

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0028076</u></p> <p>Facility Name: <u>WATERFRONT TERRACE</u></p> <p>Address: <u>7750 SOUTH SHORE DR</u> <u>CHICAGO</u> <u>60649</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/01/1983</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARSHALL MAUER</u></td> <td></td> </tr> <tr> <td>(Title) <u>TREASURER</u></td> <td></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> <tr> <td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MARSHALL MAUER</u>		(Title) <u>TREASURER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u>		(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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<p>In the event there are further questions about this report, please contact: Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>																																											

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,526	42	3,350	8,918	8
9	SNF/PED					9
10	ICF	28,558	257	579	29,394	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,084	299	3,929	38,312	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.71%

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 4/1/1983

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 118 and days of care provided 3,350

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number **WATERFRONT TERRACE** # **0028076** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

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		1,746	578,539	580,285	580,285		580,285			1
2	Food Purchase		503		503	503	(157)	346			2
3	Housekeeping		479	188,486	188,965	188,965		188,965			3
4	Laundry		13,323	127,614	140,937	140,937		140,937			4
5	Heat and Other Utilities			107,986	107,986	107,986	979	108,965			5
6	Maintenance	109,741	115,056	26,510	251,307	251,307	12,711	264,018			6
7	Other (specify):*			13,967	13,967	13,967	869	14,836			7
8	TOTAL General Services	109,741	131,107	1,043,102	1,283,950	1,283,950	14,402	1,298,352			8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000	18,000		18,000			9
10	Nursing and Medical Records	1,899,387	98,504	21,456	2,019,347	2,019,347		2,019,347			10
10a	Therapy	468,202	8,080		476,282	476,282		476,282			10a
11	Activities	149,177	28,289	2,496	179,962	179,962		179,962			11
12	Social Services	51,311		2,898	54,209	54,209		54,209			12
13	CNA Training										13
14	Program Transportation			36,066	36,066	36,066		36,066			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,568,077	134,873	80,916	2,783,866	2,783,866		2,783,866			16
	C. General Administration										
17	Administrative	112,856		18,000	130,856	130,856	133,716	264,572			17
18	Directors Fees										18
19	Professional Services			149,936	149,936	149,936	(10,992)	138,944			19
20	Dues, Fees, Subscriptions & Promotions			105,790	105,790	105,790	(42,725)	63,065			20
21	Clerical & General Office Expenses	219,237	24,593	755,403	999,233	999,233	(593,641)	405,592			21
22	Employee Benefits & Payroll Taxes			614,994	614,994	614,994		614,994			22
23	Inservice Training & Education			9,485	9,485	9,485		9,485			23
24	Travel and Seminar						1,826	1,826			24
25	Other Admin. Staff Transportation			27,439	27,439	27,439	1,526	28,965			25
26	Insurance-Prop.Liab.Malpractice			135,511	135,511	135,511	8,896	144,407			26
27	Other (specify):*			120,000	120,000	120,000	(62,262)	57,738			27
28	TOTAL General Administration	332,093	24,593	1,936,558	2,293,244	2,293,244	(563,656)	1,729,588			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,009,911	290,573	3,060,576	6,361,060	6,361,060	(549,254)	5,811,806			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	0
	REPAIRS & MAINTENANCE	0
	CONTRACTED DIETARY SERVICES	578,539
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICES	188,486
		188,486
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,957
	CONTRACTED LAUNDRY SERVICES	125,657
		127,614
5	HEAT & OTHER UTILITIES	
	GAS HEAT	32,029
	ELECTRICITY	44,575
	WATER	31,382
	CABLE TV - LOBBY	0
		107,986
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,043
	PAINTING & DECORATING	3,656
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,092
	ELEVATOR MAINTENANCE & REPAIR	2,991
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,728
	FIRE SERVICE	0
		26,510
7	OTHER	
	SCAVENGER	13,967
	SECURITY SERVICE	0
		13,967
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	8,366
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	8,250
	RN CONSULTANT XVIII B 38-2	4,840
		21,456
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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,496
		2,496
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,898
		2,898
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		36,066
			36,066
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	18,000
18	DIRECTORS FEES		
	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	72,201
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	77,735
			149,936
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	44,309
	EMPLOYEE WANT ADS	XIX F	36,488
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	14,571
	LICENSES & PERMITS	XIX F	8,334
	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	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,088
	PATIENT BACKGROUND CHECKS	XIX F	0
			105,790
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,284
	EQUIPMENT REPAIR & MAINTENANCE		27,668
	OUTSIDE CLERICAL SERVICES		700,800
	PENALTIES / OVERDRAFT CHARGES	VI 18	556
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		18,095
	MESSENGER SERVICE		0
			755,403

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	227,795
	UNEMPLOYMENT COMPENSATION	XIX D	58,371
	WORKERS COMPENSATION INSURANCE	XIX D	62,838
	HOSPITALIZATION INSURANCE	XIX D	224,965
	EMPLOYEE BENEFITS - OTHER	XIX D	41,025
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
			614,994
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		9,485
			9,485
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		27,439
			27,439
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		135,511
			135,511
27	OTHER		
	BAD DEBTS	VI 24	120,000
			120,000

GRAND TOTAL COLUMN 3 OTHER

3,060,576

**WATERFRONT TERRACE
SCHEDULES
12/31/2016**

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

TOTAL FOOD PURCHASE	503
LESS SALES TAX	<u>(157)</u>
NET FOOD	346
TOTAL PATIENT CENSUS	38,312
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	114,936
ADD # EMPLOYEE MEALS/DAY TIMES # DAYS	<u>43,188</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	114,936
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	114,936
NET FOOD	346
DIVIDE TOTAL MEALS/YEAR	<u>114,936</u>
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

Facility Name & ID Number WATERFRONT TERRACE

#0028076

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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			143,757	143,757		143,757	41,420	185,177			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			104,410	104,410		104,410	274,278	378,688			32
33	Real Estate Taxes							208,883	208,883			33
34	Rent-Facility & Grounds			813,000	813,000		813,000	(813,000)				34
35	Rent-Equipment & Vehicles			27,457	27,457		27,457	11,859	39,316			35
36	Other (specify):*											36
37	TOTAL Ownership			1,088,624	1,088,624		1,088,624	(276,560)	812,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,482		118,482		118,482		118,482			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			276,849	276,849		276,849		276,849			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		118,482	276,849	395,331		395,331		395,331			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,009,911	409,055	4,426,049	7,845,015		7,845,015	(825,814)	7,019,201			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	24,709	30		9
10	Interest and Other Investment Income	(2,026)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	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	(556)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(16,494)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	27		24
25	Fund Raising, Advertising and Promotional	(44,309)	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 SEE PG 5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (158,833)		\$	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)	(666,981)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (666,981)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (825,814)		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	

