

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,160		4,655	10,815	8
9	SNF/PED					9
10	ICF	26,427	16	496	26,939	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,587	16	5,151	37,754	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.66%

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 3,948

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: 12/31/2013 Fiscal Year: 12/31/2013

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

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	127,656	28,146	219,466	375,268	375,268		375,268		1	
2	Food Purchase		130,117		130,117	130,117	(1,012)	129,105		2	
3	Housekeeping		2,712	170,120	172,832	172,832		172,832		3	
4	Laundry		9,327	114,601	123,928	123,928		123,928		4	
5	Heat and Other Utilities			95,832	95,832	95,832	1,000	96,832		5	
6	Maintenance	98,308	84,876	25,418	208,602	208,602	14,886	223,488		6	
7	Other (specify):*			19,930	19,930	19,930	898	20,828		7	
8	TOTAL General Services	225,964	255,178	645,367	1,126,509	1,126,509	15,772	1,142,281		8	
	B. Health Care and Programs										
9	Medical Director			6,000	6,000	6,000		6,000		9	
10	Nursing and Medical Records	1,945,478	154,249	17,585	2,117,312	2,117,312		2,117,312		10	
10a	Therapy	494,765	8,239		503,004	503,004		503,004		10a	
11	Activities	126,918	35,593	2,847	165,358	165,358		165,358		11	
12	Social Services	42,154		6,609	48,763	48,763		48,763		12	
13	CNA Training									13	
14	Program Transportation			8,740	8,740	8,740		8,740		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	2,609,315	198,081	41,781	2,849,177	2,849,177		2,849,177		16	
	C. General Administration										
17	Administrative	147,763		51,000	198,763	198,763	93,142	291,905		17	
18	Directors Fees									18	
19	Professional Services			111,935	111,935	111,935	2,144	114,079		19	
20	Dues, Fees, Subscriptions & Promotions			99,868	99,868	99,868	(84,998)	14,870		20	
21	Clerical & General Office Expenses	162,126	34,589	468,412	665,127	665,127	(391,990)	273,137		21	
22	Employee Benefits & Payroll Taxes			668,476	668,476	668,476		668,476		22	
23	Inservice Training & Education			6,825	6,825	6,825		6,825		23	
24	Travel and Seminar						796	796		24	
25	Other Admin. Staff Transportation			20,005	20,005	20,005	(1,531)	18,474		25	
26	Insurance-Prop.Liab.Malpractice			147,752	147,752	147,752	860	148,612		26	
27	Other (specify):*			80,000	80,000	80,000	(36,274)	43,726		27	
28	TOTAL General Administration	309,889	34,589	1,654,273	1,998,751	1,998,751	(417,851)	1,580,900		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,145,168	487,848	2,341,421	5,974,437	5,974,437	(402,079)	5,572,358		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	6,208
	REPAIRS & MAINTENANCE	403
	CONTRACTED DIETARY SERVICE	212,855
		219,466
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICE	170,120
		0
		170,120
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,860
	CONTRACTED LAUNDRY SERVICE	112,741
		114,601
5	HEAT & OTHER UTILITIES	
	GAS HEAT	32,581
	ELECTRICITY	41,132
	WATER	22,119
	CABLE TV - LOBBY	0
		0
		95,832
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,337
	PAINTING & DECORATING	2,206
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	7,843
	ELEVATOR MAINTENANCE & REPAIR	6,395
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,637
	FIRE SERVICE	0
		0
		0
		0
		0
		25,418
7	OTHER	
	SCAVENGER	19,930
	SECURITY SERVICE	0
		0
		0
		19,930
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	9,004
	PHARMACY CONSULTANT XVIII B 39-2	7,619
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	962
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		17,585
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,847
		0
		2,847
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	6,609
		6,609
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	8,740
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	51,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	35,765
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	76,170
		0
		111,935
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	81,353
	EMPLOYEE WANT ADS XIX F	283
	CONTRIBUTIONS VI 20 XIX F	100
	DUES & SUBSCRIPTIONS XIX F	8,978
	LICENSES & PERMITS XIX F	3,827
	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	4,587
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	740
	PATIENT BACKGROUND CHECKS XIX F	0
		99,868
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,017
	EQUIPMENT REPAIR & MAINTENANCE	28,354
	OUTSIDE CLERICAL SERVICES	415,200
	PENALTIES / OVERDRAFT CHARGES VI 18	5,920
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,921
	MESSENGER SERVICE	0
		0
		468,412

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	240,109
	UNEMPLOYMENT COMPENSATION XIX D	100,564
	WORKERS COMPENSATION INSURANC XIX D	83,130
	HOSPITALIZATION INSURANCE XIX D	213,873
	EMPLOYEE BENEFITS - OTHER XIX D	29,132
	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	1,668
		0
		668,476
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	6,825
		6,825
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	20,005
		20,005
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	147,752
		147,752
27	OTHER	
	BAD DEBTS VI 24	80,000
		80,000

GRAND TOTAL COLUMN 3 OTHER

2,341,421

**WATERFRONT TERRACE
SCHEDULES
12/31/2013**

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

TOTAL FOOD PURCHASE	130,117
LESS SALES TAX	<u>(1,012)</u>
NET FOOD	129,105
TOTAL PATIENT CENSUS	37,754
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	113,262
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	113,262
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	113,262
NET FOOD	129,105
DIVIDE TOTAL MEALS/YEAR	<u>113,262</u>
COST PER MEAL	1.14
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

