

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,925	29	4,568	12,522	8
9	SNF/PED					9
10	ICF	24,778	901	858	26,537	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,703	930	5,426	39,059	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.44%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/1983 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 16 and days of care provided 4,568

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	204,572	24,243	8,364	237,179		237,179		237,179		1
2	Food Purchase		198,739		198,739		198,739	(713)	198,026		2
3	Housekeeping		19,146	125,746	144,892		144,892		144,892		3
4	Laundry		18,775	87,736	106,511		106,511		106,511		4
5	Heat and Other Utilities			124,927	124,927		124,927	1,297	126,224		5
6	Maintenance	56,762	86,138	23,085	165,985		165,985	14,158	180,143		6
7	Other (specify):*			23,562	23,562		23,562	686	24,248		7
8	TOTAL General Services	261,334	347,041	393,420	1,001,795		1,001,795	15,428	1,017,223		8
	B. Health Care and Programs										
9	Medical Director			4,500	4,500		4,500		4,500		9
10	Nursing and Medical Records	1,609,578	99,360	5,469	1,714,407		1,714,407	(3,230)	1,711,177		10
10a	Therapy	351,332	4,227		355,559		355,559		355,559		10a
11	Activities	122,385	11,212	1,604	135,201		135,201		135,201		11
12	Social Services			449	449		449		449		12
13	CNA Training										13
14	Program Transportation			390	390		390		390		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,083,295	114,799	12,412	2,210,506		2,210,506	(3,230)	2,207,276		16
	C. General Administration										
17	Administrative	139,571		73,000	212,571		212,571	89,675	302,246		17
18	Directors Fees										18
19	Professional Services			72,649	72,649		72,649	4,775	77,424		19
20	Dues, Fees, Subscriptions & Promotions			89,107	89,107		89,107	(59,777)	29,330		20
21	Clerical & General Office Expenses	143,068	27,510	402,598	573,176		573,176	(341,973)	231,203		21
22	Employee Benefits & Payroll Taxes			536,876	536,876		536,876		536,876		22
23	Inservice Training & Education			5,880	5,880		5,880		5,880		23
24	Travel and Seminar							177	177		24
25	Other Admin. Staff Transportation			24,374	24,374		24,374	(2,407)	21,967		25
26	Insurance-Prop.Liab.Malpractice			97,729	97,729		97,729	877	98,606		26
27	Other (specify):*			50,398	50,398		50,398	(10,397)	40,001		27
28	TOTAL General Administration	282,639	27,510	1,352,611	1,662,760		1,662,760	(319,050)	1,343,710		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,627,268	489,350	1,758,443	4,875,061		4,875,061	(306,852)	4,568,209		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,364
	REPAIRS & MAINTENANCE	0
		0
		8,364
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SVC	125,746
		0
		125,746
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,906
	CONTRACTED LAUNDRY SERVICE	83,830
		0
		87,736
5	HEAT & OTHER UTILITIES	
	GAS HEAT	70,533
	ELECTRICITY	42,829
	WATER	11,565
	CABLE TV - LOBBY	0
		0
		124,927
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,418
	PAINTING & DECORATING	2,147
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,432
	ELEVATOR MAINTENANCE & REPAIR	9,065
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,023
	FIRE SERVICE	0
		0
		0
		0
		0
		23,085
7	OTHER	
	SCAVENGER	23,562
	SECURITY SERVICE	0
		0
		0
		23,562
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,500
		4,500

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	5,439
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	30
		0
		0
		5,469
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,604
		0
		1,604
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	449
		0
		449
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	390
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	73,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,714
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	66,935
		0
		72,649
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	54,531
	EMPLOYEE WANT ADS XIX F	16,738
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,706
	LICENSES & PERMITS XIX F	2,589
	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	5,793
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	3,750
	PATIENT BACKGROUND CHECKS XIX F	0
		89,107
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,263
	EQUIPMENT REPAIR & MAINTENANCE	19,661
	OUTSIDE CLERICAL SERVICES	360,520
	PENALTIES / OVERDRAFT CHARGES VI 18	580
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,574
	MESSENGER SERVICE	0
		0
		402,598

