

Facility Name & ID Number WATERFRONT TERRACE

0028076 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 _____

	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	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,363	198	5,562	17,123	8
9	SNF/PED					9
10	ICF	21,433	141	579	22,153	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,796	339	6,141	39,276	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.19%

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 04/01/1983

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 42 and days of care provided 5,524

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL 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

WATERFRONT TERRACE

0028076

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	192,471	18,075	9,324	219,870		219,870		219,870		1
2	Food Purchase		196,659		196,659		196,659	(862)	195,797		2
3	Housekeeping		19,671	129,729	149,400		149,400		149,400		3
4	Laundry		18,978	97,638	116,616		116,616		116,616		4
5	Heat and Other Utilities			111,290	111,290		111,290	1,330	112,620		5
6	Maintenance	61,838	85,151	18,384	165,373		165,373	13,923	179,296		6
7	Other (specify):*			27,288	27,288		27,288	703	27,991		7
8	TOTAL General Services	254,309	338,534	393,653	986,496		986,496	15,094	1,001,590		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	1,690,384	98,747	5,660	1,794,791		1,794,791	(3,951)	1,790,840		10
10a	Therapy	580,344	1,326		581,670		581,670		581,670		10a
11	Activities	109,863	12,955	1,323	124,141		124,141		124,141		11
12	Social Services	16,147		4,056	20,203		20,203		20,203		12
13	CNA Training										13
14	Program Transportation			320	320		320		320		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,396,738	113,028	17,959	2,527,725		2,527,725	(3,951)	2,523,774		16
	C. General Administration										
17	Administrative	181,550		110,000	291,550		291,550	51,973	343,523		17
18	Directors Fees										18
19	Professional Services			101,731	101,731		101,731	461	102,192		19
20	Dues, Fees, Subscriptions & Promotions			100,116	100,116		100,116	(62,839)	37,277		20
21	Clerical & General Office Expenses	189,327	27,688	386,366	603,381		603,381	(324,524)	278,857		21
22	Employee Benefits & Payroll Taxes			591,644	591,644		591,644		591,644		22
23	Inservice Training & Education			6,951	6,951		6,951		6,951		23
24	Travel and Seminar							580	580		24
25	Other Admin. Staff Transportation			13,186	13,186		13,186	(3,156)	10,030		25
26	Insurance-Prop.Liab.Malpractice			94,457	94,457		94,457	1,528	95,985		26
27	Other (specify):*			10,000	10,000		10,000	34,121	44,121		27
28	TOTAL General Administration	370,877	27,688	1,414,451	1,813,016		1,813,016	(301,856)	1,511,160		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,021,924	479,250	1,826,063	5,327,237		5,327,237	(290,713)	5,036,524		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	9,324
	REPAIRS & MAINTENANCE	0
		0
		9,324
3	HOUSEKEEPING	
	CONTRACTED LAUNDRY SERVICES	129,729
		0
		129,729
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	10,702
	CONTRACTED LAUNDRY SERVICES	86,936
		0
		97,638
5	HEAT & OTHER UTILITIES	
	GAS HEAT	54,801
	ELECTRICITY	42,831
	WATER	13,658
	CABLE TV - LOBBY	0
		0
		111,290
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,885
	PAINTING & DECORATING	117
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,650
	ELEVATOR MAINTENANCE & REPAIR	8,582
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,150
	FIRE SERVICE	0
		0
		0
		0
		0
		18,384
7	OTHER	
	SCAVENGER	27,288
	SECURITY SERVICE	0
		0
		0
		27,288
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,600
		6,600

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	5,460
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	200
		0
		0
		5,660
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	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,323
		0
		1,323
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,056
		0
		4,056
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	320
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	110,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,066
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	89,665
		0
		101,731
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	60,159
	EMPLOYEE WANT ADS XIX F	20,483
	CONTRIBUTIONS VI 20 XIX F	1,500
	DUES & SUBSCRIPTIONS XIX F	9,343
	LICENSES & PERMITS XIX F	4,064
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,697
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,150
	PATIENT BACKGROUND CHECKS XIX F	1,720
		0
		100,116
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,061
	EQUIPMENT REPAIR & MAINTENANCE	25,069
	OUTSIDE CLERICAL SERVICES	342,320
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,916
	MESSENGER SERVICE	0
		0
		386,366