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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	(157)	0	0	0	0	0	0	0	0	0	0	(157)	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	979	0	0	0	0	0	0	0	0	979	5
6	Maintenance	0	0	6,264	6,447	0	0	0	0	0	0	0	12,711	6
7	Other (specify):*	0	0	201	0	668	0	0	0	0	0	0	869	7
8	TOTAL General Services	(157)	0	7,444	6,447	668	0	0	0	0	0	0	14,402	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	(18,000)	0	151,716	0	0	0	0	0	0	0	133,716	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,494)	0	5,502	0	0	0	0	0	0	0	0	(10,992)	19
20	Fees, Subscriptions & Promotions	(44,309)	0	1,584	0	0	0	0	0	0	0	0	(42,725)	20
21	Clerical & General Office Expenses	(556)	(700,800)	98,474	9,241	0	0	0	0	0	0	0	(593,641)	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	1,826	0	0	0	0	0	0	0	0	1,826	24
25	Other Admin. Staff Transportation	0	0	1,526	0	0	0	0	0	0	0	0	1,526	25
26	Insurance-Prop.Liab.Malpractice	0	5,978	2,918	0	0	0	0	0	0	0	0	8,896	26
27	Other (specify):*	(120,000)	0	16,487	0	41,251	0	0	0	0	0	0	(62,262)	27
28	TOTAL General Administration	(181,359)	(712,822)	128,317	160,957	41,251	0	0	0	0	0	0	(563,656)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(181,516)	(712,822)	135,761	167,404	41,919	0	0	0	0	0	0	(549,254)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	24,709	14,070	2,641	0	0	0	0	0	0	0	0	41,420	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,026)	274,005	2,299	0	0	0	0	0	0	0	0	274,278	32
33	Real Estate Taxes	0	205,025	3,858	0	0	0	0	0	0	0	0	208,883	33
34	Rent-Facility & Grounds	0	(813,000)	0	0	0	0	0	0	0	0	0	(813,000)	34
35	Rent-Equipment & Vehicles	0	0	11,859	0	0	0	0	0	0	0	0	11,859	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	22,683	(319,900)	20,657	0	0	0	0	0	0	0	0	(276,560)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(158,833)	(1,032,722)	156,418	167,404	41,919	0	0	0	0	0	0	(825,814)	45

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	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	\$ 18,000	DYNAMIC HEALTH CARE CONSULTANT		\$	\$ (18,000)	1
2	V	21 BOOKKEEPING SERVICE	700,800	" "			(700,800)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	813,000	WATERFRONT TERRACE ASSOCIATES			(813,000)	7
8	V	30 DEPRECIATION		" "		14,070	14,070	8
9	V	32 INTEREST		" "		274,005	274,005	9
10	V	33 REAL ESTATE TAXES		" "		205,025	205,025	10
11	V	6 REPAIRS & MAINTENANCE		" "				11
12	V	26 INSURANCE		" "		5,978	5,978	12
13	V							13
14	Total		\$ 1,531,800			\$ 499,078	\$ * (1,032,722)	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%	\$ 979	\$	979	15
16	V	6 REPAIR & MAINT.		" "		6,264		6,264	16
17	V	7 EMP BEN-GEN SERV		" "		201		201	17
18	V	19 PROFESSIONAL FEES		" "		5,502		5,502	18
19	V	20 DUES AND SUBSCRIPTION		" "		1,584		1,584	19
20	V	21 CLERICAL & GENERAL		" "		98,474		98,474	20
21	V	24 SEMINARS AND TRAVEL		" "		1,826		1,826	21
22	V	25 AUTO EXPENSE		" "		1,526		1,526	22
23	V	26 INSURANCE		" "		2,918		2,918	23
24	V	27 EMP. BEN. - GEN, ADMIN.		" "		16,487		16,487	24
25	V	30 DEPRECIATION		" "		2,641		2,641	25
26	V	32 INTEREST		" "		2,299		2,299	26
27	V	33 REAL ESTATE TAXES		" "		3,858		3,858	27
28	V	19 REAL ESTATE TAX PROTEST FEES		" "					28
29	V	35 AUTO RENTAL		" "		11,098		11,098	29
30	V	35 EQUIPMENT RENTAL		" "		761		761	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		\$			\$ 156,418	\$ *	156,418	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%	\$ 6,447	\$	6,447	15
16	V	17 ADMIN COMP - M MAUER		" "		19,381		19,381	16
17	V	17 ADMIN COMP - M AARON		" "		22,106		22,106	17
18	V	17 ADMIN COMP - F AARON		" "		500		500	18
19	V	17 ADMIN COMP - D AARON		" "					19
20	V	17 ADMIN COMP - S GOLDSTEIN		" "					20
21	V	17 ADMIN COMP - B FREIDMAN		" "					21
22	V	17 ADMIN COMP - R AARON		" "					22
23	V	17 ADMIN COMP - S HARAMARAS		" "		24,298		24,298	23
24	V	17 ADMIN COMP - D KUFTA		" "		16,306		16,306	24
25	V	17 ADMIN COMP - HOWARD ALTER		" "		12,000		12,000	25
26	V	17 ADMIN COMP - NON OWNER - V DAVIS		" "		12,891		12,891	26
27	V	17 ADMIN COMP - NON OWNER - A CASSATA		" "					27
28	V	17 ADMIN COMP - NON OWNER - VAR		" "		20,461		20,461	28
29	V	17 ADMIN COMP - NON OWNER - CFO		" "		23,773		23,773	29
30	V	21 CLERICAL COMP - S AARON		" "		8,635		8,635	30
31	V	21 CLERICAL COMP - E MARYLES		" "		606		606	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 167,404	\$ *	167,404	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP BEN - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 668	\$	668	15
16	V	27 EMP BEN - M MAUER		" "		4,020		4,020	16
17	V	27 EMP BEN - M AARON		" "		4,190		4,190	17
18	V	27 EMP BEN - F AARON		" "		7,947		7,947	18
19	V	27 EMP BEN - D AARON		" "					19
20	V	27 EMP BEN - S GOLDSTEIN		" "					20
21	V	27 EMP BEN - B FREIDMAN		" "					21
22	V	27 EMP BEN - R AARON		" "					22
23	V	27 EMP BEN - S HARAMARAS		" "		9,194		9,194	23
24	V	27 EMP BEN - D KUFTA		" "		1,147		1,147	24
25	V	27 EMP BEN - HOWARD ALTER		" "		1,060		1,060	25
26	V	27 EMP BEN - V DAVIS		" "		3,257		3,257	26
27	V	27 EMP BEN - A CASSATA		" "					27
28	V	27 EMP BEN - NON OWNER		" "		5,789		5,789	28
29	V	27 EMP BEN - NON OWNER - CFO		" "		2,498		2,498	29
30	V	27 EMP BEN - S AARON		" "		1,776		1,776	30
31	V	27 EMP BEN - E MARYLES		" "		373		373	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 41,919	\$ *	41,919	39