Facility Name & ID Number WATERFRONT TERRACE

#0028076

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			162,142	162,142		162,142	52,581	214,723			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,263	61,263		61,263	179,313	240,576			32
33	Real Estate Taxes			236,119	236,119		236,119	3,858	239,977			33
34	Rent-Facility & Grounds			624,000	624,000		624,000	(624,000)				34
35	Rent-Equipment & Vehicles			15,915	15,915		15,915	8,894	24,809			35
36	Other (specify):*											36
37	TOTAL Ownership			1,099,439	1,099,439		1,099,439	(379,354)	720,085			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,606	3,092	145,698		145,698		145,698			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			268,673	268,673		268,673		268,673			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		142,606	271,765	414,371		414,371		414,371			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,145,168	630,454	3,712,625	7,488,247		7,488,247	(781,433)	6,706,814			45

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

Facility Name & ID Number **WATERFRONT TERRACE**

0028076

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

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	44,218	30		9
10	Interest and Other Investment Income	(882)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,012)	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	(5,920)	21		18
19	Entertainment		20		19
20	Contributions	(4,687)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,000)	27		24
25	Fund Raising, Advertising and Promotional	(81,353)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		10		28
29	Other-Attach Schedule	(45,287)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (174,923)		\$	30

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)	(606,510)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (606,510)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (781,433)		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

BHF USE ONLY						
48		49		50		51
						52

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARY	\$ (41,687)	21	1
2	MARKETING TRAVEL	(3,600)	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		(45,287)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	(1,012)	0	0	0	0	0	0	0	0	0	0	(1,012)	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	1,000	0	0	0	0	0	0	0	0	1,000	5
6	Maintenance	0	0	8,297	6,589	0	0	0	0	0	0	0	14,886	6
7	Other (specify):*	0	0	202	0	696	0	0	0	0	0	0	898	7
8	TOTAL General Services	(1,012)	0	9,499	6,589	696	0	0	0	0	0	0	15,772	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(51,000)	0	144,142	0	0	0	0	0	0	0	93,142	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	2,144	0	0	0	0	0	0	0	0	2,144	19
20	Fees, Subscriptions & Promotions	(86,040)	0	1,042	0	0	0	0	0	0	0	0	(84,998)	20
21	Clerical & General Office Expenses	(47,607)	(415,200)	61,850	8,967	0	0	0	0	0	0	0	(391,990)	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	796	0	0	0	0	0	0	0	0	796	24
25	Other Admin. Staff Transportation	(3,600)	0	2,069	0	0	0	0	0	0	0	0	(1,531)	25
26	Insurance-Prop.Liab.Malpractice	0	0	860	0	0	0	0	0	0	0	0	860	26
27	Other (specify):*	(80,000)	0	11,554	0	32,172	0	0	0	0	0	0	(36,274)	27
28	TOTAL General Administration	(217,247)	(466,200)	80,315	153,109	32,172	0	0	0	0	0	0	(417,851)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(218,259)	(466,200)	89,814	159,698	32,868	0	0	0	0	0	0	(402,079)	29

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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	44,218	6,425	1,938	0	0	0	0	0	0	0	0	52,581	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(882)	177,127	3,068	0	0	0	0	0	0	0	0	179,313	32
33	Real Estate Taxes	0	0	3,858	0	0	0	0	0	0	0	0	3,858	33
34	Rent-Facility & Grounds	0	(624,000)	0	0	0	0	0	0	0	0	0	(624,000)	34
35	Rent-Equipment & Vehicles	0	0	8,894	0	0	0	0	0	0	0	0	8,894	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	43,336	(440,448)	17,758	0	(379,354)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(174,923)	(906,648)	107,572	159,698	32,868	0	0	0	0	0	0	(781,433)	45

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARSHALL MAUER	25	SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		
FRANCES MAUER	25					
MAURICE AARON	25					
SUSAN STERN	25					