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	227,984
	UNEMPLOYMENT COMPENSATION XIX D	53,293
	WORKERS COMPENSATION INSURANCE XIX D	76,205
	HOSPITALIZATION INSURANCE XIX D	199,508
	EMPLOYEE BENEFITS - OTHER XIX D	29,446
	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	5,208
		0
		591,644
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	6,951
		0
		6,951
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	13,186
		0
		13,186
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	94,457
		0
		94,457
27	OTHER	
	BAD DEBTS VI 24	10,000
		0
		10,000

GRAND TOTAL COLUMN 3 OTHER

1,826,063

**WATERFRONT TERRACE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	196,659
LESS SALES TAX	<u>(862)</u>
NET FOOD	195,797

TOTAL PATIENT CENSUS	39,276
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	117,828

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	117,828
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	117,828

NET FOOD	195,797
DIVIDE TOTAL MEALS/YEAR	<u>117,828</u>

COST PER MEAL	1.66
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

WATERFRONT TERRACE

#0028076

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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			113,965	113,965		113,965	44,752	158,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,892	41,892		41,892	18,136	60,028			32
33	Real Estate Taxes			112,603	112,603		112,603	3,992	116,595			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)				34
35	Rent-Equipment & Vehicles			19,292	19,292		19,292	7,439	26,731			35
36	Other (specify):*											36
37	TOTAL Ownership			748,953	748,953		748,953	(386,882)	362,071			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		189,881	9,507	199,388		199,388	(2,383)	197,005			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		189,881	74,112	263,993		263,993	(2,383)	261,610			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,021,924	669,131	2,649,128	6,340,183		6,340,183	(679,978)	5,660,205			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	34,667	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(862)	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		21		18
19	Entertainment		20		19
20	Contributions	(3,197)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(507)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,000)	27		24
25	Fund Raising, Advertising and Promotional	(60,159)	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	(49,736)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (89,794)		\$	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)	(590,184)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (590,184)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (679,978)		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.

		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

ID# 0028076
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARY	\$ -46036	21	1
2	MARKETING TRAVEL	(3,700)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(49,736)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE# 0028076

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(862)	0	0	0	0	0	0	0	0	0	0	(862)	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	1,330	0	0	0	0	0	0	0	0	1,330	5
6	Maintenance	0	0	6,776	7,147	0	0	0	0	0	0	0	13,923	6
7	Other (specify):*	0	0	0	0	703	0	0	0	0	0	0	703	7
8	TOTAL General Services	(862)	0	8,106	7,147	703	0	0	0	0	0	0	15,094	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	(3,951)	0	0	0	0	0	(3,951)	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	(3,951)	0	0	0	0	0	(3,951)	16
	C. General Administration													
17	Administrative	0	(110,000)	0	161,973	0	0	0	0	0	0	0	51,973	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(507)	0	968	0	0	0	0	0	0	0	0	461	19
20	Fees, Subscriptions & Promotions	(63,356)	0	517	0	0	0	0	0	0	0	0	(62,839)	20
21	Clerical & General Office Expenses	(46,036)	(342,320)	55,000	8,832	0	0	0	0	0	0	0	(324,524)	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	580	0	0	0	0	0	0	0	0	580	24
25	Other Admin. Staff Transportation	(3,700)	0	544	0	0	0	0	0	0	0	0	(3,156)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,528	0	0	0	0	0	0	0	0	1,528	26
27	Other (specify):*	(10,000)	0	10,680	0	33,441	0	0	0	0	0	0	34,121	27
28	TOTAL General Administration	(123,599)	(452,320)	69,817	170,805	33,441	0	0	0	0	0	0	(301,856)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(124,461)	(452,320)	77,923	177,952	34,144	(3,951)	0	0	0	0	0	(290,713)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE# 0028076