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

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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			WOODBIDGE NURSING PAVILION LTD	CHICAGO				9
10			WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11			WOODRIDGE SUPPORTING LIVING RESID	GENESEO				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

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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		SCHEDULE	3.88	9.69	SALARY	\$ 19,381	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATION		ATTACHED	4.42	11.05	SALARY	22,106	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATION			9		SALARY	42,000	21-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATION					SALARY	500	17-7	4
5	SHARON AARON	SHAREHOLDER	CLERICAL			3.88	9.69	SALARY	8,635	21-7	5
6	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR			40		SALARY	112,856	17-1	6
7	HOWARD ALTER	SHAREHOLDER	ADMINISTRATOR					SALARY	12,000	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.27	0.97	SALARY	606	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 218,084		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: 01/01/2016

Ending: 2/31/2016

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 STREET
 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	PATIENT DAYS	415,748	13	\$ 10,619	\$ 38,312	\$ 979	1	
2	6	REPAIR & MAINT.	PATIENT DAYS	415,748	13	67,972	32,339	38,312	6,264	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	415,748	13	2,182	38,312	201	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	415,748	13	59,702	38,312	5,502	4	
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	415,748	13	17,185	38,312	1,584	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	415,748	13	1,068,604	741,401	38,312	98,474	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	415,748	13	19,810	38,312	1,826	7	
8	25	AUTO EXPENSE	PATIENT DAYS	415,748	13	16,560	38,312	1,526	8	
9	26	INSURANCE	PATIENT DAYS	415,748	13	31,660	38,312	2,918	9	
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	415,748	13	178,906	38,312	16,487	10	
11	30	DEPRECIATION	PATIENT DAYS	415,748	13	28,663	38,312	2,641	11	
12	32	INTEREST	PATIENT DAYS	415,748	13	24,945	38,312	2,299	12	
13	33	REAL ESTATE TAXES	PATIENT DAYS	415,748	13	41,869	38,312	3,858	13	
14	19	REAL ESTATE TAX PROTEST FE	PATIENT DAYS	415,748	13		38,312	0	14	
15	35	AUTO RENTAL	PATIENT DAYS	415,748	13	120,431	38,312	11,098	15	
16	35	EQUIPMENT RENTAL	PATIENT DAYS	415,748	13	8,254	38,312	761	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,697,362	\$ 773,740	\$ 156,418	25	

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2016

Ending: 2/31/2016

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 STREET
 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	9	\$ 58,328	\$ 58,328	4	\$ 6,447	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	4	19,381	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	4	22,106	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500	9	500	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	76,541	76,541			5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	182,833	182,833			6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS	40	1	200,000	200,000			7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	60,541	60,541			8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	72,895	72,895	10	24,298	9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	147,459	147,459	6	16,306	10
11	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000		12,000	11
12	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	10	133,035	133,035	4	12,891	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS	40	1	94,167	94,167			13
14	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	45	8	185,179	185,179	5	20,461	14
15	17	ADMIN COMP - NON OWNER - C	WGHTD AVG HOURS	40	10	245,335	245,335	4	23,773	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	89,040	89,040	4	8,635	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	62,541	62,541	0	606	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,022,394	\$ 2,022,394		\$ 167,404	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2016

Ending: 2/31/2016

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 STREET
 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	9	\$ 6,047	\$ 4	\$ 668	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	41,488	4	4,020	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	37,909	4	4,190	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	39,733	9	7,947	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	6,379			5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	36,760			6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS	40	1	10,395			7
8	27	EMP BEN - R AARON	WGHTD AVG HOURS	40	1	4,779			8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	27,583	10	9,194	9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,371	6	1,147	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,060		1,060	11
12	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	10	33,608	4	3,257	12
13	27	EMP BEN - A CASSATA	WGHTD AVG HOURS	40	1	7,352			13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	52,388	5	5,789	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	10	25,777	4	2,498	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	18,319	4	1,776	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	38,523	0	373	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 398,471	\$	\$ 41,919	25

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	HUD		X	MORTGAGE			\$	\$ 6,808,340			\$	274,005					
2																	
3																	
4																	
5																	
Working Capital																	
6	BANK FINANCIAL		X	WORKING CAPITAL				852,138				34,827					
7	INTERCOMPANY	X		WORKING CAPITAL				1,835,334				69,583					
8																	
9	TOTAL Facility Related						\$	\$ 9,495,812			\$	378,415					
B. Non-Facility Related*																	
10	IRS,IDR,ETC		X	LATE FEES													
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$ 9,495,812			\$	378,415					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2015 report.	\$	180,000	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.)	\$	192,025	2
3. Under or (over) accrual (line 2 minus line 1).	\$	12,025	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	193,000	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 \$ <u>200</u> For <u> </u> 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.	\$	205,025	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	107,696	8
	2012	171,119	9
	2013	173,434	10
	2014	176,928	11
	2015	192,025	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2015 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.

2015 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 2015 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 2015.

(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>186,586.48</u>	\$ <u>186,586.48</u>
2. <u>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>2,506.46</u>	\$ <u>2,506.46</u>
3. <u>21-30-412-033-0000</u>	<u>PARKING LOT</u>	\$ <u>2,931.59</u>	\$ <u>2,931.59</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>192,024.53</u></u>	\$ <u><u>192,024.53</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,950 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETI 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

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	\$ 1,454,153	4
5										5
6										6
7	RELATED PARTY			40,879	1,048		1,168	120	27,252	7
8										8
Improvement Type**										
9	ROOF	1983		21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT	1985		950		15			950	10
11	LEASEHOLD IMPROVEMENT	1986		3,800		10			3,800	11
12	LEASEHOLD IMPROVEMENT	1986		1,005		15			1,005	12
13	ROOF	1990		13,634		10			13,634	13
14	SUSPENDED CEILING	1990		20,776		15			20,776	14
15	LEASEHOLD IMPROVEMENT	1991		7,956		10			7,956	15
16	LEASEHOLD IMPROVEMENT	1991		1,491		15			1,438	16
17	LEASEHOLD IMPROVEMENT	1992		18,033		10			18,033	17
18	LEASEHOLD IMPROVEMENT	1992		1,097		15			1,097	18
19	LEASEHOLD IMPROVEMENT	1993		7,742		31.5	246	246	5,832	19
20	LEASEHOLD IMPROVEMENT	1993		3,426		39	88	88	2,064	20
21	LEASEHOLD IMPROVEMENT	1994		25,007		39	642	642	14,417	21
22	ELEVATOR REPAIR	1995		1,500		39	38	38	834	22
23	SPRINKLER REPAIR	1995		4,154		39	107	107	2,331	23
24	BOILER REPAIR, WATER PUMP, ALARM	1996		6,033		39	154	154	3,190	24
25	FENCING	1996		756		15			756	25
26	NURSE STATION	1996		5,300		39	136	136	2,737	26
27	HANDRAILS	1996		3,735		39	96	96	1,924	27
28	PARKING LOT REPAVING	1997		11,968		15			11,968	28
29	TUCKPOINTING, ROOF REPAIR	1997		25,814	662	39	662		12,826	29
30	DRAPERY	1997		14,754	378	39	378		7,316	30
31	DOORS & SIGNS	1997		8,428	216	39	216		4,185	31
32	AIR HANDLER REPAIR & PUMPS	1997		17,005	436	39	436		8,448	32
33	REMODELING	1997		59,133	1,517	39	1,517		29,550	33
34	NURSE STATION	1997		5,106	131	39	131		2,538	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:

01/01/2016 Ending: 12/31/2016

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		\$ 21,180	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		3,048	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		1,721	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		3,784	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		952	41
42	REMODELING	1998	21,934	562	39	562		10,350	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		6,271	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		1,811	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		9,929	45
46	ANTENNA & INSTALLATION	1998		444	39		(444)		46
47	LIGHT FIXTURES, ARTWORK	1998	4,791	258	39	258		4,757	47
48	FIRE ALARM	1999	10,286	264	39	264		4,672	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		16,128	49
50	BOILER WORK	1999	7,345	189	39	189		3,336	50
51	CABLE WORK	1999	433	11	39	11		196	51
52	CARPET	1999	18,828	483	39	483		8,497	52
53	ELEVATOR WORK	1999	2,017	52	39	52		919	53
54	AIR CONDITIONING	1999	7,350	189	39	189		3,364	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		4,075	55
56	ROOF WORK	1999	2,187	56	39	56		982	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		26,435	57
58	WINDOWS	1999	5,513	142	39	142		2,494	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		14,530	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		8,809	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		78,985	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		9,848	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		1,673	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		6,099	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		1,916	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		6,190	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		47,972	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		4,411	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		1,586	69
70	TOTAL (lines 4 thru 69)		\$ 2,480,665	\$ 22,813		\$ 67,082	\$ 44,269	\$ 1,999,717	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:

01/01/2016 Ending: 12/31/2016

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		\$ 2,480,665	\$ 22,813		\$ 67,082	\$ 44,269	\$ 1,999,717	1
2	EXHAUST FAN	2000	890	32	27.5	32		537	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		667	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		1,868	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7			11,247	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		4,275	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		3,527	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		3,242	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		3,497	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		1,393	10
11	AC UNIT	2001	786	28	27.5	28		436	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		2,990	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		2,947	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		1,211	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		1,951	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		943	16
17	GENERATOR REPAIRS	2003	71,609	1,125	27.5	1,125		20,255	17
18	DECK & FENCE	2004	10,197	680	15	680		8,500	18
19	A/C REPAIR	2004	2,200	80	27.5	80		996	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		2,031	20
21	WATER HEATER	2004	6,937	252	27.5	252		3,140	21
22	NURSE CALL STATION	2004	585	21	27.5	21		262	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		572	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	29,943	1,370	27.5	1,370		15,698	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		6,978	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		8,101	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		5,374	27
28	ROOF REPAIRS	2005	726	26	27.5	26		298	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		1,833	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		424	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		3,263	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		1,182	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		12,540	33
34	TOTAL (lines 1 thru 33)		\$ 2,772,448	\$ 32,125		\$ 76,394	\$ 44,269	\$ 2,131,895	34

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

Facility Name & ID Number WATERFRONT TERRACE

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Report Period Beginning:

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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		\$ 2,772,448	\$ 32,125		\$ 76,394	\$ 44,269	\$ 2,131,895	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		774	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		2,698	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		25,550	4
5	DOORS	2006	15,104	549	27.5	549		5,742	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		2,102	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		27,610	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		1,412	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		627	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		941	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		565	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		1,129	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		1,140	13
14	PUMPS & CONTROL PANEL	2007	12,904	552	27.5	552		5,221	14
15	WALLCOVERING & VINYL	2007	22,847	883	27.5	883		8,352	15
16	AIR CONDITIONERS	2007	13,918	506	27.5	506		4,786	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	29,535	3,547	27.5		(3,547)	29,535	17
18	ELEVATOR WORK	2007	77,074	2,803	27.5	2,803		26,512	18
19	DOORS & FRAMES	2007	18,896	687	27.5	687		6,498	19
20	SIGNAGE	2007		87	27.5	87		823	20
21	BOILER WORK	2007		67	27.5	67		633	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	18,025	844	27.5	844		7,983	22
23	ELECTRICAL WORK	2007	2,950	172	27.5	172		1,627	23
24	PLUMBING WORK	2007		100	27.5	100		946	24
25	CABLING OF BUILDING	2007	9,497	691	27.5	691		6,535	25
26	DOORS & FRAMES	2008	11,285	410	27.5	410		3,468	26
27	FIRE ALARM SYSTEM	2008	59,313	2,157	27.5	2,157		18,245	27
28	AIR CONDITIONERS	2008	8,615	313	27.5	313		2,647	28
29	SMOKE DETECTORS-RESIDENT ROOMS	2008	10,115	368	27.5	368		3,113	29
30	ELECTRICAL WORK	2008	23,305	848	27.5	848		7,172	30
31	SECURITY SYSTEM REPAIRS	2008	3,965	144	27.5	144		1,218	31
32	PLASTER & PAINT RESIDENT BATHROOMS	2008	5,200	189	27.5	189		1,599	32
33	PLUMBING REPAIRS	2008	10,426	379	27.5	379		3,206	33
34	TOTAL (lines 1 thru 33)		\$ 3,295,148	\$ 54,593		\$ 95,315	\$ 40,722	\$ 2,342,304	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:

01/01/2016 Ending: 12/31/2016

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		\$ 3,295,148	\$ 54,593		\$ 95,315	\$ 40,722	\$ 2,342,304	1
2	REFRIGERATOR REPAIRS	2008	1,721	63	27.5	63		533	2
3	ARTWORK CORRIDOR & DINING ROOM	2008	1,521	55	27.5	55		465	3
4	R FIRE ALARM SYSTEM REPAIRS	2009	10,970	469	27.5	469		3,498	4
5	ELECTRICAL WORK	2009	53,455	1,944	27.5	1,944		14,499	5
6	ELEVATOR REPAIRS	2009	23,314	847	27.5	847		6,318	6
7	CARPET, TILE & VINYL	2009	5,857	213	27.5	213		1,589	7
8	AIR CONDITIONERS & SLEEVES	2009	6,183	225	27.5	225		1,678	8
9	DOORS	2009	3,967	144	27.5	144		1,074	9
10	PLUMBING REPAIRS	2009	15,124	550	27.5	550		4,102	10
11	DISH NETWORK EQUIPMENT	2009		58	27.5		(58)		11
12	EMERGENCY ALARM CONTROL PANEL	2009		43	27.5		(43)		12
13	DOORS AND ACCESSORIES, DOOR ALARM & KEY PAD	2010	17,232	627	27.5	627		4,049	13
14	REPLACE WATER TUBES AND GASKET	2010		72	27.5		(72)		14
15	AIR CONDITIONERS, REPLACE AIR HANDLER MOTOR	2010	13,721	499	27.5	499		3,223	15
16	ROOF REPAIR	2010	4,135	150	27.5	150		969	16
17	CEILING PIPING REPAIRS- FRONT OFFICE	2010	4,850	176	27.5	176		1,137	17
18	INSTALL FIRE DAMPERS, FIRE, CIRCULATING, BRONZ PUM	2010	5,689	207	27.5	207		1,337	18
19	BASEMENT REPAIRS	2010	2,600	95	27.5	95		613	19
20	REPLACE PRIMARY PUMP IN BASEMENT	2010	2,400	87	27.5	87		562	20
21	2ND FLOOR PATIENTS BATHROOMS AND ROOMS:	2010	54,081	1,967	27.5	1,967		12,703	21
22	INSTALL NEW WALLS, CERAMIC TILE, CALL LIGHT								22
23	LIGHTING ACCESSORIES, FIXTURES, LAMPS	2010	12,135	441	27.5	441		2,848	23
24	UTILITY ROOM SINK, REPAIR SPRINKLER SYSTEM	2010	3,299	120	27.5	120		775	24
25	WALL PROTECTION HANDRAILS	2010	9,634	350	27.5	350		2,261	25
26	BUMBERS AROUND GARBAGE AREA	2010	4,766	173	27.5	173		1,117	26
27	WALL COVERING, CUBICLE CURTAINS	2010	5,711	208	27.5	208		1,343	27
28	INSTALL STAIN & RAMP RAILINGS, SECURITY SYSTEM	2010	3,175	115	27.5	115		743	28
29	REPLACE ELECTRIC FOR TV ABOVE CEILING	2010	2,700	98	27.5	98		633	29
30	3RD FLOOR-REPLACE LIGHTS, INSTALL WATT FIXTURE	2010	3,328	121	27.5	121		781	30
31	NORTH SIDE EAST END-PERLACE BUILDING LIGHTS	2010	3,052	111	27.5	111		717	31
32	INSTALL OUTDOOR LIGHTING	2010	7,250	264	27.5	264		1,705	32
33	PATIO ROOMS-NEW DOOR, TILE, FLOOR, LIGHTING	2010	13,417	488	27.5	488		3,152	33
34	TOTAL (lines 1 thru 33)		\$ 3,590,435	\$ 65,573		\$ 106,122	\$ 40,549	\$ 2,416,728	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:

01/01/2016 Ending: 12/31/2016

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		\$ 3,590,435	\$ 65,573		\$ 106,122	\$ 40,549	\$ 2,416,728	1
2	AIR COMPRESSOR COIL REPAIR	2010		68	27.5	68		439	2
3	RECEPTION DESK/CABINETS	2011	4,802	592	27.5	592		3,231	3
4	WALLCOVERING/WINDOW TREATMENTS/ARTWORK/CO.	2011	29,370	1,298	27.5	1,298		7,085	4
5	FLOORING/WINDOW TREATMENTS	2011	96,290	3,501	27.5	3,501		19,110	5
6	DOORS/KICK PLATES	2011	22,647	824	27.5	824		4,497	6
7	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	57,913	2,106	27.5	2,106		11,495	7
8	SEE PAGE 12 F LINES 3-5								8
9	WINDOWS	2011	42,760	2,624	27.5	2,624		14,323	9
10	ROOD REPAIRS/AIR HANDLER	2011	9,686	403	27.5	403		2,200	10
11	STAIRWELL CRASH RAILS	2011	5,242	191	27.5	191		1,042	11
12	LOBBY HEAT/COOL/FLOORING	2011	29,666	1,079	27.5	1,079		5,889	12
13	SEE PAGE 12 F LINES 7-13								13
14	CAPRET, CORNER GUARDS-OFFICE, RECEPTION	2011	5,247	191	27.5	191		1,042	14
15	DOORS - RESIDENT RMS,TUB ROOM FRONT LOBBY	2011	3,370	122	27.5	122		666	15
16	BATHROOM PLUMBING/FIXTURES/ELECTRIC	2011	109,505	5,437	27.5	5,437		29,679	16
17	SEE PAGE 12 F LINES 15-22								17
18	HOT WATER HEATERS/PLUMBING WORK	2011	18,765	682	27.5	682		3,723	18
19	RECEPTION DESK	2011	21,772	792	27.5	792		4,323	19
20	ROOF REPAIR	2011		84	27.5	84		458	20
21	SECURITY/FIRE SYSTEM REPAIR	2011	19,325	703	27.5	703		3,837	21
22	HEATERS/AC UNIT	2011	17,028	619	27.5	619		3,379	22
23	SCANNERS/COMPUTER CABLING	2011	14,594	1,288	27.5	1,288		7,030	23
24	SEE PAGE 12 F LINES 24-27								24
25	SECURITY/FIRE SYSTEM REPAIR	2012	12,807	467	27.5	467		2,082	25
26	HEATING & AIR CONDITIONING	2012	7,695	255	27.5	255		1,148	26
27	LAUNDRY ROOM PIPING & REPAIR	2012	27,596	976	27.5	976		4,365	27
28	WINDOW TRTMTS, CABINETS, PICTURES-OFFICE,NURSES	2012	7,820	297	27.5	297		1,319	28
29	ELEVATOR REPAIR	2012	10,300	382	27.5	382		1,700	29
30	DOORS, TILE - TUB, RESIDENT, MEDICATION RM	2012	4,215	170	27.5	170		750	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,168,850	\$ 90,724		\$ 131,273	\$ 40,549	\$ 2,551,540	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:

01/01/2016 Ending: 12/31/2016

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		\$ 4,168,850	\$ 90,724		\$ 131,273	\$ 40,549	\$ 2,551,540	1
2	PAGE 12 E LINE 8								2
3	PLUMBING/ELECTRIC- KITCHEN	2011	11,675	418	27.5	418		2,281	3
4	PLUMBING/ELECTRIC - BOILER/MECHANICAL ROOMS	2011	27,323	986	27.5	986		5,382	4
5	PLUMBING/ELECTRIC - BASEMENT	2011	6,944	267	27.5	267		1,458	5
6	PAGE 12 E LINE 13								6
7	CUBICLE CURTAINS - SPA AREA	2011		48	27.5	48		262	7
8	PLASTER & PAINT - BACK STAIRWAY	2011	3,227	115	27.5	115		628	8
9	PLASTER & PRIME FLOORS - BASEMENT TO 4TH FL	2011	2,750	96	27.5	96		524	9
10	WALLPAPER,PAINT,WINDOW TRTMTS OFFICES	2011	11,466	413	27.5	413		2,254	10
11	MIRRORS & LIGHT FIXTURES - BATHROOM	2011		58	27.5	58		316	11
12	LIGHT FIXTURES INTSL - DINING ROOM	2011	3,600	135	27.5	135		736	12
13	WINDOW TRTMTS & LIGHTING - RESIDENT ROOMS	2011		96	27.5	96		525	13
14	PAGE 12 E LINE 17								14
15	ELECTRIC REPAIR/REPLACE - ELEVATOR ROOM	2011	1,860	60	27.5	60		327	15
16	ELECTRIC REPAIR/REPLACE - BATHROOMS	2011	8,200	298	27.5	298		1,627	16
17	ELECTRIC REPAIR/REPLACE - FIRE ALARMS 1,2,3 FLOOR	2011	4,800	179	27.5	179		977	17
18	ELECTRIC REPAIR/REPLACE - OXYGEN ROOM	2011	2,080	80	27.5	80		436	18
19	ELECTRIC REPAIR/REPLACE - NURSE CALL	2011	630	20	27.5	20		109	19
20	ELECTRIC REPAIR/REPLACE - KITCHEN & OFFICE	2011	19,471	716	27.5	716		3,908	20
21	ELECTRIC REPAIR/REPLACE - 2 & 3 FLOOR	2011	13,725	497	27.5	497		2,713	21
22	ELECTRIC REPAIR/REPLACE - TV ROOMS	2011	3,900	138	27.5	138		754	22
23	PAGE 12 E LINE 24								23
24	PLUMBING/ELECTRIC WORK - NURSE STATION	2012	1,040	42	27.5	42		183	24
25	PLUMBING/ELECTRIC WORK - TUB ROOM	2012	9,020	339	27.5	339		1,503	25
26	PLUMBING/ELECTRIC WORK - KITCHEN, HALL, RESIDEN	2012	27,757	1,018	27.5	1,018		4,527	26
27	PLUMBING/ELECTRIC WORK - LAUNDRY, BOILER ROOM	2012	8,416	297	27.5	297		1,343	27
28									28
29	LABEL & LOCK ELECTRIC PANELS-1SR,2ND,3RD FL, KITC	2013	11,225	408	27.5	408		1,418	29
30	EXTERIOR DOORS, CLOSERS & CLOSED CIRCUIT TV'S	2013	8,103	295	27.5	295		1,017	30
31	PLUMBING-MEN'S RM, BOILER RM,	2013	5,500	200	27.5	200		684	31
32	DOORS, CLOSERS & CLOSED CIRCUIT CAMERAS	2013	10,681	388	27.5	388		1,357	32
33	BATHROOM PLUMBING & ELECTRIC WORK	2013	5,980	217	27.5	217		747	33
34	TOTAL (lines 1 thru 33)		\$ 4,378,223	\$ 98,548		\$ 139,097	\$ 40,549	\$ 2,589,536	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:

01/01/2016 Ending: 12/31/2016

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 12F, Carried Forward		\$ 4,378,223	\$ 98,548		\$ 139,097	\$ 40,549	\$ 2,589,536	1
2	KITCHEN ELECTRIC & GRANITE COUNTERTOP& TRAP COVE	2013	4,750	173	27.5	173		591	2
3	HOT WATER HEATER & BOOSTER	2013	2,867	104	27.5	104		360	3
4	1ST, 2ND & 3RD FLOOR ELECTRICAL REPAIRS	2013	9,405	342	27.5	342		1,182	4
5	ELEVATOR UPGRADES	2013	4,900	178	27.5	178		618	5
6	CONFIGURED PHONE SETS & INTERCOM HANDLE CAP	2013	3,565	130	27.5	130		450	6
7	THRU WALL AIR CONDITIONERS	2013	5,217	190	27.5	190		654	7
8	ROOF REPAIR	2014	5,112	131	39	131		347	8
9	CEILING TILES	2014	945	24	39	24		64	9
10	7 BIRCH DOORS & DOOR CLOSERS	2014	2,998	77	39	77		204	10
11	LIGHTING MAIN LOBBY	2014	163	4	39	4		11	11
12	KEY PADS-3RD FLOOR ALARM,MAINTENANCE ROOM	2014	975	25	39	25		66	12
13	REPLACE WATER DAMAGED SMOKE DETECTOR ROOM 310	2014	1,038	27	39	27		71	13
14	WINDOW INSTALL	2014	585	15	39	15		40	14
15	INSTALL 200 AMP IN ELEVATOR ROOM	2014	1,960	50	39	50		133	15
16	REPAIR CUT WIRES ROOMS 205-211, 305, 303, 317	2014	2,500	64	39	64		170	16
17	OPEN SECTION OF CEILING & FLOOR TO REPAIR RADIATOR	2014	1,600	41	39	41		109	17
18	SWITCHES FOR NURSE STATION HALLWAY 2ND & 3RD FLOOR &				39				18
19	PIPE 4TH FLOOR FOR POWER TO MAIN COMPUTER	2014	1,870	48	39	48		127	19
20	REPLACE 15 AMP WITH 20 AMP ON 1ST & 2ND FLOOR, 2 SWITCHES ON 1ST FLOOR &				39				20
21	LIGHTS ON 1ST & 2ND FLOOR	2014	4,200	108	39	108		286	21
22	REPLACED LIGHTS BASEMENT, 2ND & 3RD FLOORS	2014	1,360	35	39	35		93	22
23	4 WEATHER PROOF LIGHT FIXTURES, REPAIR BREAKERS IN				39				23
24	LIVING ROOM	2014	1,100	28	39	28		74	24
25	HALLWAY LOUVERED SUPPLY REGISTERS	2014	1,521	39	39	39		103	25
26	ROOM 209 CALL SWITCH	2014	510	13	39	13		35	26
27	ROOM 118 REPAIR DAMAGED AC WIRING	2014	1,190	31	39	31		82	27
28	REMOVE 7 REPLACE SLOP SINKS & DRAIN PIPING JANITORS CLOSET				39				28
29	1ST, 2ND, 3RD FLOORS & BASEMENT	2014	1,100	28	39	28		74	29
30	2 CURB CAPS & STAINLESS STEEL PANS FOR GREASE	2014	1,430	37	39	37		98	30
31	PLUMBING PARTS	2014	4,753	122	39	122		323	31
32	10 THRU WALL AIR CONDITIONERS	2014	5,461	140	39	140		371	32
33	DOOR STRIKE & NEW WIRES FOR INTERCOM SYSTEM	2014	565	14	39	14		37	33
34	TOTAL (lines 1 thru 33)		\$ 4,451,863	\$ 100,766		\$ 141,315	\$ 40,549	\$ 2,596,309	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:

01/01/2016 Ending: 12/31/2016

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 12G, Carried Forward		\$ 4,451,863	\$ 100,766		\$ 141,315	\$ 40,549	\$ 2,596,309	1
2	MODIFICATIONS TO KITCHEN HOOD	2014	5,987	154	39	154		408	2
3	INSTALL FIRE ALARM FOR ELEVATOR RECALL	2014	4,431	114	39	114		302	3
4	INSTALL VALVE ON COLD WATER LAUNDRY	2014	2,314	59	39	59		156	4
5	CAMERAS PATIO, 1ST FL DINING ROOM, BACK OFFICE,								5
6	NURSE STATION	2014	11,980	307	39	307		814	6
7	NURSE CALL SYSTEM	2014	20,288	520	39	520		1,378	7
8	GARAGE DOOR & OPENER	2014	2,765	71	39	71		188	8
9	EYE WASH STATIONS	2014	7,088	182	39	182		482	9
10	SPRINKLER HEADS	2014	12,421	318	39	318		843	10
11	AC REPAIR INSTALL	2015	8,908	142	39	142		256	11
12	WATER MAIN REPAIR	2015	3,250	52	39	52		94	12
13	DOOR CLOSER & ALARM REPAIR,	2015	850	14	39	14		25	13
14	TAMPER & SUPERVISORY SWITCHES	2015	2,819	45	39	45		81	14
15	WIRING FOR NEW NURSE STATION	2015	1,375	22	39	22		40	15
16	ELEVATOR REPAIR	2015	1,303	21	39	21		38	16
17	1ST & 2ND FLOOR CORRIDOR WALLPAPER & CORNER GU	2015	2,169	35	39	35		63	17
18	ACOUSTIC CEILING TILE	2015	1,172	19	39	19		34	18
19	SECURITY CAMERA	2015	1,150	18	39	18		33	19
20	WATER HEATER & INSTALL	2015	5,496	87	39	87		157	20
21	WTA-NEW ELEVATOR	2015	45,018	1,154	39	1,154		1,731	21
22	WTA- REPLACE ROOF	2015	72,975	1,871	39	1,871		2,807	22
23	WTA-KITCHEN FIRE SUPPRESSION SYSTEM	2015	1,600	41	39	41		62	23
24	WTA-CEILING TILES	2015	1,253	32	39	32		48	24
25	WTA-WALLCOVERING 1ST FLOOR CORRIDOR & PT ROO	2015	7,264	186	39	186		279	25
26	WTA-7 BATHROOMS, NEW TILE & DRYWALL	2015	26,050	669	39	669		1,003	26
27	7 BATHROOMS NEW TILE & DRYWALL	2014	28,093	447	39	447		447	27
28	2ND FLOOR CORRIDOR WALLPAPER & BUMPER GUARDS	2014	6,110	97	39	97		97	28
29	ELECTRIC WORK RESIDENT ROOMS	2015	10,106	161	39	161		161	29
30	REMOVE AND INSTALL WALLPAPER & CORNER GUARDS 1ST FLOOR CORRIDOR AND DINING ROOM				39				30
31		2015	36,735	584	39	584		584	31
32	7760 PARKING LOT AND LANDSCAPING	2015	62,768		15	4,185	4,185	4,185	32
33	NEW BOILERS	2015	48,657	774	39	774		774	33
34	TOTAL (lines 1 thru 33)		\$ 4,894,258	\$ 108,962		\$ 153,696	\$ 44,734	\$ 2,613,879	34

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

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 12H, Carried Forward		\$ 4,894,258	\$ 108,962		\$ 153,696	\$ 44,734	\$ 2,613,879	1
2	BASEMENT WINDOWS, PAINTING	2015	17,251	274		274		274	2
3	1ST FLOOR RESIDENT ROOMS, DRYWALL, PAINTING, FLO	2015	160,383	2,551		2,551		2,551	3
4	THERAPY ROOM PAINTING FLOORING	2015	10,624	169		169		169	4
5	BASEMENT WINDOWS, PAINTING,FLOORING,DOORS	2016	78,304	1,246		1,246		1,246	5
6	THERAPY ROOM FLOORING	2016	4,376	70		70		70	6
7	ELECTRIC WORK BASEMENT	2016	7,820	124		124		124	7
8	7760 PARKING LOT ARCHITECT/HANDICAP INTERCOM	2016	1,795	29		29		29	8
9	PLUMBING WORK	2016	6,166	98		98		98	9
10	WALL AC UNITS	2016	4,794	76		76		76	10
11	BEAUTY SHOP-ARTWORK	2016	842	13		13		13	11
12	KITCHEN DRAIN PIPE	2016	4,500	72		72		72	12
13	ELECTRICAL WORK	2016	3,843	61		61		61	13
14	METAL WORK, ELEVATOR DOORS, RADIATOR COVERS	2016	11,935	190		190		190	14
15	THERAPY/REHAB RM LIGHTING, FLOORING & LABOR	2016	22,183	353		353		353	15
16	BASEMENT WALLPAPER,FLOORING, ELECTRIC,ARTWOR	2016	21,092	336		336		336	16
17	VIDEO MONITORING EQUIPMENT	2016	3,302	53		53		53	17
18	HEAT BOILER & SENSOR	2016	3,178	51		51		51	18
19	WALLPAPER 4TH FLOOR CONFERENCE ROOM	2016	7,064	112		112		112	19
20	ADJ BOOK DEPN			(47,315)		(47,315)			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)		\$ 5,263,711	\$ 67,525		\$ 112,259	\$ 44,734	\$ 2,619,757	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:

01/01/2016

Ending:

12/31/2016

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	\$ 668,770	\$ 20,911	\$ 66,011	\$ 45,100	10 YRS	\$ 374,381	71
72	Current Year Purchases	119,065	71,440	5,953	(65,487)	10 YRS	5,953	72
73	Fully Depreciated Assets	923,576					923,576	73
74	RELATED PARTY	51,513	592	954	362		22,863	74
75	TOTALS	\$ 1,762,924	\$ 92,943	\$ 72,918	\$ (20,025)		\$ 1,326,773	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,126,635	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 160,468	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,177	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,709	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,946,530	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

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 21,707 Description: _____

(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		2013 BUICK ENCLAVE	\$ 549.36	\$ 2,197	17
18		2016 TOYOTA HIGHLANDER	659.00	3,295	18
19		2017 BUICK ENCLAVE	830.00	3,329	19
20		PAYROLL DEDUCTION		(3,071)	20
21	TOTAL		\$ #####	\$ 5,750	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.