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEE	\$ 51,000	DYNAMIC HEALTH CARE CONSULTANT		\$	\$ (51,000)	1
2	V	21 BOOKKEEPING SERVICE	415,200	" "			(415,200)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	624,000	WATERFRONT TERRACE ASSOCIATES			(624,000)	7
8	V	30 DEPRECIATION				6,425	6,425	8
9	V	32 INTEREST				177,127	177,127	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,090,200			\$ 183,552	\$ * (906,648)	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		\$ 1,000	\$	1,000	15
16	V	6 REPAIR & MAINT.		" "		8,297		8,297	16
17	V	7 EMP BEN-GEN SERV		" "		202		202	17
18	V	19 PROFESSIONAL FEES		" "		2,144		2,144	18
19	V	20 DUES AND SUBSCRIPTION		" "		1,042		1,042	19
20	V	21 CLERICAL & GENERAL		" "		61,850		61,850	20
21	V	24 SEMINARS AND TRAVEL		" "		796		796	21
22	V	25 AUTO EXPENSE		" "		2,069		2,069	22
23	V	26 INSURANCE		" "		860		860	23
24	V	27 EMP. BEN. - GEN, ADMIN.		" "		11,554		11,554	24
25	V	30 DEPRECIATION		" "		1,938		1,938	25
26	V	32 INTEREST		" "		3,068		3,068	26
27	V	33 REAL ESTATE TAXES		" "		3,858		3,858	27
28	V	35 EQUIPMENT RENTAL		" "		8,823		8,823	28
29	V	35 EQUIPMENT RENTAL		" "		71		71	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		\$			\$ 107,572	\$ *	107,572	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		\$ 6,589	\$ 6,589
16	V	17 ADMIN COMP - M MAUER		" "		19,533	19,533
17	V	17 ADMIN COMP - M AARON		" "		22,139	22,139
18	V	17 ADMIN COMP - F AARON		" "		2,500	2,500
19	V	17 ADMIN COMP - D AARON		" "			
20	V	17 ADMIN COMP - S GOLDSTEIN		" "			
21	V	17 ADMIN COMP - S HARAMARAS		" "		18,966	18,966
22	V	17 ADMIN COMP - D KUFTA		" "		17,479	17,479
23	V	17 ADMIN COMP - HOWARD ALTER		" "		12,000	12,000
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		" "		11,538	11,538
25	V	17 ADMIN COMP - NON OWNER - VAR		" "		20,102	20,102
26	V	17 ADMIN COMP - NON OWNER - CFO		" "		19,885	19,885
27	V	21 CLERICAL COMP - S AARON		" "		8,473	8,473
28	V	21 CLERICAL COMP - E MARYLES		" "		494	494
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 159,698	\$ * 159,698

* 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		\$ 696	\$	696	15
16	V	27 EMP BEN - M MAUER		" "		1,071		1,071	16
17	V	27 EMP BEN - M AARON		" "		1,558		1,558	17
18	V	27 EMP BEN - F AARON		" "		7,537		7,537	18
19	V	27 EMP BEN - D AARON		" "					19
20	V	27 EMP BEN - S GOLDSTEIN		" "					20
21	V	27 EMP BEN - S HARAMARAS		" "		6,485		6,485	21
22	V	27 EMP BEN - D KUFTA		" "		1,231		1,231	22
23	V	27 EMP BEN - HOWARD ALTER		" "		1,080		1,080	23
24	V	27 EMP BEN - V DAVIS		" "		2,971		2,971	24
25	V	27 EMP BEN - NON OWNER		" "		6,101		6,101	25
26	V	27 EMP BEN - NON OWNER - CFO		" "		2,414		2,414	26
27	V	27 EMP BEN - S AARON		" "		1,684		1,684	27
28	V	27 EMP BEN - E MARYLES		" "		40		40	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		\$			\$ 32,868	\$ *	32,868	39

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

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			BRADLEY	BRADLEY	WATERFRONT TERRACE ASSOCIATES		BUILDING CO	1
2			BRIDGEVIEW HEALTH CARE CENTER	BRIDGEVIEW	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3			GROSS POINTE MANOR LLC	NILES	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4			OTTAWA PAVILION LTD	OTTAWA				4
5			PARK RIDGE CARE CENTER LTD	PARK RIDGE				5
6			STERLING PAVILION LTD	STERLING				6
7			WARREN PARK HEALTH AND LIVING CEN	CHICAGO				7
8			WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				8
9			WOODBRIIDGE NURSING PAVILION LTD	CHICAGO				9
10			WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11			WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12			WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	SHAREHOLDER	ADMINISTRATION			3.91	7.81	SALARY	\$ 19,533	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATION			4.43	8.86	SALARY	22,139	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATION			9		SALARY	37,500	17-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATION					SALARY	2,500	17-7	4
5	SHARON AARON	SHAREHOLDER	CLERICAL			3.91	9.77	SALARY	8,473	21-7	5
6	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR			40		SALARY	110,263	17-1	6
7	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR					SALARY	12,000	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.27	0.98	SALARY	494	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 212,902		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: 01/01/2013

Ending: 2/31/2013

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 DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	5	UTILITIES	PATIENT DAYS	407,371	12	\$ 10,786	\$ 37,754	\$ 1,000	1
2	6	REPAIR & MAINT.	PATIENT DAYS	407,371	12	89,523	37,754	8,297	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	407,371	12	2,175	37,754	202	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,371	12	23,130	37,754	2,144	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	407,371	12	11,247	37,754	1,042	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,371	12	667,372	493,233	61,850	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,371	12	8,593	37,754	796	7
8	25	AUTO EXPENSE	PATIENT DAYS	407,371	12	22,321	37,754	2,069	8
9	26	INSURANCE	PATIENT DAYS	407,371	12	9,284	37,754	860	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	407,371	12	124,673	37,754	11,554	10
11	30	DEPRECIATION	PATIENT DAYS	407,371	12	20,906	37,754	1,938	11
12	32	INTEREST	PATIENT DAYS	407,371	12	33,103	37,754	3,068	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,371	12	41,631	37,754	3,858	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	12	95,202	37,754	8,823	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	12	770	37,754	71	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,160,716	\$ 530,786	\$ 107,572	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	9	\$ 59,522	\$ 59,522	4	\$ 6,589	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	4	19,533	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	4	22,139	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	12,500	12,500	9	2,500	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271			5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	90,400	90,400			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	75,862	75,862	8	18,966	7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	158,070	158,070	6	17,479	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	11	118,147	118,147	4	11,538	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	181,559	181,559	5	20,102	11
12	17	ADMIN COMP - NON OWNER - CF	WGHTD AVG HOURS	40	11	203,618	203,618	4	19,885	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	86,700	86,700	4	8,473	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	50,541	50,541	0	494	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,509,190	\$ 1,509,190		\$ 159,698	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	9	\$ 6,291	\$	4	\$ 696	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	10,970		4	1,071	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,077		4	1,558	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	37,685		9	7,537	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,884				5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	41,051				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	25,938		8	6,485	7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	9	11,132		6	1,231	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,080		40	1,080	9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	11	30,426		4	2,971	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	9	55,102		5	6,101	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	11	24,720		4	2,414	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	11	17,233		4	1,684	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	4,119		0	40	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 284,708	\$		\$ 32,868	25