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	34,667	6,425	3,660	0	0	0	0	0	0	0	0	44,752	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	14,842	3,294	0	0	0	0	0	0	0	0	18,136	32
33	Real Estate Taxes	0	0	3,992	0	0	0	0	0	0	0	0	3,992	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	7,439	0	0	0	0	0	0	0	0	7,439	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	34,667	(439,934)	18,385	0	0	0	0	0	0	0	0	(386,882)	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	(2,383)	0	0	0	0	0	(2,383)	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	(2,383)	0	0	0	0	0	(2,383)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(89,794)	(892,254)	96,308	177,952	34,144	(6,334)	0	0	0	0	0	(679,978)	45

Facility Name & ID Number **WATERFRONT TERRACE**

0028076

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

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:	
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)	
1	V	17	MANAGEMENT FEE	\$ 110,000	DYNAMIC HEALTH CARE CONSULTANT	100.00%	\$ (110,000)	1
2	V	21	BOOKKEEPING SERVICE	342,320	" "		(342,320)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34	RENT	461,201	WATERFRONT TERRACE ASSOCIATES	100.00%	(461,201)	7
8	V	30	DEPRECIATION		" "		6,425	8
9	V	32	INTEREST		" "		14,842	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 913,521			\$ 21,267	\$ * (892,254)	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 CONSULTANTS			100.00%	\$ 1,330	\$ 1,330	15	
16	V	6	REPAIR & MAINT.		"	"	"		6,776	6,776	16	
17	V	19	PROFESSIONAL FEES		"	"	"		968	968	17	
18	V	20	DUES AND SUBSCRIPTION		"	"	"		517	517	18	
19	V	21	CLERICAL & GENERAL		"	"	"		55,000	55,000	19	
20	V	24	SEMINARS AND TRAVEL		"	"	"		580	580	20	
21	V	25	AUTO EXPENSE		"	"	"		544	544	21	
22	V	26	INSURANCE		"	"	"		1,528	1,528	22	
23	V	27	EMP. BEN. - GEN, ADMIN.		"	"	"		10,680	10,680	23	
24	V	30	DEPRECIATION		"	"	"		3,660	3,660	24	
25	V	32	INTEREST		"	"	"		3,294	3,294	25	
26	V	33	REAL ESTATE TAXES		"	"	"		3,992	3,992	26	
27	V	35	EQUIPMENT RENTAL		"	"	"		7,439	7,439	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			\$					\$ 96,308	\$ *	96,308	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 COMP - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 7,147	\$ 7,147
16	V	17 ADMIN COMP - M MAUER		" " "		19,497	19,497
17	V	17 ADMIN COMP - M AARON		" " "		22,109	22,109
18	V	17 ADMIN COMP - F AARON		" " "		21,200	21,200
19	V	17 ADMIN COMP - S GOLDSTEIN		" " "			
20	V	17 ADMIN COMP - J AARON		" " "			
21	V	17 ADMIN COMP - S KOPLIN		" " "		24,399	24,399
22	V	17 ADMIN COMP - D MAGAFAS		" " "		18,192	18,192
23	V	17 ADMIN COMP - HOWARD ALTER		" " "		12,000	12,000
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		" " "			
25	V	17 ADMIN COMP - NON OWNER - VAR		" " "		24,525	24,525
26	V	17 ADMIN COMP - NON OWNER - CFO		" " "		20,051	20,051
27	V	21 CLERICAL COMP - S AARON		" " "		8,832	8,832
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 177,952	\$ * 177,952

