

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre

0038612 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

N/A

	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	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>98</u>	Intermediate/DD	<u>98</u>	<u>35,770</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>141</u>	TOTALS	<u>141</u>	<u>51,465</u>	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	<u>14,991</u>	<u>492</u>	<u>3,593</u>	<u>19,076</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>26,282</u>	<u>1,095</u>		<u>27,377</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,273</u>	<u>1,587</u>	<u>3,593</u>	<u>46,453</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.26%

D. How many bed-hold days during this year were paid by the Department?

13 (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 07/01/82

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/82 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 24 and days of care provided 3,593

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation Ctr # 0038612 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	203,467	15,601	8,676	227,744		227,744		227,744		1
2	Food Purchase		194,905		194,905	(28,667)	166,238	(1,020)	165,218		2
3	Housekeeping	120,522	20,138		140,660		140,660		140,660		3
4	Laundry	54,662	11,597		66,259		66,259		66,259		4
5	Heat and Other Utilities			177,033	177,033		177,033		177,033		5
6	Maintenance	27,571	4,756	48,550	80,877		80,877		80,877		6
7	Other (specify):*			11,967	11,967		11,967		11,967		7
8	TOTAL General Services	406,222	246,997	246,226	899,445	(28,667)	870,778	(1,020)	869,758		8
	B. Health Care and Programs										
9	Medical Director			27,600	27,600		27,600		27,600		9
10	Nursing and Medical Records	1,812,265	92,959	51,907	1,957,131		1,957,131		1,957,131		10
10a	Therapy	58,102			58,102		58,102		58,102		10a
11	Activities	99,825	3,833	18,143	121,801		121,801	(1,815)	119,986		11
12	Social Services	33,870		3,807	37,677		37,677		37,677		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,004,062	96,792	101,457	2,202,311		2,202,311	(1,815)	2,200,496		16
	C. General Administration										
17	Administrative	73,249		300,000	373,249		373,249	(202,500)	170,749		17
18	Directors Fees										18
19	Professional Services			60,288	60,288		60,288	(6,409)	53,879		19
20	Dues, Fees, Subscriptions & Promotions			56,347	56,347		56,347	(44,803)	11,544		20
21	Clerical & General Office Expenses	178,882	8,281	31,892	219,055		219,055	(82,687)	136,368		21
22	Employee Benefits & Payroll Taxes			462,900	462,900	28,667	491,567	(3,000)	488,567		22
23	Inservice Training & Education			1,724	1,724		1,724		1,724		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,833	1,833		1,833	(1,800)	33		25
26	Insurance-Prop.Liab.Malpractice			286	286		286	110,071	110,357		26
27	Other (specify):*			175,881	175,881		175,881	(167,810)	8,071		27
28	TOTAL General Administration	252,131	8,281	1,091,151	1,351,563	28,667	1,380,230	(398,938)	981,292		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,662,415	352,070	1,438,834	4,453,319		4,453,319	(401,773)	4,051,546		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	8,676
	REPAIRS & MAINTENANCE	0
		0
		8,676
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	83,652
	ELECTRICITY	64,214
	WATER	28,986
	CABLE TV - LOBBY	181
		0
		177,033
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	52
	BUILDING REPAIRS	38,192
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	7,546
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,760
	FIRE SERVICE	0
		0
		0
		0
		0
		48,550
7	OTHER	
	SCAVENGER	11,967
	SECURITY SERVICE	0
		0
		0
		11,967
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	27,600
		27,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	45,191
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	646
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,536
	PHARMACY CONSULTANT XVIII B 39-2	4,534
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		51,907
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	1,815
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,776
	RESIDENTS EXPENSE	11,552
		18,143
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,807
		0
		3,807
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	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	300,000
		300,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	17,799
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	42,489
		0
		60,288
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	37,217
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	2,700
	DUES & SUBSCRIPTIONS XIX F	9,524
	LICENSES & PERMITS XIX F	1,495
	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	4,886
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	263
	PATIENT BACKGROUND CHECKS XIX F	262
		56,347
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,193
	EQUIPMENT REPAIR & MAINTENANCE	220
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	6,919
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,560
	MESSENGER SERVICE	0
		0
		31,892