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	BANK FINANCIAL		X	MORTGAGE	INTEREST	01/01/11	\$ 5,310,000	\$ 5,310,000	06/06/13	3.2900	\$ 177,127	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	BANK FINANCIAL		X	WORKING CAPITAL				1,056,050			48,822	6						
7	WILLOW CREST	X		WORKING CAPITAL				400,000			9,479	7						
8	PHARMACY		X	AP FINANCING				36,894			2,962	8						
9	TOTAL Facility Related						\$ 5,310,000	\$ 6,802,944			\$ 238,390	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 5,310,000	\$ 6,802,944			\$ 238,390	15						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2012 report.		\$	110,000		1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	171,119		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	61,119		3										
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	175,000		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.		\$	236,119		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2008	111,603	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2012 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2009	103,696	9												
	2010	108,146	10												
	2011	107,696	11												
	2012	171,119	12												
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL															
THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.															

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(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>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>1,645.37</u>	\$ <u>1,645.37</u>
2. <u>21-30-412-045-0000</u>	<u>NURSING HOME</u>	\$ <u>169,473.28</u>	\$ <u>169,473.28</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>171,118.65</u></u>	\$ <u><u>171,118.65</u></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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

01/01/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NUESING HOME</u>	<u>37,824</u>	<u>1983</u>	<u>\$ 100,000</u>	1
2					2
3	TOTALS	37,824		\$ 100,000	3

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 1,324,895	4
5										5
6										6
7										7
8	RELATED PARTY			41,112	1,054	35	1,175	121	23,884	8
	Improvement Type**									
9	ROOF	1983		21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT	1985		950		15			950	10
11	LEASEHOLD IMPROVEMENT	1986		3,800		10			3,800	11
12	LEASEHOLD IMPROVEMENT	1986		1,005		15			1,005	12
13	ROOF	1990		13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING	1990		20,776	660	15		(660)	20,776	14
15	LEASEHOLD IMPROVEMENT	1991		7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT	1991		1,491	47	15		(47)	1,438	16
17	LEASEHOLD IMPROVEMENT	1992		18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT	1992		1,097	35	15		(35)	1,097	18
19	LEASEHOLD IMPROVEMENT	1993		7,742	246	31.5	246		5,094	19
20	LEASEHOLD IMPROVEMENT	1993		3,426	88	39	88		1,800	20
21	LEASEHOLD IMPROVEMENT	1994		25,007	642	39	642		12,491	21
22	ELEVATOR REPAIR	1995		1,500	38	39	38		720	22
23	SPRINKLER REPAIR	1995		4,154	107	39	107		2,010	23
24	BOILER REPAIR, WATER PUMP, ALARM	1996		6,033	154	39	154		2,728	24
25	FENCING	1996		756		15			756	25
26	NURSE STATION	1996		5,300	136	39	136		2,329	26
27	HANDRAILS	1996		3,735	96	39	96		1,636	27
28	PARKING LOT REPAVING	1997		14,968		15	402	402	14,968	28
29	TUCKPOINTING, ROOF REPAIR	1997		25,814	662	39	662		10,840	29
30	DRAPERY	1997		14,754	378	39	378		6,182	30
31	DOORS & SIGNS	1997		8,428	216	39	216		3,537	31
32	AIR HANDLER REPAIR & PUMPS	1997		17,005	436	39	436		7,140	32
33	REMODELING	1997		59,133	1,517	39	1,517		24,999	33
34	NURSE STATION	1997		5,106	131	39	131		2,145	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:

01/01/2013

Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	\$ 44,786	\$ 1,148	39	\$ 1,148	\$	\$ 17,736	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		2,553	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,442	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		3,169	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		796	41
42	REMODELING	1998	21,934	562	39	562		8,664	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		5,254	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,517	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		8,312	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		6,847	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		3,983	47
48	FIRE ALARM	1999	10,286	264	39	264		3,880	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		13,386	49
50	BOILER WORK	1999	7,345	189	39	189		2,769	50
51	CABLE WORK	1999	433	11	39	11		163	51
52	CARPET	1999	18,828	483	39	483		7,048	52
53	ELEVATOR WORK	1999	2,017	52	39	52		763	53
54	AIR CONDITIONING	1999	7,350	189	39	189		2,797	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		3,376	55
56	ROOF WORK	1999	2,187	56	39	56		814	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		21,866	57
58	WINDOWS	1999	5,513	142	39	142		2,068	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		12,034	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		7,294	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		65,413	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		8,156	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		1,370	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		4,998	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,571	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		5,071	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		39,299	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		1,324	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		1,298	69
70	TOTAL (lines 4 thru 69)		\$ 2,506,480	\$ 26,326		\$ 67,935	\$ 41,609	\$ 1,805,661	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:

01/01/2013

Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,506,480	\$ 26,326		\$ 67,935	\$ 41,609	\$ 1,805,661	1
2	EXHAUST FAN	2000	890	32	27.5	32		441	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		547	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,532	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		3,462	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		2,852	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		2,621	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		2,828	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		1,126	10
11	AC UNIT	2001	786	28	27.5	28		352	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		2,438	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		2,266	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		941	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		1,516	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		733	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		16,880	17
18	DECK & FENCE	2004	10,197	680	15	680		6,460	18
19	A/C REPAIR	2004	2,200	80	27.5	80		756	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		1,542	20
21	WATER HEATER	2004	6,937	252	27.5	252		2,384	21
22	NURSE CALL STATION	2004	585	21	27.5	21		199	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		434	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		11,588	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		5,151	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		5,980	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		3,967	27
28	ROOF REPAIRS	2005	726	26	27.5	26		220	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		1,353	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		313	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		2,327	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		843	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		8,943	33
34	TOTAL (lines 1 thru 33)		\$ 2,765,306	\$ 35,638		\$ 77,247	\$ 41,609	\$ 1,909,903	34

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

Facility Name & ID Number WATERFRONT TERRACE

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,765,306	\$ 35,638		\$ 77,247	\$ 41,609	\$ 1,909,903	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		552	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		1,924	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		18,221	4
5	DOORS	2006	15,104	549	27.5	549		4,095	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		1,499	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		19,690	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		1,007	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		447	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		671	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		403	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		805	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		813	13
14	PUMPS & CONTROL PANEL	2007	15,172	552	27.5	552		3,565	14
15	WALLCOVERING & VINYL	2007	24,279	883	27.5	883		5,703	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		3,268	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	3,547	27.5	3,547		22,908	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		18,103	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		4,437	19
20	SIGNAGE	2007	2,403	87	27.5	87		562	20
21	BOILER WORK	2007	1,835	67	27.5	67		432	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	844	27.5	844		5,451	22
23	ELECTRICAL WORK	2007	4,730	172	27.5	172		1,111	23
24	PLUMBING WORK	2007	2,752	100	27.5	100		646	24
25	CABLING OF BUILDING	2007	19,000	691	27.5	691		4,462	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		2,238	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		11,774	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		1,708	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		2,009	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		4,628	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		786	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		1,032	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		2,069	33
34	TOTAL (lines 1 thru 33)		\$ 3,383,169	\$ 58,106		\$ 99,715	\$ 41,609	\$ 2,056,922	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:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,383,169	\$ 58,106		\$ 99,715	\$ 41,609	\$ 2,056,922	1
2	REFRIGERATOR REPAIRS	2008	1,721	63	27.5	63		344	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	55	27.5	55		300	3
4	RFIRE ALARM SYSTEM REPAIRS	2009	12,907	469	27.5	469		2,091	4
5	ELECTRICAL WORK	2009	53,455	1,944	27.5	1,944		8,667	5
6	ELEVATOR REPAIRS	2009	23,314	847	27.5	847		3,777	6
7	CARPET, TILE & VINYL	2009	5,857	213	27.5	213		950	7
8	AIR CONDITIONERS & SLEEVES	2009	6,183	225	27.5	225		1,003	8
9	DOORS	2009	3,967	144	27.5	144		642	9
10	PLUMBING REPAIRS	2009	15,124	550	27.5	550		2,452	10
11	DISH NETWORK EQUIPMENT	2009	1,575	58	27.5	58		258	11
12	EMERGENCY ALARM CONTROL PANEL	2009	1,175	43	27.5	43		191	12
13	DOORS AND ACCESSORIES, DOOR ALARM & KEY PAD	2010	17,232	627	27.5	627		2,168	13
14	REPLACE WATER TUBES AND GASKET	2010	1,992	72	27.5	72		249	14
15	AIR CONDITIONERS, REPLACE AIR HANDLER MOTOR	2010	13,721	499	27.5	499		1,726	15
16	ROOF REPAIR	2010	4,135	150	27.5	150		519	16
17	CEILING PIPING REPAIRS- FRONT OFFICE	2010	4,850	176	27.5	176		609	17
18	INSTALL FIRE DAMPERS, FIRE, CIRCULATING, BRONZ PUM	2010	5,689	207	27.5	207		716	18
19	BASEMENT REPAIRS	2010	2,600	95	27.5	95		328	19
20	REPLACE PRIMARY PUMP IN BASEMENT	2010	2,400	87	27.5	87		301	20
21	2ND FLOOR PATIENTS BATHROOMS AND ROOMS:	2010	54,081	1,967	27.5	1,967		6,802	21
22	INSTALL NEW WALLS, CERAMIC TILE, CALL LIGHT								22
23	LIGHTING ACCESSORIES, FIXTURES, LAMPS	2010	12,135	441	27.5	441		1,525	23
24	UTILITY ROOM SINK, REPAIR SPRINKLER SYSTEM	2010	3,299	120	27.5	120		415	24
25	WALL PROTECTION HANDRAILS	2010	9,634	350	27.5	350		1,211	25
26	BUMBERS AROUND GARBAGE AREA	2010	4,766	173	27.5	173		598	26
27	WALLCOVERING, CUBICLE CURTAINS	2010	5,711	208	27.5	208		719	27
28	INSTALL STAIN & RAMP RAILINGS, SECURITY SYSTEM	2010	3,175	115	27.5	115		398	28
29	REPLACE ELECTRIC FOR TV ABOVE CEILING	2010	2,700	98	27.5	98		339	29
30	3RD FLOOR-REPLACE LIGHTS, INSTALL WATT FIXTURE	2010	3,328	121	27.5	121		418	30
31	NORTH SIDE EAST END-PERLACE BUILDING LIGHTS	2010	3,052	111	27.5	111		384	31
32	INSTALL OUTDOOR LIGHTING	2010	7,250	264	27.5	264		913	32
33	PATIO ROOMS-NEW DOOR, TILE, FLOOR, LIGHTING	2010	13,417	488	27.5	488		1,688	33
34	TOTAL (lines 1 thru 33)		\$ 3,685,135	\$ 69,086		\$ 110,695	\$ 41,609	\$ 2,099,623	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:

01/01/2013

Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,685,135	\$ 69,086		\$ 110,695	\$ 41,609	\$ 2,099,623	1
2	AIR COMPRESSOR COIL REPAIR	2010	1,850	68	27.5	68		235	2
3	RECEPTION DESK/CABINETS	2011	16,284	592	27.5	592		1,455	3
4	WALL COVERING/WINDOW TREATMENTS/ARTWORK/COI	2011	35,692	1,298	27.5	1,298		3,191	4
5	FLOORING/WINDOW TREATMENTS	2011	96,290	3,501	27.5	3,501		8,607	5
6	DOORS/KICK PLATES	2011	22,647	824	27.5	824		2,025	6
7	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	57,913	2,106	27.5	2,106		5,177	7
8	SEE PAGE 12 F LINES 3-5								8
9	WINDOWS	2011	72,160	2,624	27.5	2,624		6,451	9
10	ROOD REPAIRS/AIR HANDLER	2011	11,093	403	27.5	403		991	10
11	STAIRWELL CRASH RAILS	2011	5,242	191	27.5	191		469	11
12	LOBBY HEAT/COOL/FLOORING	2011	29,666	1,079	27.5	1,079		2,652	12
13	SEE PAGE 12 F LINES 7-13								13
14	CAPRET, CORNER GUARDS-OFFICE, RECEPTION	2011	5,247	191	27.5	191		469	14
15	DOORS - RESIDENT RMS,TUB ROOM FRONT LOBBY	2011	3,370	122	27.5	122		300	15
16	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	149,510	5,437	27.5	5,437		13,368	16
17	SEE PAGE 12 F LINES 15-22								17
18	HOT WATER HEATERS/PLUMBING WORK	2011	18,765	682	27.5	682		1,677	18
19	RECEPTION DESK	2011	21,772	792	27.5	792		1,947	19
20	ROOF REPAIR	2011	2,310	84	27.5	84		206	20
21	SECURITY/FIRE SYSTEM REPAIR	2011	19,325	703	27.5	703		1,728	21
22	HEATERS/AC UNIT	2011	17,028	619	27.5	619		1,522	22
23	SCANNERS/COMPUTER CABLING	2011	35,424	1,288	27.5	1,288		3,166	23
24	SEE PAGE 12 F LINES 24-27								24
25	SECURITY/FIRE SYSTEM REPAIR	2012	12,807	467	27.5	467		681	25
26	HEATING & AIR CONDITIONING	2012	7,695	255	27.5	255		383	26
27	LAUNDRY ROOM PIPING & REPAIR	2012	27,596	976	27.5	976		1,437	27
28	WINDOW TRTMTS, CABINETS, PICTURES-OFFICE,NURSES	2012	7,820	297	27.5	297		428	28
29	ELEVATOR REPAIR	2012	10,300	382	27.5	382		554	29
30	DOORS, TILE - TUB, RESIDENT, MEDICATION RM	2012	4,215	170	27.5	170		240	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,377,156	\$ 94,237		\$ 135,846	\$ 41,609	\$ 2,158,982	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:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,377,156	\$ 94,237		\$ 135,846	\$ 41,609	\$ 2,158,982	1
2	PAGE 12 E LINE 8								2
3	PLUMBING/ELECTRIC- KITCHEN	2011	11,675	418	27.5	418		1,027	3
4	PLUMBING/ELECTRIC - BOILER/MECHANICAL ROOMS	2011	27,323	986	27.5	986		2,424	4
5	PLUMBING/ELECTRIC - BASEMENT	2011	6,944	267	27.5	267		657	5
6	PAGE 12 E LINE 13								6
7	CUBICLE CURTAINS - SPA AREA	2011	1,380	48	27.5	48		118	7
8	PLASTER & PAINT - BACK STAIRWAY	2011	3,227	115	27.5	115		283	8
9	PLASTER & PRIME FLOORS - BASEMENT TO 4TH FL	2011	2,750	96	27.5	96		236	9
10	WALLPAPER,PAINT,WINDOW TRTMTS OFFICES	2011	11,466	413	27.5	413		1,015	10
11	MIRRORS & LIGHT FIXTURES - BATHROOM	2011	1,615	58	27.5	58		142	11
12	LIGHT FIXTURES INTSL - DINING ROOM	2011	3,600	135	27.5	135		331	12
13	WINDOW TRTMTS & LIGHTING - RESIDENT ROOMS	2011	2,387	96	27.5	96		237	13
14	PAGE 12 E LINE 17								14
15	ELECTRIC REPAIR/REPLACE - ELEVATOR ROOM	2011	1,860	60	27.5	60		147	15
16	ELECTRIC REPAIR/REPLACE - BATHROOMS	2011	8,200	298	27.5	298		733	16
17	ELECTRIC REPAIR/REPLACE - FIRE ALARMS 1,2,3 FLOOR	2011	4,800	179	27.5	179		440	17
18	ELECTRIC REPAIR/REPLACE - OXYGEN ROOM	2011	2,080	80	27.5	80		196	18
19	ELECTRIC REPAIR/REPLACE - NURSE CALL	2011	630	20	27.5	20		49	19
20	ELECTRIC REPAIR/REPLACE - KITCHEN & OFFICE	2011	19,471	716	27.5	716		1,760	20
21	ELECTRIC REPAIR/REPLACE - 2 & 3 FLOOR	2011	13,725	497	27.5	497		1,222	21
22	ELECTRIC REPAIR/REPLACE - TV ROOMS	2011	3,900	138	27.5	138		340	22
23	PAGE 12 E LINE 24								23
24	PLUMBING/ELECTRIC WORK - NURSE STATION	2012	1,040	42	27.5	42		57	24
25	PLUMBING/ELECTRIC WORK - TUB ROOM	2012	9,020	339	27.5	339		486	25
26	PLUMBING/ELECTRIC WORK - KITCHEN, HALL, RESIDEN	2012	27,757	1,018	27.5	1,018		1,473	26
27	PLUMBING/ELECTRIC WORK - LAUNDRY, BOILER ROOM	2012	8,416	297	27.5	297		452	27
28									28
29	LABEL & LOCK ELECTRIC PANELS-1SR,2ND,3RD FL, KITC	2013	11,225	194	27.5	194		194	29
30	EXTERIOR DOORS, CLOSERS & CLOSED CIRCUIT TV'S	2013	8,103	132	27.5	132		132	30
31	PLUMBING-MEN'S RM, BOILER RM,	2013	5,500	84	27.5	84		84	31
32	DOORS, CLOSERS & CLOSED CIRCUIT CAMERAS	2013	10,681	193	27.5	193		193	32
33	BATHROOM PLUMBING & ELECTRIC WORK	2013	5,980	96	27.5	96		96	33
34	TOTAL (lines 1 thru 33)		\$ 4,591,911	\$ 101,252		\$ 142,861	\$ 41,609	\$ 2,173,506	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:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,591,911	\$ 101,252		\$ 142,861	\$ 41,609	\$ 2,173,506	1
2	KITCHEN ELECTRIC & GRANITE COUNTERTOP& TRAP COVE	2013	4,750	72	27.5	72		72	2
3	HOT WATER HEATER & BOOSTER	2013	2,867	48	27.5	48		48	3
4	1ST, 2ND & 3RD FLOOR ELECTRICAL REPAIRS	2013	9,405	156	27.5	156		156	4
5	ELEVATOR UPGRADES	2013	4,900	84	27.5	84		84	5
6	CONFIGURED PHONE SETS & INTERCOM HANDLE CAP	2013	3,565	60	27.5	60		60	6
7	THRU WALL AIR CONDITIONERS	2013	5,217	84	27.5	84		84	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	TOTAL (lines 1 thru 33)		\$ 4,622,615	\$ 101,756		\$ 143,365	\$ 41,609	\$ 2,174,010	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:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 656,262	\$ 23,575	\$ 62,132	\$ 38,557	10YRS	\$ 319,283	71
72	Current Year Purchases	77,141	44,291	3,857	(40,434)	10 YRS	3,857	72
73	Fully Depreciated Assets	777,091					777,091	73
74	RELATED PARTY	21,806	218	695	477		19,791	74
75	TOTALS	\$ 1,532,300	\$ 68,084	\$ 66,684	\$ (1,400)		\$ 1,120,022	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			\$ 21,843	\$ 665	\$ 4,674	\$ 4,009		\$ 10,176	76
77										77
78										78
79										79
80	TOTALS			\$ 21,843	\$ 665	\$ 4,674	\$ 4,009		\$ 10,176	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,276,758	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,505	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 214,723	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,218	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,304,208	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 8,328 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2010 BUICK ENCLAVE	\$ 578.56	\$ 1,736	17
18	ADMINISTRATOR	2013 BUICK ENCLAVE	549.36	4,944	18
19		2012 GMC ACADIA	489.27	5,871	19
20		PAYROLL ADJ		(4,964)	20
21	TOTAL		\$ #####	\$ 7,587	21

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

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
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		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	Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,325				1,325	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts				123,180			123,180	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	INHALATION THERAPY Other (specify): SUPPLIES, XRAY,EKG,LAB					450 1,317	19,426		450 20,743		13
14	TOTAL			\$		\$ 3,092	\$ 142,606		\$ 145,698		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# 0028076Report Period Beginning: 01/01/2013Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(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	\$ 37,744	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (370,000))	1,133,520		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,888		6
7	Other Prepaid Expenses	25,550		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>REAL ESTATE TAX ESCROW</u>	152,621		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,447,323	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,822,938		15
16	Equipment, at Historical Cost	1,510,492		16
17	Accumulated Depreciation (book methods)	(2,159,871)		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): <u>DEPOSIT</u>	23,589		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,197,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,644,471	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,183,782	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,092,944		29
30	Accrued Salaries Payable	153,473		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,715		31
32	Accrued Real Estate Taxes(Sch.IX-B)	175,000		32
33	Accrued Interest Payable	5,908		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)	\$ 2,630,822	\$	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)	\$ 2,630,822	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,013,649	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,644,471	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,471,857	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,471,857	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(218,208)	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)	\$ (458,208)	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)	\$ 1,013,649	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,229,387	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,229,387	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	207,126	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 207,126	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***	882	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 882	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)	\$ 7,437,395	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,126,509	31
32	Health Care	2,849,177	32
33	General Administration	1,998,751	33
B. Capital Expense			
34	Ownership	1,099,439	34
C. Ancillary Expense			
35	Special Cost Centers	145,698	35
36	Provider Participation Fee	268,673	36
D. Other Expenses (specify):			
37	<u>OUT-OF-PERIOD EXPENSES</u>	161,001	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,649,248	40
41	Income before Income Taxes (line 30 minus line 40)**	(211,853)	41
42	Income Taxes	(6,355)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (218,208)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,870,249	44
45	Private Pay - Net Inpatient Revenue	2,160	45
46	Medicare - Net Inpatient Revenue	2,176,006	46
47	Other-(specify) <u>HOSPICE</u>	180,972	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,229,387	49

**TAX RETURN PREPARED ON CASH BASIS

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

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

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

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

Facility Name & ID Number **WATERFRONT TERRACE**

0028076

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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	1,390	1,486	\$ 60,079	\$ 40.43	1
2	Assistant Director of Nursing	1,586	1,877	65,793	35.05	2
3	Registered Nurses	4,137	4,339	184,923	42.62	3
4	Licensed Practical Nurses	34,150	39,661	964,954	24.33	4
5	CNAs & Orderlies	60,545	65,515	651,552	9.95	5
6	CNA Trainees					6
7	Licensed Therapist	12,631	13,695	494,765	36.13	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,038	27,412	13.45	9
10	Activity Assistants	9,229	10,352	99,506	9.61	10
11	Social Service Workers	1,913	1,988	42,154	21.20	11
12	Dietician					12
13	Food Service Supervisor	1,393	1,591	27,639	17.37	13
14	Head Cook	3,453	4,142	46,159	11.14	14
15	Cook Helpers/Assistants	4,945	5,902	53,858	9.13	15
16	Dishwashers					16
17	Maintenance Workers	5,152	5,482	98,308	17.93	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,989	2,166	147,763	68.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,869	9,095	162,126	17.83	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	1,553	1,880	18,177	9.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,855	171,209	\$ 3,145,168 *	\$ 18.37	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	\$ 6,208	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	9,004	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,619	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,847	11-3	44
45	Social Service Consultant	E	6,609	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,287		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
HOWARD ALTER	ADMINISTRATOR		\$ 147,763	Workers' Compensation Insurance	\$ 83,130	IDPH License Fee	\$ 3,090		
				Unemployment Compensation Insurance	100,564	Advertising: Employee Recruitment	283		
				FICA Taxes	240,109	Health Care Worker Background Check	740		
				Employee Health Insurance	213,873	(Indicate # of checks performed <u>70</u>)			
				Employee Meals	0	Patient Background Checks	0		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,687		
				EMPLOYEE BENEFITS - OTHER	29,132	MARKETING/ADV/PROMO	81,353		
						LICENSES/DUES/SUBSCRIPTIONS	9,715		
						MGMT CO ALLOC	1,042		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 147,763	CHICAGO HEAD TAX	1,668	TRUST/FRANCHISE/CONTRIB/ETC	(4,687)		
(List each licensed administrator separately.)						Less: Public Relations Expense	(0)		
						Non-allowable advertising	(81,353)		
						Yellow page advertising	(0)		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,870		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
					\$ 668,476				
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
MANAGEMENT FEES			\$ 51,000	Description	Line #	Amount	Description	Amount	
							Out-of-State Travel	\$	
							In-State Travel		
								0	
							MGMT CO ALLOC	796	
							Seminar Expense		
								0	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 51,000	TOTAL		\$	TOTAL	\$ 796	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
			\$						
SEE SCHEDULE ATTACHED			111,935						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 111,935						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
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19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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 \$8,054
- (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. \$ 6,394 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. \$ 268,673
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.