* 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%	\$ 703	\$ 703
16	V	27 EMP BEN - M MAUER		" " "		1,399	1,399
17	V	27 EMP BEN - M AARON		" " "		1,825	1,825
18	V	27 EMP BEN - F AARON		" " "		8,736	8,736
19	V	27 EMP BEN - S GOLDSTEIN		" " "			
20	V	27 EMP BEN - J AARON		" " "			
21	V	27 EMP BEN - S KOPLIN		" " "		8,513	8,513
22	V	27 EMP BEN - D MAGAFAS		" " "		1,179	1,179
23	V	27 EMP BEN - HOWARD ALTER		" " "		1,079	1,079
24	V	27 EMP BEN - V DAVIS		" " "			
25	V	27 EMP BEN - NON OWNER		" " "		6,921	6,921
26	V	27 EMP BEN - NON OWNER - CFO		" " "		2,218	2,218
27	V	27 EMP BEN - S AARON		" " "		1,571	1,571
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 34,144	\$ * 34,144

* 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	\$ 36,599	LINCOLN MEDICAL SUPPLIES INC	100.00%	\$ 32,648	\$	(3,951)	15
16	V	39	ANCILLARY EXPENSE	22,077	" " "		19,694		(2,383)	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			\$ 58,676			\$ 52,342	\$ *	(6,334)	39

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

Facility Name & ID Number

WATERFRONT TERRACE

#

0028076

Report Period Beginning:

01/01/2009

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	MARSHALL MAUER	ADMINISTRATION				SCHEDULE ATTACHED		SALARY	\$ 19,497	17-7	1
2	MAURICE AARON	ADMINISTRATION						SALARY	22,109	17-7	2
3	FRED AARON	ADMINISTRATION						SALARY	21,200	17-7	3
4	FRED AARON	ADMINISTRATION						SALARY	35,000	17-1	4
5	SHARON AARON	CLERICAL						SALARY	8,832	21-7	5
6	HOWARD ALTER	ADMINISTRATOR						SALARY	12,000	17-7	6
7	HOWARD ALTER	ADMINISTRATOR						SALARY	146,550	17-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 265,188		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:

01/01/2009

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

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

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN 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	393,498	11	\$ 13,322	\$ 39,276	\$ 1,330	1
2	6	REPAIR & MAINT.	TOTAL PATIENT DAYS	393,498	11	67,883	39,276	6,776	2
3	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	393,498	11	9,699	39,276	968	3
4	20	DUES AND SUBSCRIPTION	TOTAL PATIENT DAYS	393,498	11	5,183	39,276	517	4
5	21	CLERICAL & GENERAL	TOTAL PATIENT DAYS	393,498	11	551,031	404,350	55,000	5
6	24	SEMINARS AND TRAVEL	TOTAL PATIENT DAYS	393,498	11	5,810	39,276	580	6
7	25	AUTO EXPENSE	TOTAL PATIENT DAYS	393,498	11	5,452	39,276	544	7
8	26	INSURANCE	TOTAL PATIENT DAYS	393,498	11	15,305	39,276	1,528	8
9	27	EMP. BEN. - GEN, ADMIN.	TOTAL PATIENT DAYS	393,498	11	107,005	39,276	10,680	9
10	30	DEPRECIATION	TOTAL PATIENT DAYS	393,498	11	36,672	39,276	3,660	10
11	32	INTEREST	TOTAL PATIENT DAYS	393,498	11	33,003	39,276	3,294	11
12	33	REAL ESTATE TAXES	TOTAL PATIENT DAYS	393,498	11	39,991	39,276	3,992	12
13	35	EQUIPMENT RENTAL	TOTAL PATIENT DAYS	393,498	11	74,530	39,276	7,439	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					\$ 964,886	\$ 404,350	\$ 96,308	25