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	203,675
	UNEMPLOYMENT COMPENSATION XIX D	19,455
	WORKERS COMPENSATION INSURANC XIX D	45,674
	HOSPITALIZATION INSURANCE XIX D	161,167
	EMPLOYEE BENEFITS - OTHER XIX D	3,210
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	3,000
	PENSION/PROFIT SHARING PLANS XIX D	21,391
	CHICAGO HEAD TAX XIX D	5,328
		0
		462,900
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,724
		1,724
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,833
		1,833
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	286
		286
27	OTHER	
	BAD DEBTS VI 24	175,881
		175,881

GRAND TOTAL COLUMN 3 OTHER **1,438,834**

The Waterford Nursing & Rehabilitation Centre
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	194,905	
LESS SALES TAX	<u>(1,020)</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	193,885	
TOTAL PATIENT CENSUS	46,453	
TIME 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	139,359	
ADD # EMPLOYEE MEALS/DAY	66	
TIME # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	24,090	
PATIENT MEALS	139,359	
ADD EMPLOYEE MEALS	<u>24,090</u>	
TOTAL MEALS/YEAR	163,449	
NET FOOD	193,885	
DIVIDE TOTAL MEALS/YEAR	<u>163,449</u>	
COST PER MEAL	1.19	
TIME EMPLOYEE MEALS	<u>24,090</u>	
EMPLOYEE MEAL RECLASSIFICATION	28,667	
	=====	

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			49,387	49,387		49,387	126,567	175,954			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,528	14,528		14,528	268,688	283,216			32
33	Real Estate Taxes							147,694	147,694			33
34	Rent-Facility & Grounds			709,192	709,192		709,192	(709,192)				34
35	Rent-Equipment & Vehicles			427	427		427		427			35
36	Other (specify):*							22,317	22,317			36
37	TOTAL Ownership			773,534	773,534		773,534	(143,926)	629,608			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		162,469	374,170	536,639		536,639		536,639			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,198	77,198		77,198		77,198			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		162,469	451,368	613,837		613,837		613,837			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,662,415	514,539	2,663,736	5,840,690		5,840,690	(545,699)	5,294,991			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 The Waterford Nursing & Rehabilitation Centre

0038612

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	(1,815)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,020)	2		13
14	Non-Care Related Interest	(3,798)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,919)	21		18
19	Entertainment	(37,217)	20		19
20	Contributions	(7,586)	20		20
21	Owner or Key-Man Insurance	(3,000)	22		21
22	Special Legal Fees & Legal Retainers	(7,009)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(175,881)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(77,712)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (321,957)		\$	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	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)	(223,742)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (223,742)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (545,699)		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.		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

The Waterford Nursing & Rehabilitation Centre

ID# 0038612

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	MARKETING SALARY	(75,912)	21	2
3	MARKETING TRAVEL	(1,800)	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
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		(77,712)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre# 0038612

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(1,020)	0	0	0	0	0	0	0	0	0	0	(1,020)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,020)	0	0	0	0	0	0	0	0	0	0	(1,020)	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	(1,815)	0	0	0	0	0	0	0	0	0	0	(1,815)	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	(1,815)	0	0	0	0	0	0	0	0	0	0	(1,815)	16
	C. General Administration													
17	Administrative	0	0	(202,500)	0	0	0	0	0	0	0	0	(202,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,009)	600	0	0	0	0	0	0	0	0	0	(6,409)	19
20	Fees, Subscriptions & Promotions	(44,803)	0	0	0	0	0	0	0	0	0	0	(44,803)	20
21	Clerical & General Office Expenses	(82,831)	0	144	0	0	0	0	0	0	0	0	(82,687)	21
22	Employee Benefits & Payroll Taxes	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800)	25
26	Insurance-Prop.Liab.Malpractice	0	110,071	0	0	0	0	0	0	0	0	0	110,071	26
27	Other (specify):*	(175,881)	0	8,071	0	0	0	0	0	0	0	0	(167,810)	27
28	TOTAL General Administration	(315,324)	110,671	(194,285)	0	(398,938)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(318,159)	110,671	(194,285)	0	(401,773)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre

0038612

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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	0	126,567	0	0	0	0	0	0	0	0	0	126,567	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,798)	272,486	0	0	0	0	0	0	0	0	0	268,688	32
33	Real Estate Taxes	0	147,694	0	0	0	0	0	0	0	0	0	147,694	33
34	Rent-Facility & Grounds	0	(709,192)	0	0	0	0	0	0	0	0	0	(709,192)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	22,317	0	0	0	0	0	0	0	0	0	22,317	36
37	TOTAL Ownership	(3,798)	(140,128)	0	0	0	0	0	0	0	0	0	(143,926)	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)	(321,957)	(29,457)	(194,285)	0	(545,699)	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
Dan Shabat	100%	Heritage Nursing Home Inc	Chicago	Deauville Associates LLC		Building Co
				Pharmore Drugs LLC		Drug Co
				Lifescan Laboratory Inc		Lab Co
				Pro Health Care Inc		Mgmt Co
				SFMA Inc		Mgmt Co

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 709,192	Deauville Associates LLC	100.00%	\$	\$ (709,192)	1
2	V	32 Interest	475	Deauville Associates LLC			(475)	2
3	V							3
4	V	32 Interest		Deauville Associates LLC		267,830	267,830	4
5	V	19 Professional Fees		Deauville Associates LLC		600	600	5
6	V	26 Insurance		Deauville Associates LLC		110,071	110,071	6
7	V	33 R E Taxes		Deauville Associates LLC		147,694	147,694	7
8	V	30 Depreciation		Deauville Associates LLC		126,567	126,567	8
9	V	32 Interest Mortgage Cost		Deauville Associates LLC		5,131	5,131	9
10	V	36 MIP Expense		Deauville Associates LLC		22,317	22,317	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 709,667			\$ 680,210	\$ * (29,457)	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	17 Management Fees	\$ 294,000	SFMA, INC	100.00%	\$	\$ (294,000)
16	V	17 Dan Shabat Comp		SFMA, INC		97,500	97,500
17	V	21 Office		SFMA, INC		144	144
18	V	27 Admin Benefits		SFMA, INC		6,421	6,421
19	V						
20	V						
21	V	17 Management Fees	6,000	Pro Health Care Inc	100.00%		(6,000)
22	V	27 Salary - Stan Aron		Pro Health Care Inc		1,512	1,512
23	V	27 Payroll Taxes		Pro Health Care Inc		138	138
24	V						
25	V						
26	V	10 In House Drugs	10,481	Pharmore Drugs LLC	100.00%	10,481	
27	V	39 Exp - Drugs	126,224	Pharmore Drugs LLC		126,224	
28	V	10 Pharmacy Consultant	4,534	Pharmore Drugs LLC		4,534	
29	V						
30	V						
31	V	39 Exp - Laboratory	5,388	Lifescan Laboratory Inc	26.00%	5,388	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 446,627			\$ 252,342	\$ * (194,285)