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	199,692
	UNEMPLOYMENT COMPENSATION XIX D	56,778
	WORKERS COMPENSATION INSURANC XIX D	90,480
	HOSPITALIZATION INSURANCE XIX D	170,432
	EMPLOYEE BENEFITS - OTHER XIX D	19,494
	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
		536,876
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,880
		5,880
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	24,374
		24,374
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	97,729
		97,729
27	OTHER	
	BAD DEBTS VI 24	50,398
		50,398

GRAND TOTAL COLUMN 3 OTHER

1,758,443

**WATERFRONT TERRACE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	198,739
LESS SALES TAX	<u>(713)</u>
NET FOOD	198,026

TOTAL PATIENT CENSUS	39,059
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	117,177

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	117,177
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	117,177

NET FOOD	198,026
DIVIDE TOTAL MEALS/YEAR	<u>117,177</u>

COST PER MEAL	1.69
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

WATERFRONT TERRACE

#0028076

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			99,269	99,269		99,269	60,137	159,406			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,607	46,607		46,607	49,513	96,120			32
33	Real Estate Taxes			109,495	109,495		109,495	4,433	113,928			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)				34
35	Rent-Equipment & Vehicles			8,417	8,417		8,417	7,526	15,943			35
36	Other (specify):*											36
37	TOTAL Ownership			724,989	724,989		724,989	(339,592)	385,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,185	111,642	267,827		267,827	(1,176)	266,651			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		156,185	176,424	332,609		332,609	(1,176)	331,433			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,627,268	645,535	2,659,856	5,932,659		5,932,659	(647,620)	5,285,039			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	51,200	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(713)	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	(580)	21		18
19	Entertainment		20		19
20	Contributions	(5,793)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(415)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,398)	27		24
25	Fund Raising, Advertising and Promotional	(54,531)	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	(44,966)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (106,207)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(543,063)		34
35	Other- Attach Schedule	1,650	19	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (541,413)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (647,620)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (40,144)	21	1
2	MARKETING TRAVEL	(4,800)	25	2
3	COLLECTION FEE	(22)	19	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	(44,966)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(713)	0	0	0	0	0	0	0	0	0	0	(713)	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	1,297	0	0	0	0	0	0	0	0	1,297	5
6	Maintenance	0	0	7,014	7,144	0	0	0	0	0	0	0	14,158	6
7	Other (specify):*	0	0	0	0	686	0	0	0	0	0	0	686	7
8	TOTAL General Services	(713)	0	8,311	7,144	686	0	0	0	0	0	0	15,428	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	(3,230)	0	0	0	0	0	(3,230)	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	(3,230)	0	0	0	0	0	(3,230)	16
	C. General Administration													
17	Administrative	0	(73,000)	0	162,675	0	0	0	0	0	0	0	89,675	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	1,213	2,960	602	0	0	0	0	0	0	0	0	4,775	19
20	Fees, Subscriptions & Promotions	(60,324)	0	547	0	0	0	0	0	0	0	0	(59,777)	20
21	Clerical & General Office Expenses	(40,724)	(360,520)	51,686	7,585	0	0	0	0	0	0	0	(341,973)	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	177	0	0	0	0	0	0	0	0	177	24
25	Other Admin. Staff Transportation	(4,800)	0	2,393	0	0	0	0	0	0	0	0	(2,407)	25
26	Insurance-Prop.Liab.Malpractice	0	0	877	0	0	0	0	0	0	0	0	877	26
27	Other (specify):*	(50,398)	0	12,089	0	27,912	0	0	0	0	0	0	(10,397)	27
28	TOTAL General Administration	(155,033)	(430,560)	68,371	170,260	27,912	0	0	0	0	0	0	(319,050)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(155,746)	(430,560)	76,682	177,404	28,598	(3,230)	0	0	0	0	0	(306,852)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	51,200	6,425	2,512	0	0	0	0	0	0	0	0	60,137	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	47,140	2,384	0	0	0	0	0	0	0	0	49,513	32
33	Real Estate Taxes	0	0	4,433	0	0	0	0	0	0	0	0	4,433	33
34	Rent-Facility & Grounds	0	(461,201)	0	0	0	0	0	0	0	0	0	(461,201)	34
35	Rent-Equipment & Vehicles	0	0	7,526	0	0	0	0	0	0	0	0	7,526	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	51,189	(407,636)	16,855	0	0	0	0	0	0	0	0	(339,592)	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	(1,176)	0	0	0	0	0	(1,176)	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	(1,176)	0	0	0	0	0	(1,176)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(104,557)	(838,196)	93,537	177,404	28,598	(4,406)	0	0	0	0	0	(647,620)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEE	\$ 73,000	DYNAMIC HEALTHCARE CONSULTANT	100.00%	\$	\$	(73,000) 1
2	V	21 BOOKKEEPING SERVICES	360,520	" "				(360,520) 2
3	V							
4	V							
5	V							
6	V							
7	V	34 RENT	461,201	WATERFRONT TERRACE ASSOCIATES	100.00%			(461,201) 7
8	V	30 DEPRECIATION		" "		6,425		6,425 8
9	V	19 ACCOUNTING & LEGAL		" "		2,960		2,960 9
10	V	32 INTEREST		" "		47,140		47,140 10
11	V							
12	V							
13	V							
14	Total		\$ 894,721			\$ 56,525	\$ *	(838,196) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANT	100.00%	\$ 1,297	\$	1,297	15
16	V	6 REPAIR & MAINT.		"		7,014		7,014	16
17	V	19 PROFESSIONAL FEES		"		602		602	17
18	V	20 DUES AND SUBSCRIPTION		"		547		547	18
19	V	21 CLERICAL & GENERAL		"		51,686		51,686	19
20	V	24 SEMINARS AND TRAVEL		"		177		177	20
21	V	25 AUTO EXPENSE		"		2,393		2,393	21
22	V	26 INSURANCE		"		877		877	22
23	V	27 EMP. BEN.- GEN, ADMIN.		"		12,089		12,089	23
24	V	30 DEPRECIATION		"		2,512		2,512	24
25	V	32 INTEREST		"		2,384		2,384	25
26	V	33 REAL ESTATE TAXES		"		4,433		4,433	26
27	V	35 EQUIPMENT RENTAL		"		7,526		7,526	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 93,537	\$ *	93,537	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP.- D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 7,144	\$	7,144	15
16	V	10 DON SALARY - NON OWNER		"					16
17	V	17 ADMIN CMP.- M. MAUER		"		19,569		19,569	17
18	V	17 ADMIN CMP.- M. AARON		"		24,176		24,176	18
19	V	17 ADMIN CMP.- F. AARON		"		25,100		25,100	19
20	V	17 ADMIN CMP.- S. GOLDSTEIN		"					20
21	V	17 ADMIN CMP.- S. KOPLIN		"		24,249		24,249	21
22	V	17 ADMIN CMP.- D. MAGAFAS		"		17,448		17,448	22
23	V	17 ADMIN CMP.- HOWARD ALTER		"		12,000		12,000	23
24	V	17 ADMIN CMP.- NON-OWNER		"		22,419		22,419	24
25	V	17 ADMIN CMP.- CFO NON-OWNER		"		17,714		17,714	25
26	V	21 CLERICAL. CMP. - S. AARON		"		7,585		7,585	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 177,404	\$ *	177,404	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7 EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 686	\$ 686	15
16	V	17 DON SALARY - NON OWNER		"				16
17	V	27 EMP. BEN. - M. MAUER		"		1,380	1,380	17
18	V	27 EMP. BEN. - M. AARON		"		1,954	1,954	18
19	V	27 EMP. BEN. - F. AARON		"		8,047	8,047	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		"				20
21	V	27 EMP. BEN. - S. KOPLIN		"		7,743	7,743	21
22	V	27 EMP. BEN. - D. MAGAFAS		"		1,136	1,136	22
23	V	27 EMP. BEN. - H. ALTER		"		1,129	1,129	23
24	V	27 EMP. BEN. - NON-OWNER		"		3,027	3,027	24
25	V	27 EMP. BEN. - CFO NON-OWNER		"		2,084	2,084	25
26	V	27 EMP. BEN. - S. AARON				1,412	1,412	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 28,598	\$ * 28,598	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 MEDICAL SUPPLIES	\$ 34,744	LINCOLN MEDICAL SUPPLIES, INC	100.00%	\$ 31,514	\$ (3,230)	15
16	V	39 ANCILLARY SERVICES	12,649	" "		11,473	(1,176)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 47,393			\$ 42,987	\$ * (4,406)	39

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

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	ADMINISTRATION				SCHEDULE ATTACHED		SALARY	\$ 19,569	17-7	1
2	MAURICE AARON	ADMINISTRATION						SALARY	24,176	17-7	2
3	FRED AARON	ADMINISTRATION						SALARY	25,100	17-7	3
4	FRED AARON	ADMINISTRATION						SALARY	23,000	17-1	4
5	SHARON AARON	CLERICAL						SALARY	7,585	21-7	5
6	HOWARD ALTER	ADMINISTRATOR						SALARY	12,000	17-7	6
7	HOWARD ALTER	ADMINISTRATOR						SALARY	116,570	17-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 228,000		13

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

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

Facility Name & ID Number **WATERFRONT TERRACE**

0028076 Report Period Beginning: **01/01/2008**

Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	389,945	11	\$ 12,950	\$ 39,059	\$ 1,297	1
2	6	REPAIR & MAINT.	"	389,945	11	70,023	39,059	7,014	2
3	19	PROFESSIONAL FEES	"	389,945	11	6,008	39,059	602	3
4	20	DUES AND SUBSCRIPTION	"	389,945	11	5,456	39,059	547	4
5	21	CLERICAL & GENERAL	"	389,945	11	516,008	397,203	51,686	5
6	24	SEMINARS AND TRAVEL	"	389,945	11	1,768	39,059	177	6
7	25	AUTO EXPENSE	"	389,945	11	23,890	39,059	2,393	7
8	26	INSURANCE	"	389,945	11	8,755	39,059	877	8
9	27	EMP. BEN.- GEN, ADMIN.	"	389,945	11	120,690	39,059	12,089	9
10	30	DEPRECIATION	"	389,945	11	25,083	39,059	2,512	10
11	32	INTEREST	"	389,945	11	23,800	39,059	2,384	11
12	33	REAL ESTATE TAXES	"	389,945	11	44,257	39,059	4,433	12
13	35	EQUIPMENT RENTAL	"	389,945	11	75,134	39,059	7,526	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 933,822	\$ 397,203	\$ 93,537	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	11	\$ 62,290	5	\$ 7,144	1
2	10	DON DALARY - NON OWNER	" "	40	11	73,680			2
3	17	ADMIN CMP.- M. MAUER	" "	40	11	195,000	4	19,569	3
4	17	ADMIN CMP.- M. AARON	" "	40	11	195,000	5	24,176	4
5	17	ADMIN CMP.- F. AARON	" "	45	11	125,500	9	25,100	5
6	17	ADMIN CMP.- S. GOLDSTEIN	" "	45	11	72,353			6
7	17	ADMIN CMP.- S. KOPLIN	" "	30	11	72,748	10	24,249	7
8	17	ADMIN CMP.- D. MAGAFAS	" "	50	11	152,220	6	17,448	8
9	17	ADMIN CMP.- HOWARD ALTER	" "	40	11	12,000	40	12,000	9
10	17	ADMIN CMP.- NON-OWNER	" "	45	11	195,473	5	22,419	10
11	17	ADMIN CMP.- CFO NON-OWNER	" "	45	11	176,522	5	17,714	11
12	21	CLERICAL. CMP. - S. AARON	" "	40	11	75,677	4	7,585	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,408,463	\$ 1,408,463	\$ 177,404	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	11	\$ 5,985	5	\$ 686	1
2	17	EMP. BEN. - DON NON OWNER	" "	40	11	18,419			2
3	27	EMP. BEN. - M. MAUER	" "	40	11	13,750	4	1,380	3
4	27	EMP. BEN. - M. AARON	" "	40	11	15,761	5	1,954	4
5	27	EMP. BEN. - F. AARON	" "	45	11	40,234	9	8,047	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	11	32,869			6
7	27	EMP. BEN. - S. KOPLIN	" "	30	11	23,230	10	7,743	7
8	27	EMP. BEN. - D. MAGAFAS	" "	50	11	9,910	6	1,136	8
9	27	EMP. BEN. - H. ALTER	" "	40	11	1,129	40	1,129	9
10	27	EMP. BEN. - NON-OWNER	" "	45	11	26,397	5	3,027	10
11	27	EMP. BEN. - CFO NON-OWNER	" "	45	11	20,765	5	2,084	11
12	27	EMP. BEN. - S. AARON	" "	40	11	14,086	4	1,412	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 222,535		\$ 28,598	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization LINCOLN MEDICAL SUPPLIES
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	LINCOLN MEDICAL SUPPLIES				\$	\$		\$	1
2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						31,514	2
3	39 ANCILLARY SERVICES	" "						11,473	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 42,987	25

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	BANK FINANCIAL		X	MORTGAGE	\$43,437.00	10/99	\$ 3,050,000	\$ 418,639	11/09	7.7500	\$ 47,140	1						
2												2						
3												3						
4	RELATED PARTY											2,384	4					
5	INSURANCE FINANCING		X									1,536	5					
	Working Capital																	
6	BANK FINANCIAL			LINE OF CREDIT		10/07	1,000,000	557,435				38,717	6					
7	WOODBIDGE			WORKING CAPITAL				100,000				4,792	7					
8	WINDMILL			WORKING CAPITAL								1,562	8					
9	TOTAL Facility Related				\$43,437.00		\$ 4,050,000	\$ 1,076,074			\$ 96,131	9						
	B. Non-Facility Related*																	
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$		14					
15	TOTALS (line 9+line14)						\$ 4,050,000	\$ 1,076,074			\$ 96,131	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	114,000	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.)		\$	110,495	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,505)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	113,000	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.		\$	109,495	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	107,158	8
	2004	109,538	9
	2005	110,653	10
	2006	111,687	11
	2007	110,495	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-412-045-0000</u>	<u>NURSING HOME</u>	\$ <u>109,494.95</u>	\$ <u>109,494.95</u>
2. <u>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>999.85</u>	\$ <u>999.85</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>110,494.80</u>	\$ <u>110,494.80</u>

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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,824 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETE Number of Stories 3

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: NURSING HOME, 37,824, 1983, \$ 100,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 37,824, (blank), \$ 100,000, 3.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	118	1983		\$ 1,508,000	\$	35	\$ 43,086	\$ 43,086	\$ 1,109,465	4
5										5
6										6
7										7
8	RELATED PARTY			44,433	1,139	1270		(1,139)	19,466	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	163	(497)	20,776	14
15	LEASEHOLD IMPROVEMENT	1991		7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT	1991		1,491	47	15	47		1,391	16
17	LEASEHOLD IMPROVEMENT	1992		18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT	1992		1,097	35	15	35		977	18
19	LEASEHOLD IMPROVEMENT	1993		7,742	246	31.5	246		3,864	19
20	LEASEHOLD IMPROVEMENT	1993		3,426	88	39	88		1,360	20
21	LEASEHOLD IMPROVEMENT	1994		25,007	642	39	642		9,281	21
22	ELEVATOR REPAIR	1995		1,500	38	39	38		530	22
23	SPRINKLER REPAIR	1995		4,154	107	39	107		1,475	23
24	BOILER REPAIR, WATER PUMP, ALARM	1996		6,033	154	39	154		1,958	24
25	FENCING	1996		756	50	15	50		625	25
26	NURSE STATION	1996		5,300	136	39	136		1,649	26
27	HANDRAILS	1996		3,735	96	39	96		1,156	27
28	PARKING LOT REPAVING	1997		14,968	998	15	998		10,574	28
29	TUCKPOINTING, ROOF REPAIR	1997		25,814	662	39	662		7,530	29
30	DRAPERY	1997		14,754	378	39	378		4,292	30
31	DOORS & SIGNS	1997		8,428	216	39	216		2,457	31
32	AIR HANDLER REPAIR & PUMPS	1997		17,005	436	39	436		4,960	32
33	REMODELING	1997		59,133	1,517	39	1,517		17,414	33
34	NURSE STATION	1997		5,106	131	39	131		1,490	34
35										35
36										36

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

See Page 12A, Line 70 for total

**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:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	\$ 44,786	\$ 1,148	39	\$ 1,148	\$	\$ 11,996	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		1,728	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		977	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		2,144	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		536	41
42	REMODELING	1998	21,934	562	39	562		5,854	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		3,559	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,027	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		5,617	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		4,627	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		2,693	47
48	FIRE ALARM	1999	10,286	264	39	264		2,560	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		8,816	49
50	BOILER WORK	1999	7,345	189	39	189		1,824	50
51	CABLE WORK	1999	433	11	39	11		108	51
52	CARPET	1999	18,828	483	39	483		4,633	52
53	ELEVATOR WORK	1999	2,017	52	39	52		503	53
54	AIR CONDITIONING	1999	7,350	189	39	189		1,852	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		2,211	55
56	ROOF WORK	1999	2,187	56	39	56		534	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		14,251	57
58	WINDOWS	1999	5,513	142	39	142		1,358	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		7,874	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		4,769	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		42,793	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		5,336	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		865	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		3,163	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		996	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		3,206	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		24,844	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		834	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		818	69
70	TOTAL (lines 4 thru 69)		\$ 2,509,801	\$ 27,459		\$ 67,651	\$ 40,192	\$ 1,464,761	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:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,509,801	\$ 27,459		\$ 67,651	\$ 40,192	\$ 1,464,761	1
2	EXHAUST FAN	2000	890	32	27.5	32		281	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		347	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		972	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7	148	148	11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		2,107	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		1,727	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		1,586	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		1,713	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		681	10
11	AC UNIT	2001	786	28	27.5	28		212	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		1,518	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		1,131	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		491	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		791	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		383	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		11,255	17
18	DECK & FENCE	2004	10,197	680	15	680		3,060	18
19	A/C REPAIR	2004	2,200	80	27.5	80		356	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		727	20
21	WATER HEATER	2004	6,937	252	27.5	252		1,124	21
22	NURSE CALL STATION	2004	585	21	27.5	21		94	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		204	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		4,738	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		2,106	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		2,445	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		1,622	27
28	ROOF REPAIRS	2005	726	26	27.5	26		90	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		553	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		128	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		767	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		278	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		2,948	33
34	TOTAL (lines 1 thru 33)		\$ 2,768,627	\$ 36,771		\$ 77,111	\$ 40,340	\$ 1,522,443	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:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,768,627	\$ 36,771		\$ 77,111	\$ 40,340	\$ 1,522,443	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		182	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		634	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		6,006	4
5	DOORS	2006	15,104	549	27.5	549		1,350	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		494	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		6,490	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		332	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		147	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		221	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		133	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		265	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		268	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		805	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		1,288	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		738	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		5,173	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		4,088	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		1,002	19
20	SIGNAGE	2007	2,403	87	27.5	87		127	20
21	BOILER WORK	2007	1,835	67	27.5	67		97	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		1,231	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		251	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		146	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		1,007	25
26	DOORS & FRAMES	2008	11,285	188	27.5	188		188	26
27	FIRE ALARM SYSTEM	2008	59,313	989	27.5	989		989	27
28	AIR CONDITIONERS	2008	8,615	143	27.5	143		143	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	169	27.5	169		169	29
30	ELECTRICAL WORK	2008	23,305	388	27.5	388		388	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	66	27.5	66		66	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	87	27.5	87		87	32
33	PLUMBING REPAIRS	2008	10,426	174	27.5	174		174	33
34	TOTAL (lines 1 thru 33)		\$ 3,386,490	\$ 56,635		\$ 96,975	\$ 40,340	\$ 1,557,122	34

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,386,490	\$ 56,635		\$ 96,975	\$ 40,340	\$ 1,557,122	1
2	REFRIGERATOR REPAIRS	2008	1,721	29	27.5	29		29	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	25	27.5	25		25	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,389,732	\$ 56,689		\$ 97,029	\$ 40,340	\$ 1,557,176	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:

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 608,673	\$ 28,704	\$ 55,094	\$ 26,390	10 YRS	\$ 430,647	71
72	Current Year Purchases	35,733	21,440	1,787	(19,653)	10 YRS	1,787	72
73	Fully Depreciated Assets	387,159					387,159	73
74	RELATED PARTY	34,212	87	1,623	1,536	5-10 YRS	28,703	74
75	TOTALS	\$ 1,065,777	\$ 50,231	\$ 58,504	\$ 8,273		\$ 848,296	75

D. Vehicle Depreciation (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	FACILITY		2002	\$ 14,925	\$	\$	\$		\$ 14,925	76
77	RELATED PARTY			28,094	1,286	3,873	2,587		15,328	77
78										78
79										79
80	TOTALS			\$ 43,019	\$ 1,286	\$ 3,873	\$ 2,587		\$ 30,253	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,598,528	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 108,206	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,406	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 51,200	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,435,725	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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: _____*

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: \$ 6,014 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			\$ _____	\$ <u>2,403</u>	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ <u>2,403</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 53,761	\$		\$ 53,761	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			692			692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			57,189			57,189	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				128,412		128,412	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	SUPPLIES, LAB,RADIOLOGY Other (specify):	39-2					27,773		27,773	13
14	TOTAL			\$		\$ 111,642	\$ 156,185		\$ 267,827	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>85,000</u>)	1,265,366		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,963		6
7	Other Prepaid Expenses	16,899		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX ESCROW</u>	155,590		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,486,818	\$	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	1,586,734		15
16	Equipment, at Historical Cost	1,046,489		16
17	Accumulated Depreciation (book methods)	(1,334,554)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,298,669	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,785,487	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 570,616	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	566,504		29
30	Accrued Salaries Payable	228,686		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,919		31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,000		32
33	Accrued Interest Payable	2,932		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)	\$ 1,503,657	\$	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)	\$ 1,503,657	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,281,830	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,785,487	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,061,495	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,061,495	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	220,335	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 220,335	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)	\$ 1,281,830	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,907,189	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,907,189	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	245,794	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 245,794	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***	11	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11	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)	\$ 6,152,994	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,001,795	31
32	Health Care	2,210,506	32
33	General Administration	1,662,760	33
	B. Capital Expense		
34	Ownership	724,989	34
	C. Ancillary Expense		
35	Special Cost Centers	267,827	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,932,659	40
41	Income before Income Taxes (line 30 minus line 40)**	220,335	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 220,335	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,922	2,179	\$ 76,778	\$ 35.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,267	1,267	37,912	29.92	3
4	Licensed Practical Nurses	36,280	40,751	914,611	22.44	4
5	CNAs & Orderlies	54,262	58,883	559,271	9.50	5
6	CNA Trainees					6
7	Licensed Therapist	8,621	8,958	351,332	39.22	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,978	2,227	23,606	10.60	9
10	Activity Assistants	9,161	9,992	98,779	9.89	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,256	3,685	61,631	16.72	13
14	Head Cook	5,646	6,314	67,331	10.66	14
15	Cook Helpers/Assistants	7,776	8,563	75,610	8.83	15
16	Dishwashers					16
17	Maintenance Workers	3,666	3,859	56,762	14.71	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,937	2,154	116,571	54.12	20
21	Assistant Administrator					21
22	Other Administrative	468	468	23,000	49.15	22
23	Office Manager					23
24	Clerical	7,759	8,317	143,068	17.20	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	1,807	1,989	21,006	10.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,806	159,606	\$ 2,627,268 *	\$ 16.46	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	261	\$ 8,364	1-3	35
36	Medical Director	90	4,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	1	30	10-3	38
39	Pharmacist Consultant	130	5,439	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	33	1,604	11-3	44
45	Social Service Consultant	8	449	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	523	\$ 20,386		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
HOWARD ALTER	ADMINISTRATOR		\$ 116,571	Workers' Compensation Insurance	\$ 90,480	IDPH License Fee	\$		
FRED AARON	ADMINISTRATIVE		23,000	Unemployment Compensation Insurance	56,778	Advertising: Employee Recruitment	16,738		
				FICA Taxes	199,692	Health Care Worker Background Check	3,750		
				Employee Health Insurance	170,432	(Indicate # of checks performed)			
				Employee Meals	0	Patient Background Checks	0		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	5,793		
				EMPLOYEE BENEFITS - OTHER	19,494	MARKETING/ADV/PROMO	54,531		
						LICENSES/DUES/SUBSCRIPTIONS	8,295		
						MGMT CO ALLOC	547		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 139,571			TRUST/FRANCHISE/CONTRIB/ETC	(5,793)		
B. Administrative - Other						Less: Public Relations Expense	(0)		
Description			Amount			Non-allowable advertising	(54,531)		
MANAGEMENT FEES			\$ 73,000			Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 73,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 536,876	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,330		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	0	
							Seminar Expense	0	
							MGMT CO ALLOC	177	
							Entertainment Expense	()	
SEE SCHEDULE ATTACHED			72,649				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 72,649	TOTAL		\$	TOTAL	\$ 177	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 \$4,175
- (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. \$ 4,226 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. \$ 64,782
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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