Facility Name & ID Number WATERFRONT TERRACE

0028076

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

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

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN 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 COMP - D NEHMER	WGHTD AVG. HOURS	40	8	\$ 63,031	\$ 63,031	5	\$ 7,147	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG. HOURS	40	10	195,000	195,000	4	19,497	2
3	17	ADMIN COMP - M AARON	WGHTD AVG. HOURS	40	8	195,000	195,000	5	22,109	3
4	17	ADMIN COMP - F AARON	WGHTD AVG. HOURS	45	5	106,000	106,000	9	21,200	4
5	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG. HOURS	40	2	94,542	94,542			5
6	17	ADMIN COMP - J AARON	WGHTD AVG. HOURS	40	1	2,657	2,657			6
7	17	ADMIN COMP - S KOPLIN	WGHTD AVG. HOURS	30	3	73,196	73,196	10	24,399	7
8	17	ADMIN COMP - D MAGAFAS	WGHTD AVG. HOURS	50	8	160,425	160,425	6	18,192	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG. HOURS	40	1	12,000	12,000	40	12,000	9
10	17	ADMIN COMP - NON OWNER - V	WGHTD AVG. HOURS	40	1	74,152	74,152			10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG. HOURS	45	8	216,303	216,303	5	24,525	11
12	17	ADMIN COMP - NON OWNER - CI	WGHTD AVG. HOURS	45	10	200,543	200,543	5	20,051	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG. HOURS	40	10	88,338	88,338	4	8,832	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					\$ 1,481,187	\$ 1,481,187		\$ 177,952	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 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

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

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN 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	8	\$ 6,197	\$ 5	\$ 703	1
2	27	EMP BEN - M MAUER	WGHTD AVG. HOURS	40	10	13,995	4	1,399	2
3	27	EMP BEN - M AARON	WGHTD AVG. HOURS	40	8	16,097	5	1,825	3
4	27	EMP BEN - F AARON	WGHTD AVG. HOURS	45	5	43,678	9	8,736	4
5	27	EMP BEN - S GOLDSTEIN	WGHTD AVG. HOURS	40	2	37,728			5
6	27	EMP BEN - J AARON	WGHTD AVG. HOURS	40	1				6
7	27	EMP BEN - S KOPLIN	WGHTD AVG. HOURS	30	3	25,540	10	8,513	7
8	27	EMP BEN - D MAGAFAS	WGHTD AVG. HOURS	50	8	10,394	6	1,179	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG. HOURS	40	1	1,079	40	1,079	9
10	27	EMP BEN - V DAVIS	WGHTD AVG. HOURS	40	1	17,756			10
11	27	EMP BEN - NON OWNER	WGHTD AVG. HOURS	45	8	61,038	5	6,921	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG. HOURS	45	10	22,185	5	2,218	12
13	27	EMP BEN - S AARON	WGHTD AVG. HOURS	40	10	15,719	4	1,571	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					\$ 271,406	\$	\$ 34,144	25

Facility Name & ID Number WATERFRONT TERRACE

0028076

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

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	10	MEDICAL SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 32,648	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					19,694	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				\$	\$		\$ 52,342	25

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	CHASE BANK		X	MORTGAGE			\$ 3,050,000	\$		\$ 14,842	1								
2											2								
3											3								
4											4								
5	RELATED PARTY	X								3,294	5								
Working Capital																			
6	BANK FINANCIAL		X	WORKING CAPITAL			1,000,000			36,532	6								
7	WOODBIDGE	X		WORKING CAPITAL			200,000			3,750	7								
8			X	INSURANCE FINANCING						1,610	8								
9	TOTAL Facility Related						\$ 3,050,000	\$ 1,200,000		\$ 60,028	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$	14								
15	TOTALS (line 9+line14)						\$ 3,050,000	\$ 1,200,000		\$ 60,028	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

1. Real Estate Tax accrual used on 2008 report.		\$	113,000	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.)		\$	111,603	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,397)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	114,000	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.		\$	112,603	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	109,538	8
	2005	110,653	9
	2006	111,687	10
	2007	110,495	11
	2008	111,603	12

2009 REAL ESTATE TAX ACCRUAL IS 102% OF THE 2008 REAL ESTATE TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-30-412-045-0000</u>	<u>NURSING HOME</u>	\$ <u>110,593.56</u>	\$ <u>110,593.56</u>
2. <u>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>1,009.87</u>	\$ <u>1,009.87</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>111,603.43</u>	\$ <u>111,603.43</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.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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.

(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).