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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					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				102,929		102,929	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): MED SUPPLIES, LAB, ETC						15,553		15,553	13	
14	TOTAL			\$		\$	\$ 118,482		\$ 118,482	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(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	\$	\$ 81,793	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 205,000)	1,058,398	1,058,398	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,402	106,867	6
7	Other Prepaid Expenses	6,401	6,401	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROWS		305,358	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,150,201	\$ 1,558,817	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,508,000	14
15	Leasehold Improvements, at Historical Cost	3,442,410	3,881,469	15
16	Equipment, at Historical Cost	1,711,416	1,738,275	16
17	Accumulated Depreciation (book methods)	(2,368,885)	(4,013,863)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		145,557	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,717)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	46,136	46,136	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,831,077	\$ 3,390,857	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,981,278	\$ 4,949,674	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 875,161	\$ 875,161	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	852,138	852,138	29
30	Accrued Salaries Payable	211,572	211,572	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,904	20,904	31
32	Accrued Real Estate Taxes(Sch.IX-B)		193,000	32
33	Accrued Interest Payable	16,202	38,896	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY PAYABLE	1,835,334	1,734,186	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,811,311	\$ 3,925,857	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,808,340	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)	\$	\$ 6,808,340	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,811,311	\$ 10,734,197	46
47	TOTAL EQUITY(page 18, line 24)	\$ 169,967	\$ (5,784,523)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,981,278	\$ 4,949,674	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 426,455	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 426,455	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(256,488)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (256,488)	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)	\$ 169,967	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 7,251,298	1
2	Discounts and Allowances for all Levels	(36,469)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,214,829	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	311,332	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 311,332	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***	2,026	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,026	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)	\$ 7,528,187	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,283,950	31
32	Health Care	2,783,866	32
33	General Administration	2,293,244	33
B. Capital Expense			
34	Ownership	1,088,624	34
C. Ancillary Expense			
35	Special Cost Centers	118,482	35
36	Provider Participation Fee	276,849	36
D. Other Expenses (specify):			
37	PRIOR PERIOD ADJUSTMENT	(60,340)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,784,675	40
41	Income before Income Taxes (line 30 minus line 40)**	(256,488)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (256,488)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,246,649	44
45	Private Pay - Net Inpatient Revenue	48,401	45
46	Medicare - Net Inpatient Revenue	1,829,789	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	89,990	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,214,829	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: **01/01/2016**

Ending:

12/31/2016

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	1,966	2,017	\$ 89,601	\$ 44.42	1
2	Assistant Director of Nursing	950	1,059	39,153	36.97	2
3	Registered Nurses	1,843	1,963	115,433	58.80	3
4	Licensed Practical Nurses	32,520	36,474	996,667	27.33	4
5	CNAs & Orderlies	55,017	58,634	658,533	11.23	5
6	CNA Trainees					6
7	Licensed Therapist	11,197	11,707	468,202	39.99	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	2,024	29,426	14.54	9
10	Activity Assistants	9,370	10,023	119,751	11.95	10
11	Social Service Workers	2,248	2,312	51,311	22.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,055	5,302	109,741	20.70	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,934	2,017	112,856	55.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,300	8,612	219,237	25.46	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,276	142,144	\$ 3,009,911 *	\$ 21.18	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	\$ 0	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	4,840	10-3	38
39	Pharmacist Consultant	H	8,366	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	2,496	11-3	44
45	Social Service Consultant	E	2,898	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,600		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

**WATERFRONT TERRACE
LEGAL FEES
12/31/16**

DATE	NAME	DESCRIPTION	AMOUNT
2/1/2016	MUCH SHELIST	GENERAL COUNSELING	187.50
3/1/2016	MUCH SHELIST	GENERAL COUNSELING	150.00
4/1/2016	MUCH SHELIST	GENERAL COUNSELING	3,375.00
4/25/2016	MUCH SHELIST	GENERAL COUNSELING	250.00
5/1/2016	MUCH SHELIST	GENERAL COUNSELING	2,850.00
5/31/2016	MUCH SHELIST	GENERAL COUNSELING	1,430.47
6/27/2016	MUCH SHELIST	GENERAL COUNSELING	250.00
6/30/2016	MUCH SHELIST	GENERAL COUNSELING	637.50
8/31/2016	MUCH SHELIST	GENERAL COUNSELING	837.50
9/30/2016	MUCH SHELIST	GENERAL COUNSELING	487.50
10/31/2016	MUCH SHELIST	GENERAL COUNSELING	150.00
11/30/2016	MUCH SHELIST	GENERAL COUNSELING	451.78
12/27/2016	MUCH SHELIST	GENERAL COUNSELING	350.00
12/31/2016	MUCH SHELIST	GENERAL COUNSELING	187.50
1/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	667.64
2/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	188.04
2/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	226.96
3/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	606.00
4/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,848.95
5/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	250.70
6/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	622.72
7/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	587.50
8/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	425.00
9/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	868.29
10/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	370.00
11/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	515.00
12/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,500.84
2/29/2016	SIMANDL LAW GROUP	EMPLOYEE HANDBOOK	89.59
2/29/2016	SIMANDL LAW GROUP	EMPLOYEE HANDBOOK	241.34
3/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	535.00
4/30/2016	SIMANDL LAW GROUP	FACILITY AUDITS	2,299.50
5/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	100.50
5/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	25.13
5/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	1,140.69
6/30/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	8.18
6/30/2016	SIMANDL LAW GROUP	FACILITY AUDITS	457.05
7/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	320.41
7/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	2,219.50
8/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	268.00
9/30/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	670.00
10/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	234.50
10/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	1.92
10/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	126.65
10/31/2016	SIMANDL LAW GROUP	GENERAL LITIGATION & COLLECTIONS	14.54
3/1/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	935.00
3/30/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	309.50
3/31/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	574.75
4/30/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	227.01
6/30/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	1,554.00
7/31/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	868.80
9/26/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	967.01
6/23/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	17.00
10/31/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	465.38
11/29/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	673.00
11/30/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	469.50
12/31/2016	HAMLIN & BURTON/JOHNSON & BELL	GILL,GEORGE II V. WATERFRONT TERRACE	755.00
9/1/2016		LOAN RENEWAL FEES	800.50
2/11/2016	HAMLIN & BURTON	GENERAL	131.59
			37,772.93

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC \$12,248
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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. \$ 6,695 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. \$ 276,849
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees