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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0028076

Facility Name: WATERFRONT TERRACE

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

County: COOK

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/2014 to 12/31/2014 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) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2014 Ending: 12/31/2014

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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,109	330	4,770	8,209	8
9	SNF/PED					9
10	ICF	26,520	243	434	27,197	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,629	573	5,204	35,406	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.21%

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 118 and days of care provided 4,648

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		12,169	554,251	566,420		566,420		566,420			1
2	Food Purchase		2,619		2,619		2,619	(443)	2,176			2
3	Housekeeping		1,156	173,985	175,141		175,141		175,141			3
4	Laundry		12,832	116,965	129,797		129,797		129,797			4
5	Heat and Other Utilities			109,392	109,392		109,392	923	110,315			5
6	Maintenance	92,955	75,682	39,123	207,760		207,760	27,557	235,317			6
7	Other (specify):*			18,667	18,667		18,667	747	19,414			7
8	TOTAL General Services	92,955	104,458	1,012,383	1,209,796		1,209,796	28,784	1,238,580			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	1,881,943	141,603	11,979	2,035,525		2,035,525		2,035,525			10
10a	Therapy	513,663	3,216		516,879		516,879		516,879			10a
11	Activities	125,653	24,022	2,756	152,431		152,431		152,431			11
12	Social Services	52,416		1,466	53,882		53,882		53,882			12
13	CNA Training											13
14	Program Transportation			10,872	10,872		10,872		10,872			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,573,675	168,841	41,073	2,783,589		2,783,589		2,783,589			16
	C. General Administration											
17	Administrative	157,331		53,000	210,331		210,331	68,320	278,651			17
18	Directors Fees											18
19	Professional Services			106,802	106,802		106,802	(6,198)	100,604			19
20	Dues, Fees, Subscriptions & Promotions			160,224	160,224		160,224	(110,276)	49,948			20
21	Clerical & General Office Expenses	172,713	38,955	469,068	680,736		680,736	(367,050)	313,686			21
22	Employee Benefits & Payroll Taxes			640,609	640,609		640,609		640,609			22
23	Inservice Training & Education			5,296	5,296		5,296		5,296			23
24	Travel and Seminar							843	843			24
25	Other Admin. Staff Transportation			12,264	12,264		12,264	3,029	15,293			25
26	Insurance-Prop.Liab.Malpractice			139,361	139,361		139,361	3,305	142,666			26
27	Other (specify):*			111,500	111,500		111,500	(72,774)	38,726			27
28	TOTAL General Administration	330,044	38,955	1,698,124	2,067,123		2,067,123	(480,801)	1,586,322			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,996,674	312,254	2,751,580	6,060,508		6,060,508	(452,017)	5,608,491			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: 01/01/2014** **Ending: 12/31/2014**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		1,168	
	OUTSIDE DIETARY SERVICE		553,083	554,251
3	**HOUSEKEEPING**			
	OUTSIDE HOUSEKEEPING SERVICE		173,985	
				173,985
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		976	
	OUTSIDE LAUNDRY SERVICE		115,989	116,965
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		40,913	
	ELECTRICITY		43,754	
	WATER		24,725	
	CABLE TV - LOBBY		0	
				109,392
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		11,403	
	PAINTING & DECORATING		3,759	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,703	
	ELEVATOR MAINTENANCE & REPAIR		9,388	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,870	
	FIRE SERVICE		0	
				39,123
7	**OTHER**			
	SCAVENGER		18,667	
	SECURITY SERVICE		0	
				18,667
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,000	14,000

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	7,077	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	4,902	
				11,979
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,756	
				2,756
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,466	
				1,466
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE **#0028076** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		10,872	
				10,872
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	53,000	53,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	46,280	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	60,522	
				106,802
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	110,472	
	EMPLOYEE WANT ADS	XIX F	18,461	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	13,285	
	LICENSES & PERMITS	XIX F	13,604	
	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	2,099	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,253	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				160,224
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,489	
	EQUIPMENT REPAIR & MAINTENANCE		34,743	
	OUTSIDE CLERICAL SERVICES		414,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,850	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,586	
	MESSENGER SERVICE		0	
				469,068

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	228,173	
	UNEMPLOYMENT COMPENSATION	XIX D	94,190	
	WORKERS COMPENSATION INSURANC	XIX D	73,052	
	HOSPITALIZATION INSURANCE	XIX D	212,097	
	EMPLOYEE BENEFITS - OTHER	XIX D	33,097	
	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	
				640,609
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,296	
				5,296
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,264	
				12,264
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		139,361	
				139,361
27	**OTHER**			
	BAD DEBTS	VI 24	111,500	
				111,500

GRAND TOTAL COLUMN 3 OTHER **2,751,580**

WATERFRONT TERRACE
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	2,619
LESS SALES TAX	(443)
NET FOOD	2,176
TOTAL PATIENT CENSUS	35,406
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	106,218
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	106,218
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	106,218
NET FOOD	2,176
DIVIDE TOTAL MEALS/YEAR	106,218
COST PER MEAL	0.02
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number WATERFRONT TERRACE #0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			152,693	152,693		152,693	59,396	212,089			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,244	69,244		69,244	279,455	348,699			32
33	Real Estate Taxes			58,333	58,333		58,333	120,260	178,593			33
34	Rent-Facility & Grounds			728,000	728,000		728,000	(728,000)				34
35	Rent-Equipment & Vehicles			17,334	17,334		17,334	8,529	25,863			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,025,604	1,025,604		1,025,604	(260,360)	765,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,392	8,940	113,332		113,332		113,332			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,141	251,141		251,141		251,141			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		104,392	260,081	364,473		364,473		364,473			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,996,674	416,646	4,037,265	7,450,585		7,450,585	(712,377)	6,738,208			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: 01/01/2014 Ending: 12/31/2014

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	51,134	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(443)	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	(2,850)	21		18
19	Entertainment		20		19
20	Contributions	(2,149)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(7,380)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(111,500)	27		24
25	Fund Raising, Advertising and Promotional	(110,472)	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	(15,846)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (199,507)		$	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)	(512,870)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (512,870)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (712,377)		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**

WATERFRONT TERRACE

ID# **0028076**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (15,846)	21	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
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**	(15,846)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(443)	0	0	0	0	0	0	0	0	0	0	(443)	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	923	0	0	0	0	0	0	0	0	923	5
6	Maintenance	0	16,575	5,490	5,492	0	0	0	0	0	0	0	27,557	6
7	Other (specify):*	0	0	177	0	570	0	0	0	0	0	0	747	7
8	**TOTAL General Services**	(443)	16,575	6,590	5,492	570	0	0	0	0	0	0	28,784	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	(53,000)	0	121,320	0	0	0	0	0	0	0	68,320	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,380)	0	1,182	0	0	0	0	0	0	0	0	(6,198)	19
20	Fees, Subscriptions & Promotions	(112,621)	0	2,345	0	0	0	0	0	0	0	0	(110,276)	20
21	Clerical & General Office Expenses	(18,696)	(414,400)	58,361	7,685	0	0	0	0	0	0	0	(367,050)	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	843	0	0	0	0	0	0	0	0	843	24
25	Other Admin. Staff Transportation	0	0	3,029	0	0	0	0	0	0	0	0	3,029	25
26	Insurance-Prop.Liab.Malpractice	0	4,352	(1,047)	0	0	0	0	0	0	0	0	3,305	26
27	Other (specify):*	(111,500)	0	10,370	0	28,356	0	0	0	0	0	0	(72,774)	27
28	**TOTAL General Administration**	(250,197)	(463,048)	75,083	129,005	28,356	0	0	0	0	0	0	(480,801)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(250,640)	(446,473)	81,673	134,497	28,926	0	0	0	0	0	0	(452,017)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	51,134	6,425	1,837	0	0	0	0	0	0	0	0	59,396	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1)	277,879	1,577	0	0	0	0	0	0	0	0	279,455	32
33	Real Estate Taxes	0	117,101	3,159	0	0	0	0	0	0	0	0	120,260	33
34	Rent-Facility & Grounds	0	(728,000)	0	0	0	0	0	0	0	0	0	(728,000)	34
35	Rent-Equipment & Vehicles	0	0	8,529	0	0	0	0	0	0	0	0	8,529	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	51,133	(326,595)	15,102	0	0	0	0	0	0	0	0	(260,360)	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)	(199,507)	(773,068)	96,775	134,497	28,926	0	0	0	0	0	0	(712,377)	45

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 53,000	DYNAMIC HEALTH CARE CONSULTANT	100.00%	$	$ (53,000)	1
2	V	21	BOOKKEEPING SERVICE	414,400	" "			(414,400)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	728,000	WATERFRONT TERRACE ASSOCIATES	100.00%		(728,000)	7
8	V	30	DEPRECIATION		" "		6,425	6,425	8
9	V	32	INTEREST		" "		277,879	277,879	9
10	V	33	REAL ESTATE TAXES		" "		117,101	117,101	10
11	V	6	REPAIRS & MAINTENANCE		" "		16,575	16,575	11
12	V	26	INSURANCE		" "		4,352	4,352	12
13	V								13
14	Total			$ 1,195,400			$ 422,332	$ * (773,068)	14

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 923	$ 923	15
16	V	6	REPAIR & MAINT.		" "		5,490	5,490	16
17	V	7	EMP BEN-GEN SERV		" "		177	177	17
18	V	19	PROFESSIONAL FEES		" "		786	786	18
19	V	20	DUES AND SUBSCRIPTION		" "		2,345	2,345	19
20	V	21	CLERICAL & GENERAL		" "		58,361	58,361	20
21	V	24	SEMINARS AND TRAVEL		" "		843	843	21
22	V	25	AUTO EXPENSE		" "		3,029	3,029	22
23	V	26	INSURANCE		" "		(1,047)	(1,047)	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" "		10,370	10,370	24
25	V	30	DEPRECIATION		" "		1,837	1,837	25
26	V	32	INTEREST		" "		1,577	1,577	26
27	V	33	REAL ESTATE TAXES		" "		3,159	3,159	27
28	V	19	REAL ESTATE TAX PROTEST FEES		" "		396	396	28
29	V	35	AUTO RENTAL		" "		8,466	8,466	29
30	V	35	EQUIPMENT RENTAL		" "		63	63	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			$			$ 96,775	$ * 96,775	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 5,492	$ 5,492	15
16	V	17	ADMIN COMP - M MAUER		" "		16,478	16,478	16
17	V	17	ADMIN COMP - M AARON		" "		18,528	18,528	17
18	V	17	ADMIN COMP - F AARON		" "		2,200	2,200	18
19	V	17	ADMIN COMP - D AARON		" "				19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "				20
21	V	17	ADMIN COMP - S HARAMARAS		" "		19,184	19,184	21
22	V	17	ADMIN COMP - D KUFTA		" "		13,911	13,911	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "		12,000	12,000	23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		10,515	10,515	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		12,028	12,028	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		16,476	16,476	26
27	V	21	CLERICAL COMP - S AARON		" "		7,186	7,186	27
28	V	21	CLERICAL COMP - E MARYLES		" "		499	499	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			$			$ 134,497	$ * 134,497	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 570	$ 570	15
16	V	27	EMP BEN - M MAUER		" "		947	947	16
17	V	27	EMP BEN - M AARON		" "		1,334	1,334	17
18	V	27	EMP BEN - F AARON		" "		7,526	7,526	18
19	V	27	EMP BEN - D AARON		" "				19
20	V	27	EMP BEN - S GOLDSTEIN		" "				20
21	V	27	EMP BEN - S HARAMARAS		" "		6,459	6,459	21
22	V	27	EMP BEN - D KUFTA		" "		996	996	22
23	V	27	EMP BEN - HOWARD ALTER		" "		1,085	1,085	23
24	V	27	EMP BEN - V DAVIS		" "		2,550	2,550	24
25	V	27	EMP BEN - NON OWNER		" "		3,816	3,816	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		1,997	1,997	26
27	V	27	EMP BEN - S AARON		" "		1,391	1,391	27
28	V	27	EMP BEN - E MARYLES		" "		255	255	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			$			$ 28,926	$ * 28,926	39

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			BRADLEY	BRADLEY	WATERFRONT TERRACE ASSOCIATES		BUILDING CO	1
2			BRIDGEVIEW HEALTH CARE CENTER	BRIDGEVIEW	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3			GROSS POINTE MANOR LLC	NILES	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4			OTTAWA PAVILION LTD	OTTAWA				4
5			PARK RIDGE CARE CENTER LTD	PARK RIDGE				5
6			STERLING PAVILION LTD	STERLING				6
7			WARREN PARK HEALTH AND LIVING CEN	CHICAGO				7
8			WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				8
9			WOODBRIDGE NURSING PAVILION LTD	CHICAGO				9
10			WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11			WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12			WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				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: 01/01/2014 Ending: 12/31/2014

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	ADMINISTRATION		SCHEDULE	3.3	6.59	SALARY	$ 16,478	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATION		ATTACHED	3.71	7.41	SALARY	18,528	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATION			9		SALARY	42,000	17-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATION					SALARY	2,200	17-7	4
5	SHARON AARON	SHAREHOLDER	CLERICAL			3.3	8.24	SALARY	7,186	21-7	5
6	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR			40		SALARY	115,331	17-1	6
7	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR					SALARY	12,000	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.23	0.82	SALARY	499	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 214,222		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: 01/01/2014 Ending: 2/31/2014

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	452,396	12	$ 11,795	$	35,406	$ 923	1
2	6	REPAIR & MAINT.	PATIENT DAYS	452,396	12	70,149	38,885	35,406	5,490	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	452,396	12	2,266		35,406	177	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	12	10,039		35,406	786	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	452,396	12	29,965		35,406	2,345	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	12	745,706	528,878	35,406	58,361	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	12	10,766		35,406	843	7
8	25	AUTO EXPENSE	PATIENT DAYS	452,396	12	38,698		35,406	3,029	8
9	26	INSURANCE	PATIENT DAYS	452,396	12	(13,379)		35,406	(1,047)	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	452,396	12	132,506		35,406	10,370	10
11	30	DEPRECIATION	PATIENT DAYS	452,396	12	23,478		35,406	1,837	11
12	32	INTEREST	PATIENT DAYS	452,396	12	20,148		35,406	1,577	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	12	40,366		35,406	3,159	13
14	19	REAL ESTATE TAX PROTEST FEI	PATIENT DAYS	452,396	12	5,056		35,406	396	14
15	35	AUTO RENTAL	PATIENT DAYS	452,396	12	108,178		35,406	8,466	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	12	802		35,406	63	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,236,539	$ 567,763		$ 96,775	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	9	$ 59,284	$ 59,284	4	$ 5,492	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	3	16,478	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	4	18,528	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	11,000	11,000	9	2,200	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271			5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	103,196	103,196			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	76,737	76,737	8	19,184	7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	150,258	150,258	5	13,911	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	11	127,632	127,632	3	10,515	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	129,197	129,197	4	12,028	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	40	11	200,000	200,000	3	16,476	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	87,119	87,119	3	7,186	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	60,541	60,541	0	499	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,477,235	$ 1,477,235		$ 134,497	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	9	$ 6,150	$	4	$ 570	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	11,498		3	947	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,402		4	1,334	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	37,628		9	7,526	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,909				5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,033				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	25,836		8	6,459	7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	9	10,754		5	996	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,085		40	1,085	9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	11	30,956		3	2,550	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	9	40,985		4	3,816	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	11	24,244		3	1,997	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	11	16,859		3	1,391	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	30,999		0	255	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 293,338	$		$ 28,926	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	06/06/13	3.2900	$ 277,879	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				1,110,989			38,283	6
7	RELATED PARTY	X		WORKING CAPITAL				760,334			28,437	7
8	PHARMACY		X	AP FINANCING							2,524	8
9	TOTAL Facility Related						$ 5,310,000	$ 1,871,323			$ 347,123	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,310,000	$ 1,871,323			$ 347,123	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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 175,000	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.)		$ 173,434	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,566)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 177,000	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.		$ 175,434	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	103,696	8
	2010	108,146	9
	2011	107,696	10
	2012	171,119	11
	2013	173,434	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-412-038-0000	NURSING HOME	$ 1,667.62	$ 1,667.62
2.	21-30-412-045-0000	NURSING HOME	$ 171,766.80	$ 171,766.80
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 173,434.42	$ 173,434.42

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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	$ 1,367,981	4
5											5
6											6
7	RELATED PARTY				34,718	890	35	992	102	21,161	7
8											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		5,340	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		1,888	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		13,133	21
22	ELEVATOR REPAIR			1995	1,500	38	39	38		758	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		2,117	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		2,882	24
25	FENCING			1996	756		15			756	25
26	NURSE STATION			1996	5,300	136	39	136		2,465	26
27	HANDRAILS			1996	3,735	96	39	96		1,732	27
28	PARKING LOT REPAVING			1997	14,968		15			14,968	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		11,502	29
30	DRAPERY			1997	14,754	378	39	378		6,560	30
31	DOORS & SIGNS			1997	8,428	216	39	216		3,753	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		7,576	32
33	REMODELING			1997	59,133	1,517	39	1,517		26,516	33
34	NURSE STATION			1997	5,106	131	39	131		2,276	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: 01/01/2014 Ending: 12/31/2014

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	$	$ 18,884	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		2,718	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,535	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		3,374	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		848	41
42	REMODELING	1998	21,934	562	39	562		9,226	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		5,593	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,615	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		8,851	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		7,291	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		4,241	47
48	FIRE ALARM	1999	10,286	264	39	264		4,144	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		14,300	49
50	BOILER WORK	1999	7,345	189	39	189		2,958	50
51	CABLE WORK	1999	433	11	39	11		174	51
52	CARPET	1999	18,828	483	39	483		7,531	52
53	ELEVATOR WORK	1999	2,017	52	39	52		815	53
54	AIR CONDITIONING	1999	7,350	189	39	189		2,986	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		3,609	55
56	ROOF WORK	1999	2,187	56	39	56		870	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		23,389	57
58	WINDOWS	1999	5,513	142	39	142		2,210	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		12,866	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		7,799	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		69,937	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		8,720	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		1,471	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		5,365	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,686	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		5,444	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		42,190	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		1,422	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		1,394	69
70	TOTAL (lines 4 thru 69)		$ 2,500,086	$ 26,162		$ 67,350	$ 41,188	$ 1,869,296	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: 01/01/2014 Ending: 12/31/2014

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		$ 2,500,086	$ 26,162		$ 67,350	$ 41,188	$ 1,869,296	1
2	EXHAUST FAN	2000	890	32	27.5	32		473	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		587	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,644	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		3,733	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		3,077	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		2,828	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		3,051	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		1,215	10
11	AC UNIT	2001	786	28	27.5	28		380	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		2,622	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		2,493	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		1,031	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		1,661	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		803	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		18,005	17
18	DECK & FENCE	2004	10,197	680	15	680		7,140	18
19	A/C REPAIR	2004	2,200	80	27.5	80		836	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		1,705	20
21	WATER HEATER	2004	6,937	252	27.5	252		2,636	21
22	NURSE CALL STATION	2004	585	21	27.5	21		220	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		480	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		12,958	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		5,760	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		6,687	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		4,436	27
28	ROOF REPAIRS	2005	726	26	27.5	26		246	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		1,513	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		350	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		2,639	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		956	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		10,142	33
34	TOTAL (lines 1 thru 33)		$ 2,758,912	$ 35,474		$ 76,662	$ 41,188	$ 1,982,850	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: 01/01/2014 Ending: 12/31/2014

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		$ 2,758,912	$ 35,474		$ 76,662	$ 41,188	$ 1,982,850	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		626	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		2,182	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		20,664	4
5	DOORS	2006	15,104	549	27.5	549		4,644	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		1,700	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		22,330	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		1,142	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		507	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		761	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		457	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		913	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		922	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		4,117	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		6,586	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		3,774	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		26,455	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		20,906	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		5,124	19
20	SIGNAGE	2007	2,403	87	27.5	87		649	20
21	BOILER WORK	2007	1,835	67	27.5	67		499	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		6,295	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		1,283	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		746	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		5,153	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		2,648	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		13,931	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		2,021	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		2,377	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		5,476	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		930	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		1,221	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		2,448	33
34	TOTAL (lines 1 thru 33)		$ 3,376,775	$ 57,942		$ 99,130	$ 41,188	$ 2,152,337	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: 01/01/2014 Ending: 12/31/2014

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		$ 3,376,775	$ 57,942		$ 99,130	$ 41,188	$ 2,152,337	1
2	REFRIGERATOR REPAIRS	2008	1,721	63	27.5	63		407	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	55	27.5	55		355	3
4	RFIRE ALARM SYSTEM REPAIRS	2009	12,907	469	27.5	469		2,560	4
5	ELECTRICAL WORK	2009	53,455	1,944	27.5	1,944		10,611	5
6	ELEVATOR REPAIRS	2009	23,314	847	27.5	847		4,624	6
7	CARPET, TILE & VINYL	2009	5,857	213	27.5	213		1,163	7
8	AIR CONDITIONERS & SLEEVES	2009	6,183	225	27.5	225		1,228	8
9	DOORS	2009	3,967	144	27.5	144		786	9
10	PLUMBING REPAIRS	2009	15,124	550	27.5	550		3,002	10
11	DISH NETWORK EQUIPMENT	2009	1,575	58	27.5	58		316	11
12	EMERGENCY ALARM CONTROL PANEL	2009	1,175	43	27.5	43		234	12
13	DOORS AND ACCESSORIES, DOOR ALARM & KEY PAD	2010	17,232	627	27.5	627		2,795	13
14	REPLACE WATER TUBES AND GASKET	2010	1,992	72	27.5	72		321	14
15	AIR CONDITIONERS, REPLACE AIR HANDLER MOTOR	2010	13,721	499	27.5	499		2,225	15
16	ROOF REPAIR	2010	4,135	150	27.5	150		669	16
17	CEILING PIPING REPAIRS- FRONT OFFICE	2010	4,850	176	27.5	176		785	17
18	INSTALL FIRE DAMPERS,FIRE,CIRCULATING,BRONZ PUM	2010	5,689	207	27.5	207		923	18
19	BASEMENT REPAIRS	2010	2,600	95	27.5	95		423	19
20	REPLACE PRIMARY PUMP IN BASEMENT	2010	2,400	87	27.5	87		388	20
21	2ND FLOOR PATIENTS BATHROOMS AND ROOMS:	2010	54,081	1,967	27.5	1,967		8,769	21
22	INSTALL NEW WALLS, CERAMIC TILE,CALL LIGHT								22
23	LIGHTING ACCESSORIES, FIXTURES, LAMPS	2010	12,135	441	27.5	441		1,966	23
24	UTILITYU ROOM SINK, REPAIR SPRINKLER SYSTEM	2010	3,299	120	27.5	120		535	24
25	WALL PROTECTION HANDRAILS	2010	9,634	350	27.5	350		1,561	25
26	BUMBERS AROUND GARBAGE AREA	2010	4,766	173	27.5	173		771	26
27	WALLCOVERING, CUBICLE CURTAINS	2010	5,711	208	27.5	208		927	27
28	INSTALL STAIN & RAMP RAILINGS, SECURITY SYSTEM	2010	3,175	115	27.5	115		513	28
29	REPLACE ELECTRIC FOR TV ABOVE CEILING	2010	2,700	98	27.5	98		437	29
30	3RD FLOOR-REPLACE LIGHTS, INSTALL WATT FIXTURE	2010	3,328	121	27.5	121		539	30
31	NORTH SIDE EAST END-PERLACE BUILDING LIGHTS	2010	3,052	111	27.5	111		495	31
32	INSTALL OUTDOOR LIGHTING	2010	7,250	264	27.5	264		1,177	32
33	PATIO ROOMS-NEW DOOR, TILE, FLOOR, LIGHTING	2010	13,417	488	27.5	488		2,176	33
34	TOTAL (lines 1 thru 33)		$ 3,678,741	$ 68,922		$ 110,110	$ 41,188	$ 2,206,018	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: 01/01/2014 Ending: 12/31/2014

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		$ 3,678,741	$ 68,922		$ 110,110	$ 41,188	$ 2,206,018	1
2	AIR COMPRESSOR COIL REPAIR	2010	1,850	68	27.5	68		303	2
3	RECEPTION DESK/CABINETS	2011	16,284	592	27.5	592		2,047	3
4	WALLCOVERING/WINDOW TREATMENTS/ARTWORK/COI	2011	35,692	1,298	27.5	1,298		4,489	4
5	FLOORING/WINDOW TREATMENTS	2011	96,290	3,501	27.5	3,501		12,108	5
6	DOORS/KICK PLATES	2011	22,647	824	27.5	824		2,849	6
7	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	57,913	2,106	27.5	2,106		7,283	7
8	SEE PAGE 12 F LINES 3-5								8
9	WINDOWS	2011	72,160	2,624	27.5	2,624		9,075	9
10	ROOD REPAIRS/AIR HANDLER	2011	11,093	403	27.5	403		1,394	10
11	STAIRWELL CRASH RAILS	2011	5,242	191	27.5	191		660	11
12	LOBBY HEAT/COOL/FLOORING	2011	29,666	1,079	27.5	1,079		3,731	12
13	SEE PAGE 12 F LINES 7-13								13
14	CAPRET, CORNER GUARDS-OFFICE, RECEPTION	2011	5,247	191	27.5	191		660	14
15	DOORS - RESIDENT RMS,TUB ROOM FRONT LOBBY	2011	3,370	122	27.5	122		422	15
16	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	149,510	5,437	27.5	5,437		18,805	16
17	SEE PAGE 12 F LINES 15-22								17
18	HOT WATER HEATERS/PLUMBING WORK	2011	18,765	682	27.5	682		2,359	18
19	RECEPTION DESK	2011	21,772	792	27.5	792		2,739	19
20	ROOF REPAIR	2011	2,310	84	27.5	84		290	20
21	SECURITY/FIRE SYSTEM REPAIR	2011	19,325	703	27.5	703		2,431	21
22	HEATERS/AC UNIT	2011	17,028	619	27.5	619		2,141	22
23	SCANNERS/COMPUTER CABLING	2011	35,424	1,288	27.5	1,288		4,454	23
24	SEE PAGE 12 F LINES 24-27								24
25	SECURITY/FIRE SYSTEM REPAIR	2012	12,807	467	27.5	467		1,148	25
26	HEATING & AIR CONDITIONING	2012	7,695	255	27.5	255		638	26
27	LAUNDRY ROOM PIPING & REPAIR	2012	27,596	976	27.5	976		2,413	27
28	WINDOW TRTMTS, CABINETS, PICTURES-OFFICE,NURSES	2012	7,820	297	27.5	297		725	28
29	ELEVATOR REPAIR	2012	10,300	382	27.5	382		936	29
30	DOORS, TILE - TUB, RESIDENT, MEDICATION RM	2012	4,215	170	27.5	170		410	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,370,762	$ 94,073		$ 135,261	$ 41,188	$ 2,290,528	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: 01/01/2014 Ending: 12/31/2014

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		$ 4,370,762	$ 94,073		$ 135,261	$ 41,188	$ 2,290,528	1
2	PAGE 12 E LINE 8								2
3	PLUMBING/ELECTRIC- KITCHEN	2011	11,675	418	27.5	418		1,445	3
4	PLUMBING/ELECTRIC - BOILER/MECHANICAL ROOMS	2011	27,323	986	27.5	986		3,410	4
5	PLUMBING/ELECTRIC - BASEMENT	2011	6,944	267	27.5	267		924	5
6	PAGE 12 E LINE 13								6
7	CUBICLE CURTAINS - SPA AREA	2011	1,380	48	27.5	48		166	7
8	PLASTER & PAINT - BACK STAIRWAY	2011	3,227	115	27.5	115		398	8
9	PLASTER & PRIME FLOORS - BASEMENT TO 4TH FL	2011	2,750	96	27.5	96		332	9
10	WALLPAPER,PAINT,WINDOW TRTMTS OFFICES	2011	11,466	413	27.5	413		1,428	10
11	MIRRORS & LIGHT FIXTURES - BATHROOM	2011	1,615	58	27.5	58		200	11
12	LIGHT FIXTURES INTSL - DINING ROOM	2011	3,600	135	27.5	135		466	12
13	WINDOW TRTMTS & LIGHTING - RESIDENT ROOMS	2011	2,387	96	27.5	96		333	13
14	PAGE 12 E LINE 17								14
15	ELECTRIC REPAIR/REPLACE - ELEVATOR ROOM	2011	1,860	60	27.5	60		207	15
16	ELECTRIC REPAIR/REPLACE - BATHROOMS	2011	8,200	298	27.5	298		1,031	16
17	ELECTRIC REPAIR/REPLACE - FIRE ALARMS 1,2,3 FLOOR	2011	4,800	179	27.5	179		619	17
18	ELECTRIC REPAIR/REPLACE - OXYGEN ROOM	2011	2,080	80	27.5	80		276	18
19	ELECTRIC REPAIR/REPLACE - NURSE CALL	2011	630	20	27.5	20		69	19
20	ELECTRIC REPAIR/REPLACE - KITCHEN & OFFICE	2011	19,471	716	27.5	716		2,476	20
21	ELECTRIC REPAIR/REPLACE - 2 & 3 FLOOR	2011	13,725	497	27.5	497		1,719	21
22	ELECTRIC REPAIR/REPLACE - TV ROOMS	2011	3,900	138	27.5	138		478	22
23	PAGE 12 E LINE 24								23
24	PLUMBING/ELECTRIC WORK - NURSE STATION	2012	1,040	42	27.5	42		99	24
25	PLUMBING/ELECTRIC WORK - TUB ROOM	2012	9,020	339	27.5	339		825	25
26	PLUMBING/ELECTRIC WORK - KITCHEN, HALL, RESIDEN'	2012	27,757	1,018	27.5	1,018		2,491	26
27	PLUMBING/ELECTRIC WORK - LAUNDRY, BOILER ROOM	2012	8,416	297	27.5	297		749	27
28									28
29	LABEL & LOCK ELECTRIC PANELS-1SR,2ND,3RD FL, KITC	2013	11,225	408	27.5	408		602	29
30	EXTERIOR DOORS, CLOSERS & CLOSED CIRCUIT TV'S	2013	8,103	295	27.5	295		427	30
31	PLUMBING-MEN'S RM, BOILER RM,	2013	5,500	200	27.5	200		284	31
32	DOORS, CLOSERS & CLOSED CIRCUIT CAMERAS	2013	10,681	388	27.5	388		581	32
33	BATHROOM PLUMBING & ELECTRIC WORK	2013	5,980	217	27.5	217		313	33
34	TOTAL (lines 1 thru 33)		$ 4,585,517	$ 101,897		$ 143,085	$ 41,188	$ 2,312,876	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: 01/01/2014 Ending: 12/31/2014

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 12F, Carried Forward		$ 4,585,517	$ 101,897		$ 143,085	$ 41,188	$ 2,312,876	1
2	KITCHEN ELECTRIC & GRANITE COUNTERTOP& TRAP COVE	2013	4,750	173	27.5	173		245	2
3	HOT WATER HEATER & BOOSTER	2013	2,867	104	27.5	104		152	3
4	1ST, 2ND & 3RD FLOOR ELECTRICAL REPAIRS	2013	9,405	342	27.5	342		498	4
5	ELEVATOR UPGRADES	2013	4,900	178	27.5	178		262	5
6	CONFIGURED PHONE SETS & INTERCOM HANDLE CAP	2013	3,565	130	27.5	130		190	6
7	THRU WALL AIR CONDITIONERS	2013	5,217	190	27.5	190		274	7
8	ROOF REPAIR	2014	5,112	85	27.5	85		85	8
9	CEILING TILES	2014	945	16	27.5	16		16	9
10	7 BIRCH DOORS & DOOR CLOSERS	2014	2,998	50	27.5	50		50	10
11	LIGHTING MAIN LOBBY	2014	163	3	27.5	3		3	11
12	KEY PADS-3RD FLOOR ALARM,MAINTENANCE ROOM	2014	975	16	27.5	16		16	12
13	REPLACE WATER DAMAGED SMOKE DETECTOR ROOM 310	2014	1,038	17	27.5	17		17	13
14	WINDOW INSTALL	2014	585	10	27.5	10		10	14
15	INSTALL 200 AMP IN ELEVATOR ROOM	2014	1,960	33	27.5	33		33	15
16	REPAIR CUT WIRES ROOMS 205-211, 305, 303, 317	2014	2,500	42	27.5	42		42	16
17	OPEN SECTION OF CEILING & FLOOR TO REPAIR RADIATOR	2014	1,600	27	27.5	27		27	17
18	SWITCHES FOR NURSE STATION HALLWAY 2ND & 3RD FLOOR &								18
19	PIPE 4TH FLOOR FOR POWER TO MAIN COMPUTER	2014	1,870	31	27.5	31		31	19
20	REPLACE 15 AMP WITH 20 AMP ON 1ST & 2ND FLOOR, 2 SWITCHES ON 1ST FLOOR &								20
21	LIGHTS ON 1ST & 2ND FLOOR	2014	4,200	70	27.5	70		70	21
22	REPLACED LIGHTS BASEMENT, 2ND & 3RD FLOORS	2014	1,360	23	27.5	23		23	22
23	4 WEATHER PROOF LIGHT FIXTURES, REPAIR BREAKERS IN								23
24	LIVING ROOM	2014	1,100	18	27.5	18		18	24
25	HALLWAY LOUVERED SUPPLY REGISTERS	2014	1,521	25	27.5	25		25	25
26	ROOM 209 CALL SWITCH	2014	510	9	27.5	9		9	26
27	ROOM 118 REPAIR DAMAGED AC WIRING	2014	1,190	20	27.5	20		20	27
28	REMOVE 7 REPLACE SLOP SINKS & DRAIN PIPING JANITORS CLOSET								28
29	1ST, 2ND, 3RD FLOORS & BASEMENT	2014	1,100	18	27.5	18		18	29
30	2 CURB CAPS & STAINLESS STEEL PANS FOR GREASE	2014	1,430	24	27.5	24		24	30
31	PLUMBING PARTS	2014	4,753	79	27.5	79		79	31
32	10 THRU WALL AIR CONDITIONERS	2014	5,461	91	27.5	91		91	32
33	DOOR STRIKE & NEW WIRES FOR INTERCOM SYSTEM	2014	565	9	27.5	9		9	33
34	TOTAL (lines 1 thru 33)		$ 4,659,157	$ 103,730		$ 144,918	$ 41,188	$ 2,315,213	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: 01/01/2014 Ending: 12/31/2014

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 12G, Carried Forward		$ 4,659,157	$ 103,730		$ 144,918	$ 41,188	$ 2,315,213	1
2	MODIFICATIONS TO KITCHEN HOOD	2014	5,987	100	27.5	100		100	2
3	INSTALL FIRE ALARM FOR ELEVATOR RECALL	2014	4,431	74	27.5	74		74	3
4	INSTALL VALVE ON COLD WATER LAUNDRY	2014	2,314	38	27.5	38		38	4
5	CAMERAS PATIO, 1ST FL DINING ROOM, BACK OFFICE,								5
6	NURSE STATION	2014	11,980	200	27.5	200		200	6
7	NURSE CALL SYSTEM	2014	20,288	338	27.5	338		338	7
8	GARAGE DOOR & OPENER	2014	2,765	46	27.5	46		46	8
9	EYE WASH STATIONS	2014	7,088	118	27.5	118		118	9
10	SPRINKLER HEADS	2014	12,421	207	27.5	207		207	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,726,431	$ 104,851		$ 146,039	$ 41,188	$ 2,316,334	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: 01/01/2014 Ending: 12/31/2014

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	$ 681,016	$ 27,394	$ 62,790	$ 35,396	10 YRS	$ 333,543	71
72	Current Year Purchases	46,267	27,763	2,313	(25,450)	10 YRS	2,313	72
73	Fully Depreciated Assets	829,478					829,478	73
74								74
75	TOTALS	$ 1,556,761	$ 55,157	$ 65,103	$ 9,946		$ 1,165,334	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 6,383,192	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,008	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,142	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 51,134	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,481,668	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: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 7,849 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			$	$ 9,485	17
18					18
19					19
20					20
21	TOTAL		$	$ 9,485	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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RX,SUPPLIES,LAB,XRAY					8,410	104,392		112,802	13
14	TOTAL			$		$ 8,940	$ 104,392		$ 113,332	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 64,738	$ 98,050	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 475,000)	1,099,089	1,099,089	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,218	111,992	6
7	Other Prepaid Expenses	9,535	9,535	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROWS		431,628	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,264,580	$ 1,750,294	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,508,000	14
15	Leasehold Improvements, at Historical Cost	2,938,070	3,188,634	15
16	Equipment, at Historical Cost	1,556,762	1,556,762	16
17	Accumulated Depreciation (book methods)	(2,312,564)	(3,913,461)	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 (spe LOAN COSTS(NET)		141,514	22
23	Other(specify): DEPOSITS	291,692	291,692	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,473,960	$ 2,873,141	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,738,540	$ 4,623,435	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 856,883	$ 856,883	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,871,323	1,760,988	29
30	Accrued Salaries Payable	164,484	164,484	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,136	23,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)		177,000	32
33	Accrued Interest Payable	6,770	30,345	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)**	$ 2,922,596	$ 3,012,836	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,072,448	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)**	$	$ 7,072,448	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,922,596	$ 10,085,284	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 815,944	$ (5,461,849)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,738,540	$ 4,623,435	48

***(See instructions.)**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,013,650	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,013,650	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	42,294	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)**	$ (197,706)	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)**	$ 815,944	24	*

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 7,517,296	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,517,296	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	157,715	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 157,715	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***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,675,012	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,209,796	31
32	Health Care	2,783,589	32
33	General Administration	2,067,123	33
	B. Capital Expense		
34	Ownership	1,025,604	34
	C. Ancillary Expense		
35	Special Cost Centers	113,332	35
36	Provider Participation Fee	251,141	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	182,133	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,632,718	40
41	**Income before Income Taxes (line 30 minus line 40)****	42,294	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 42,294	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,673,304	44
45	Private Pay - Net Inpatient Revenue	82,980	45
46	Medicare - Net Inpatient Revenue	2,672,974	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	88,038	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,517,296	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: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,029	2,086	$ 88,726	$ 42.53	1
2	Assistant Director of Nursing	2,029	2,134	73,940	34.65	2
3	Registered Nurses	7,132	7,757	263,904	34.02	3
4	Licensed Practical Nurses	29,950	33,598	847,686	25.23	4
5	CNAs & Orderlies	56,346	61,754	601,816	9.75	5
6	CNA Trainees					6
7	Licensed Therapist	12,062	12,775	513,663	40.21	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	1,976	29,907	15.14	9
10	Activity Assistants	8,473	9,413	95,746	10.17	10
11	Social Service Workers	2,402	2,504	52,416	20.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,888	5,203	92,955	17.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,029	2,166	157,331	72.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,376	9,027	172,713	19.13	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	343	477	5,871	12.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,966	150,870	$ 2,996,674 *	$ 19.86	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		$ 0	1-3	35
36	Medical Director	96	14,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	48	4,902	10-3	38
39	Pharmacist Consultant	96	7,077	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,756	11-3	44
45	Social Service Consultant	30	1,466	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	318	$ 30,201		49

C. CONTRACT NURSES

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMINISTRATOR	0	$ 115,331
FRED AARON	ADMINISTRATIVE	0	42,000
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 157,331

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 53,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 53,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 106,802
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 106,802

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,052
Unemployment Compensation Insurance	94,190
FICA Taxes	228,173
Employee Health Insurance	212,097
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	33,097
TOTAL (agree to Schedule V, line 22, col.8)	$ 640,609

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	$ 3,090
Advertising: Employee Recruitment	18,461
Health Care Worker Background Check	2,253
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	2,149
MARKETING/ADV/PROMO	110,472
LICENSES/DUES/SUBSCRIPTIONS	23,799
MGMT CO ALLOC	2,345
TRUST/FRANCHISE/CONTRIB/ETC	(2,149)
Less: Public Relations Expense	(0)
Non-allowable advertising	(110,472)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,948

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOC	843
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 843

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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													
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12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $ 12,390**

(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? _____ 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. $ **12,974** 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. $ **251,141**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.