N/A

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>37,824</u>	<u>1983</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	37,824		\$ 100,000	3

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	\$ 1,152,551	4
5											5
6											6
7											7
8	RELATED PARTY				44,277	1,135	35	1,265	130	20,662	8
	Improvement Type**										
9	ROOF		1983		21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT		1985		950		15			950	10
11	LEASEHOLD IMPROVEMENT		1986		3,800		10			3,800	11
12	LEASEHOLD IMPROVEMENT		1986		1,005		15			1,005	12
13	ROOF		1990		13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING		1990		20,776	660	15		(660)	20,776	14
15	LEASEHOLD IMPROVEMENT		1991		7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT		1991		1,491	47	15	47		1,438	16
17	LEASEHOLD IMPROVEMENT		1992		18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT		1992		1,097	35	15	35		1,012	18
19	LEASEHOLD IMPROVEMENT		1993		7,742	246	31.5	246		4,110	19
20	LEASEHOLD IMPROVEMENT		1993		3,426	88	39	88		1,448	20
21	LEASEHOLD IMPROVEMENT		1994		25,007	642	39	642		9,923	21
22	ELEVATOR REPAIR		1995		1,500	38	39	38		568	22
23	SPRINKLER REPAIR		1995		4,154	107	39	107		1,582	23
24	BOILER REPAIR, WATER PUMP, ALARM		1996		6,033	154	39	154		2,112	24
25	FENCING		1996		756	50	15	50		675	25
26	NURSE STATION		1996		5,300	136	39	136		1,785	26
27	HANDRAILS		1996		3,735	96	39	96		1,252	27
28	PARKING LOT REPAVING		1997		14,968	998	15	998		11,572	28
29	TUCKPOINTING, ROOF REPAIR		1997		25,814	662	39	662		8,192	29
30	DRAPERY		1997		14,754	378	39	378		4,670	30
31	DOORS & SIGNS		1997		8,428	216	39	216		2,673	31
32	AIR HANDLER REPAIR & PUMPS		1997		17,005	436	39	436		5,396	32
33	REMODELING		1997		59,133	1,517	39	1,517		18,931	33
34	NURSE STATION		1997		5,106	131	39	131		1,621	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	\$ 44,786	\$ 1,148	39	\$ 1,148	\$	\$ 13,144	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNETS	1998	6,419	165	39	165		1,893	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,070	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		2,349	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		588	41
42	REMODELING	1998	21,934	562	39	562		6,416	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		3,898	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,125	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		6,156	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		5,071	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		2,951	47
48	FIRE ALARM	1999	10,286	264	39	264		2,824	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		9,730	49
50	BOILER WORK	1999	7,345	189	39	189		2,013	50
51	CABLE WORK	1999	433	11	39	11		119	51
52	CARPET	1999	18,828	483	39	483		5,116	52
53	ELEVATOR WORK	1999	2,017	52	39	52		555	53
54	AIR CONDITIONING	1999	7,350	189	39	189		2,041	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		2,444	55
56	ROOF WORK	1999	2,187	56	39	56		590	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		15,774	57
58	WINDOWS	1999	5,513	142	39	142		1,500	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		8,706	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		5,274	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		47,317	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		5,900	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		966	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		3,530	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,111	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		3,579	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		27,735	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		932	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		914	69
70	TOTAL (lines 4 thru 69)		\$ 2,509,645	\$ 27,455		\$ 68,753	\$ 41,298	\$ 1,533,445	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:

01/01/2009 Ending: 12/31/2009

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 12A, Carried Forward		\$ 2,509,645	\$ 27,455		\$ 68,753	\$ 41,298	\$ 1,533,445	1
2	EXHAUST FAN	2000	890	32	27.5	32		313	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		387	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,084	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		2,378	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		1,952	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		1,793	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		1,936	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		770	10
11	AC UNIT	2001	786	28	27.5	28		240	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		1,702	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		1,358	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		581	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		936	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		453	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		12,380	17
18	DECK & FENCE	2004	10,197	680	15	680		3,740	18
19	A/C REPAIR	2004	2,200	80	27.5	80		436	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		890	20
21	WATER HEATER	2004	6,937	252	27.5	252		1,376	21
22	NURSE CALL STATION	2004	585	21	27.5	21		115	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		250	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		6,108	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		2,715	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		3,152	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		2,091	27
28	ROOF REPAIRS	2005	726	26	27.5	26		116	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		713	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		165	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		1,079	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		391	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		4,147	33
34	TOTAL (lines 1 thru 33)		\$ 2,768,471	\$ 36,767		\$ 78,065	\$ 41,298	\$ 1,600,439	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:

01/01/2009 Ending: 12/31/2009

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 12B, Carried Forward		\$ 2,768,471	\$ 36,767		\$ 78,065	\$ 41,298	\$ 1,600,439	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		256	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		892	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		8,449	4
5	DOORS	2006	15,104	549	27.5	549		1,899	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		695	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		9,130	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		467	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		207	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		311	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		187	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		373	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		377	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		1,357	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		2,171	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		1,244	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		8,720	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		6,891	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		1,689	19
20	SIGNAGE	2007	2,403	87	27.5	87		214	20
21	BOILER WORK	2007	1,835	67	27.5	67		164	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		2,075	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		423	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		246	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		1,698	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		598	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		3,146	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		456	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		537	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		1,236	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		210	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		276	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		553	33
34	TOTAL (lines 1 thru 33)		\$ 3,386,334	\$ 59,235		\$ 100,533	\$ 41,298	\$ 1,657,586	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	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		\$ 3,386,334	\$ 59,235		\$ 100,533	\$ 41,298	\$ 1,657,586	1
2	2008	1,721	63	27.5	63		92	2
3	2008	1,521	55	27.5	55		80	3
4	2009	12,907	215	27.5	215		215	4
5	2009	53,455	891	27.5	891		891	5
6	2009	23,314	389	27.5	389		389	6
7	2009	5,857	98	27.5	98		98	7
8	2009	6,183	103	27.5	103		103	8
9	2009	3,967	66	27.5	66		66	9
10	2009	15,124	252	27.5	252		252	10
11	2009	1,575	26	27.5	26		26	11
12	2009	1,175	19	27.5	19		19	12
13								13
14								14
15								15
16								16
17								17
18								18
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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		\$ 3,513,133	\$ 61,412		\$ 102,710	\$ 41,298	\$ 1,659,817	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:

01/01/2009

Ending:

12/31/2009

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	\$ 581,516	\$ 22,215	\$ 48,634	\$ 26,419	10 YRS	\$ 418,179	71
72	Current Year Purchases	63,162	37,898	3,158	(34,740)	10 YRS	3,158	72
73	Fully Depreciated Assets	450,049					450,049	73
74	RELATED PARTY	22,771		981	981		18,263	74
75	TOTALS	\$ 1,117,498	\$ 60,113	\$ 52,773	\$ (7,340)		\$ 889,649	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	RELATED PARTY			\$ 19,762	\$ 2,525	\$ 3,234	\$ 709		\$ 4,133	76
77										77
78										78
79										79
80	TOTALS			\$ 19,762	\$ 2,525	\$ 3,234	\$ 709		\$ 4,133	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,750,393	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,050	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,717	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,667	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,553,599	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?

16. Rental Amount for movable equipment: \$ 15,270 Description: YES NO 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>2010 TOYOTA CAMRY</u>	\$ <u>343.00</u>	\$ <u>1,637</u>	17
18		<u>2007 TOYOTA HIGHLANDER</u>	<u>425.00</u>	<u>5,120</u>	18
19					19
20		<u>AUTO FRINGE</u>		<u>(2,735)</u>	20
21	TOTAL		\$ <u>768.00</u>	\$ <u>4,022</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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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?</p> <p><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			
		1	2	3	4
		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		4 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	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				162,086		162,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>SUPPLIES, LAB, XRAY</u>					9,507	27,795		37,302	12
13	Other (specify):									13
14	TOTAL			\$		\$ 9,507	\$ 189,881		\$ 199,388	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: 01/01/2009

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	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 466,000)	2,138,485		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,331		6
7	Other Prepaid Expenses	7,623		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESC/EMP LOANS	197,043		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,408,482	\$	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	1,710,290		15
16	Equipment, at Historical Cost	1,109,650		16
17	Accumulated Depreciation (book methods)	(1,448,519)		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)	\$ 1,371,421	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,779,903	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 806,064	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,000,000		29
30	Accrued Salaries Payable	239,373		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,740		31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,000		32
33	Accrued Interest Payable	4,191		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,188,368	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,188,368	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,591,535	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,779,903	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,281,829	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,281,829	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	549,706	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(240,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 309,706	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,591,535	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	\$ 6,710,172	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,710,172	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	385,369	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 385,369	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)	\$ 7,095,541	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	986,496	31
32	Health Care	2,527,725	32
33	General Administration	1,813,016	33
B. Capital Expense			
34	Ownership	748,953	34
C. Ancillary Expense			
35	Special Cost Centers	199,388	35
36	Provider Participation Fee	64,605	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	201,513	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,541,696	40
41	Income before Income Taxes (line 30 minus line 40)**	553,845	41
42	Income Taxes	(4,139)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 549,706	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:

01/01/2009

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	1,750	2,181	\$ 78,208	\$ 35.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	55	55	1,354	24.62	3
4	Licensed Practical Nurses	38,706	43,726	1,008,170	23.06	4
5	CNAs & Orderlies	55,942	60,278	585,230	9.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,298	14,939	580,344	38.85	8
9	Activity Director	2,273	2,507	27,455	10.95	9
10	Activity Assistants	7,797	8,508	82,408	9.69	10
11	Social Service Workers	1,025	1,033	16,147	15.63	11
12	Dietician					12
13	Food Service Supervisor	2,186	2,433	41,373	17.00	13
14	Head Cook	5,685	6,386	70,907	11.10	14
15	Cook Helpers/Assistants	8,003	8,832	80,191	9.08	15
16	Dishwashers					16
17	Maintenance Workers	4,113	4,183	61,838	14.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,993	2,197	181,550	82.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,950	9,554	189,327	19.82	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	1,322	1,571	17,422	11.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,098	168,383	\$ 3,021,924 *	\$ 17.95	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	\$ 9,324	1-3	35
36	Medical Director	6,600	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	200	10-3	38
39	Pharmacist Consultant	5,460	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	27	11-3	44
45	Social Service Consultant	74	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	101	\$ 26,963	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			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	0	\$ 146,550	Workers' Compensation Insurance		\$ 76,205	IDPH License Fee	\$ 1,089
FRED AARON	OTHER ADMIN	0	35,000	Unemployment Compensation Insurance		53,293	Advertising: Employee Recruitment	20,483
				FICA Taxes		227,984	Health Care Worker Background Check	1,150
				Employee Health Insurance		199,508	(Indicate # of checks performed <u>115</u>)	
				Employee Meals		0	Patient Background Checks	172 1,720
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	3,197
				EMPLOYEE BENEFITS - OTHER		29,446	MARKETING/ADV/PROMO	60,159
							LICENSES/DUES/SUBSCRIPTIONS	12,318
							MGMT CO ALLOC	517
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 181,550	CHICAGO HEAD TAX		5,208	TRUST/FRANCHISE/CONTRIB/ETC	(3,197)
(List each licensed administrator separately.)							Less: Public Relations Expense	(0)
							Non-allowable advertising	(60,159)
							Yellow page advertising	(0)
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 591,644	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 37,277
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEE			\$ 110,000				Out-of-State Travel	\$
							In-State Travel	
								0
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 110,000				MGMT CO ALLOC	580
(Attach a copy of any management service agreement)							Seminar Expense	
								0
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 580
			\$					
SEE SCHEDULE ATTACHED			101,731	TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 101,731					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **WATERFRONT TERRACE**

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

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$7,507 ILL ASSOC OF HC \$1,416
- (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. \$ 5,015 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. \$ 64,605
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.