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation C # 0038612 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	Dan Shabat	Owner	Administrative	100.00	See Attached	20	33.00	Alloc Salary	\$ 97,500	17-7	1
2	Stan Aron		Administrative	0.00	See Attached	2	4.65	Alloc Salary	1,512	17-7	2
3	Chaim Shabat	Relative	Clerical	0.00	See Attached	19.7	100.00	Salary	14,058	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 113,070		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 The Waterford Nursing & Rehabilitation Centre # 0038612 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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		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	Heartland Bank		X	Mortgage	\$27,769.38	08/25/06	\$ 4,631,700	\$ 4,433,690	09/01/36	6.0000	\$ 267,830	1					
2	HUD		X	Mortgage Costs		08/25/06	153,941	136,837	09/01/36		5,131	2					
3												3					
4												4					
5												5					
Working Capital																	
6	Bank Financial		X	Line of Credit				102,300	05/22/10	4.5000	10,730	6					
7												7					
8												8					
9	TOTAL Facility Related				\$27,769.38		\$ 4,785,641	\$ 4,672,827			\$ 283,691	9					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							3,798	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 3,798	14					
15	TOTALS (line 9+line14)						\$ 4,785,641	\$ 4,672,827			\$ 287,489	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,317 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.)

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>146,197.87</u>	\$ <u>146,197.87</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 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>Facility</u>		<u>1984</u>	<u>\$ 195,934</u>	1
2					2
3	TOTALS			\$ 195,934	3

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	141	1994	1977	\$ 2,189,665	\$ 56,145	39	\$ 56,145	\$	\$ 1,459,777	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	BUILDING:									9
10	Deauville Associates		1982	3,174		15			3,174	10
11	Deauville Associates		1983	22,000		15			22,000	11
12	Deauville Associates		1984	78,473		15			78,473	12
13	Deauville Associates		1985	65,697		19			65,697	13
14	Deauville Associates		1986	11,600		19			11,600	14
15	Deauville Associates		1987	17,548		10			17,548	15
16	Deauville Associates		1990	16,762		10			16,762	16
17	Deauville Associates		1991	36,643		10			36,643	17
18	Deauville Associates		1992	27,806		10			27,806	18
19	Boilers		2006	70,593	14,119	5	14,119		43,532	19
20	Nurses Station		2007	50,000	5,000	10	5,000		11,667	20
21	Window Replacement		2007	60,000	6,000	10	6,000		14,000	21
22	Physical Therapy Room		2007	29,808	2,981	10	2,981		7,204	22
23	Windows		2007	118,715	11,872	10	11,872		28,689	23
24	Boilers		2007	33,629	6,726	5	6,726		20,177	24
25	Door Handles, Locks		2007	13,243	2,649	5	2,649		6,401	25
26	Shower Room		2007	18,866	1,887	10	1,887		4,874	26
27	Nurses Call System 3rd Floor		2007	9,492	949	10	949		2,373	27
28	Shower Room		2007	23,046	2,305	10	2,305		5,954	28
29	Window Treatments		2007	10,090	1,009	10	1,009		2,523	29
30	Nurses Call System 2nd Floor		2007	4,746	475	10	475		1,186	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39	1993	63,831	3,192	20	3,192		51,369	39
40	1994	17,273	738	20	738		14,145	40
41	1995	34,505	1,125	20	1,125		28,826	41
42	1996	19,396	891	20	891		13,757	42
43	1997	79,650	3,983	20	3,983		50,114	43
44	1999	35,500		3			35,500	44
45	2000	17,386		5			17,386	45
46	2001	19,348	338	20	338		11,063	46
47	2002	34,272	616	20	616		32,807	47
48	2004	76,500	7,650	20	7,650		43,988	48
49	2007	7,500	750	20	750		1,781	49
50	2007	45,287	4,529	20	4,529		11,699	50
51	2007	2,176	218	20	218		490	51
52	2008	1,524	152	20	152		241	52
53	2008	14,924	1,492	20	1,492		2,611	53
54	2009	3,350	223	27.5	223		223	54
55	2009	2,948	214	27.5	214		214	55
56	2009	3,225	117	27.5	117		117	56
57	2009	2,400	87	27.5	87		87	57
58	2009	10,930	499	27.5	499		499	58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,403,521	\$ 138,931		\$ 138,931	\$	\$ 2,204,977	70

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

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	\$ 221,026	\$ 22,573	\$ 22,573	\$	5 - 10 Yrs	\$ 140,047	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	166,438				5 - 10 Yrs	166,438	73
74	Deauville Health Care Center	498,071	14,450	14,450		5 - 10 Yrs	449,368	74
75	TOTALS	\$ 885,535	\$ 37,023	\$ 37,023	\$		\$ 755,853	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				\$	\$	\$	\$		\$	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)	\$ 4,484,990	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,954	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,960,830	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: N/A

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 427 Description: POSTAGE METER RENTAL

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre # 0038612 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 165,247	\$		\$ 165,247	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,201			2,201	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			197,972			197,972	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				126,224		126,224	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39-3				8,750			8,750	12
13	Other (specify): <u>Lab, Med Supplies</u>	39-2					36,245		36,245	13
14	TOTAL			\$		\$ 374,170	\$ 162,469		\$ 536,639	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 The Waterford Nursing & Rehabilitation Centre # 0038612 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2009 (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	\$ 5,795	\$ 88,820	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>453,518</u>)	1,739,165	1,739,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,553	79,628	6
7	Other Prepaid Expenses	142	142	7
8	Accounts Receivable (owners or related parties)	180,251	1,104,297	8
9	Other(specify): <u>Employee Loans & Advances</u>	1,160	1,160	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,945,066	\$ 3,013,212	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,934	13
14	Buildings, at Historical Cost		2,189,665	14
15	Leasehold Improvements, at Historical Cost	491,925	1,046,436	15
16	Equipment, at Historical Cost	387,464	1,052,954	16
17	Accumulated Depreciation (book methods)	(623,402)	(2,960,830)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		483,835	21
22	Other Long-Term Assets (specify: <u>Mortgage Costs</u>)		136,837	22
23	Other(specify): <u>Security Deposit</u>	5,000	5,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 260,987	\$ 2,149,831	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,206,053	\$ 5,163,043	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 804,371	\$ 839,449	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120,230	120,230	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,643	111,643	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,481	5,481	31
32	Accrued Real Estate Taxes(Sch.IX-B)		150,584	32
33	Accrued Interest Payable		22,168	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Parties</u>	510,530	515,530	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,552,255	\$ 1,765,085	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	102,300	102,300	39
40	Mortgage Payable		4,433,690	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)	\$ 102,300	\$ 4,535,990	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,654,555	\$ 6,301,075	46
47	TOTAL EQUITY(page 18, line 24)	\$ 551,498	\$ (1,138,032)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,206,053	\$ 5,163,043	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 998,421	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 998,423	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(446,925)	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)	\$ (446,925)	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)	\$ 551,498	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	\$ 6,200,790	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,200,790	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	270,268	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 270,268	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			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)	\$ 6,471,058	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	899,445	31
32	Health Care	2,202,311	32
33	General Administration	1,351,563	33
B. Capital Expense			
34	Ownership	773,534	34
C. Ancillary Expense			
35	Special Cost Centers	536,639	35
36	Provider Participation Fee	77,198	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	1,077,293	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,917,983	40
41	Income before Income Taxes (line 30 minus line 40)**	(446,925)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (446,925)	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 The Waterford Nursing & Rehabilitation Centre

0038612

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	2,008	2,240	\$ 95,196	\$ 42.50	1
2	Assistant Director of Nursing	1,920	2,080	63,173	30.37	2
3	Registered Nurses	15,332	16,674	438,361	26.29	3
4	Licensed Practical Nurses	16,079	17,350	399,474	23.02	4
5	CNAs & Orderlies	59,762	72,713	664,011	9.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,529	6,327	58,102	9.18	8
9	Activity Director	785	796	9,956	12.51	9
10	Activity Assistants	7,438	8,651	89,869	10.39	10
11	Social Service Workers	1,924	2,128	33,870	15.92	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,128	29,792	14.00	13
14	Head Cook	5,607	9,067	77,930	8.59	14
15	Cook Helpers/Assistants	6,328	7,101	65,392	9.21	15
16	Dishwashers	3,001	3,538	30,353	8.58	16
17	Maintenance Workers	1,960	2,200	27,571	12.53	17
18	Housekeepers	11,316	13,000	120,522	9.27	18
19	Laundry	5,810	6,389	54,662	8.56	19
20	Administrator	1,968	2,160	73,249	33.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,915	10,493	178,882	17.05	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	1,987	2,189	19,690	8.99	31
32	Other Health C: <u>PsychoSoc,Rehab</u>	7,632	8,572	132,360	15.44	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,253	195,796	\$ 2,662,415 *	\$ 13.60	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	M	\$ 8,676	1-3	35
36	Medical Director	O	27,600	9-3	36
37	Medical Records Consultant	N	1,536	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,534	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,776	11-3	44
45	Social Service Consultant	E	3,807	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 50,929		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	884	\$ 33,589	10-3	50
51	Licensed Practical Nurses	266	11,602	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,150	\$ 45,191		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Kathleen Donahue</u>	<u>ADMINISTRATOR</u>		\$ <u>73,249</u>	<u>Workers' Compensation Insurance</u>	\$ <u>45,674</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>	<u>19,455</u>	<u>Advertising: Employee Recruitment</u>	<u>0</u>	
				<u>FICA Taxes</u>	<u>203,675</u>	<u>Health Care Worker Background Check</u>	<u>263</u>	
				<u>Employee Health Insurance</u>	<u>161,167</u>	<u>(Indicate # of checks performed <u>30</u>)</u>		
				<u>Employee Meals</u>	<u>28,667</u>	<u>Patient Background Checks <u>30</u></u>	<u>262</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	<u>7,586</u>	
				<u>EMPLOYEE BENEFITS - OTHER</u>	<u>3,210</u>	<u>MARKETING/ADV/PROMO</u>	<u>37,217</u>	
				<u>EMPLOYEE PHYSICAL EXAMS</u>	<u>0</u>	<u>LICENSES/DUES/SUBSCRIPTIONS</u>	<u>11,019</u>	
				<u>PENSION/PROFIT SHARING PLANS</u>	<u>21,391</u>	<u>MGMT CO ALLOC</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>73,249</u>	<u>CHICAGO HEAD TAX</u>	<u>5,328</u>	<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	<u>(7,586)</u>	
(List each licensed administrator separately.)				<u>INSURANCE - EXECUTIVE LIFE</u>	<u>3,000</u>	Less: Public Relations Expense	(37,217)	
B. Administrative - Other				<u>INSURANCE - EXECUTIVE LIFE VI 21</u>	<u>(3,000)</u>	<u>Non-allowable advertising</u>	<u>(0)</u>	
Description			Amount			<u>Yellow page advertising</u>	<u>(0)</u>	
<u>Management Fees - SFMA</u>			\$ <u>294,000</u>					
<u>Management Fees - Pro Health</u>			<u>6,000</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>300,000</u>	TOTAL (agree to Schedule V,	\$ <u>488,567</u>	TOTAL (agree to Sch. V,	\$ <u>11,544</u>	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
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
			\$ _____			\$ _____	<u>Out-of-State Travel</u>	\$ _____
							<u>In-State Travel</u>	<u>0</u>
							<u>Seminar Expense</u>	<u>0</u>
							<u>Entertainment Expense</u>	<u>(_____)</u>
<u>SEE SCHEDULE ATTACHED</u>			<u>60,288</u>	TOTAL		\$ _____	TOTAL	\$ _____
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>60,288</u>				(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$

Facility Name & ID Number The Waterford Nursing & Rehabilitation Centre# 0038612Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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 \$7,150 IL ASSOC HEALTH CARE \$1,692
- (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? N/A
- (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. \$ 5,185 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. N/A
- (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. \$ 77,198
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. \$ 28,667 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
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: N/A
- (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.