	40
41	**Income before Income Taxes (line 30 minus line 40)****	578,500	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 578,500	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,889,823	44
45	Private Pay - Net Inpatient Revenue	80,195	45
46	Medicare - Net Inpatient Revenue	2,498,023	46
47	Other-(specify) HOSPICE	67,433	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,535,474	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 WATERFRONT TERRACE # 0028076 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	1,965	2,091	$ 97,511	$ 46.63	1
2	Assistant Director of Nursing	1,600	1,739	74,949	43.10	2
3	Registered Nurses	802	855	70,227	82.14	3
4	Licensed Practical Nurses	34,297	39,078	955,016	24.44	4
5	CNAs & Orderlies	51,712	55,916	545,245	9.75	5
6	CNA Trainees					6
7	Licensed Therapist	13,664	14,447	553,971	38.35	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,042	29,093	14.25	9
10	Activity Assistants	9,030	9,788	92,194	9.42	10
11	Social Service Workers	2,012	2,085	39,739	19.06	11
12	Dietician					12
13	Food Service Supervisor	2,177	2,398	43,908	18.31	13
14	Head Cook	5,944	6,605	77,358	11.71	14
15	Cook Helpers/Assistants	7,905	8,914	84,759	9.51	15
16	Dishwashers					16
17	Maintenance Workers	5,355	5,542	99,621	17.98	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,038	2,091	149,145	71.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,935	8,753	175,927	20.10	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	1,789	1,837	19,138	10.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,142	164,181	$ 3,107,801 *	$ 18.93	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	$ 9,312	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	5,901	10-3	38
39	Pharmacist Consultant	H	7,174	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	2,275	11-3	44
45	Social Service Consultant	E	3,833	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,495		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMINISTRATOR		$ 119,145
FRED AARON	ADMINISTRATIVE		30,000
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 149,145

B. Administrative - Other

Description	Amount
	$ 87,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 87,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		110,081
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 110,081

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,591
Unemployment Compensation Insurance	118,620
FICA Taxes	235,301
Employee Health Insurance	217,877
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	20,290
TOTAL (agree to Schedule V, line 22, col.8)	$ 683,679

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	1,508
Health Care Worker Background Check	1,830
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	1,800
MARKETING/ADV/PROMO	161,548
LICENSES/DUES/SUBSCRIPTIONS	17,469
MGMT CO ALLOC	670
TRUST/FRANCHISE/CONTRIB/ETC	(1,800)
Less: Public Relations Expense	(0)
Non-allowable advertising	(161,548)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,477

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	2,485
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,485

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 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 WATERFRONT TERRACE **#** 0028076 **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 $11,682**

(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. $ **3,787** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **265,359**
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. $ **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 for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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