

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

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 Facility ID Number: <u>0028076</u></p> <p>Facility Name: <u>WATERFRONT TERRACE</u></p> <p>Address: <u>7750 S. SHORE DR.</u> <u>CHICAGO</u> <u>60645</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 679 - 8219</u> Fax # <u>(847) 679 - 7377</u></p> <p>IDPA ID Number: <u>36-3230699</u></p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<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>01/01/2000</u> to <u>12/31/2000</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Type or Print Name) <u>MARSHALL MAUER</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>TREASURER</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA/PARTNER</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1</u> (Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 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>BOB KAGDA/PARTNER</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1</u> (Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Print Preview

Facility Name & ID Number WATERFRONT TERRACE# 0028076 Report Period Beginning: 01/01/2000 Ending: 12/31/2000**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	1,243	3	1,200	2,446	8
9	SNF/PED					9
10	ICF	37,300	1,362	10	38,672	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,543	1,365	1,210	41,118	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 95.21%)D. How many bed-hold days during this year were paid by Public Aid?
1,501 (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)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO I. On what date did you start providing long term care at this location?
Date started 04/01/83J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/83 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number
of beds certified 16 and days of care provided 1105Medicare Intermediary MUTUAL OF OMAHA**IV. ACCOUNTING BASIS**ACCURAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **WATERFRONT TERRACE** # **0028076** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	148,439	23,247	7,883	179,569		179,569	0	179,569		1
2	Food Purchase		153,563		153,563	(21,539)	132,024	(3,588)	128,436		2
3	Housekeeping	65,827	28,532	0	94,359		94,359	0	94,359		3
4	Laundry	44,115	14,545	1,700	60,360		60,360	0	60,360		4
5	Heat and Other Utilities			63,869	63,869		63,869	584	64,453		5
6	Maintenance	60,097	23,824	10,078	93,999		93,999	23,353	117,352		6
7	Other (specify):*			14,297	14,297		14,297	489	14,786		7
8	TOTAL General Services	318,478	243,711	97,827	660,016	(21,539)	638,477	20,838	659,315		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400	0	2,400		9
10	Nursing and Medical Records	1,072,044	47,705	1,578	1,121,327		1,121,327	(667)	1,120,660		10
10a	Therapy	0		7,412	7,412		7,412	0	7,412		10a
11	Activities	101,071	6,954	3,385	111,410		111,410	0	111,410		11
12	Social Services	0		6,334	6,334		6,334	0	6,334		12
13	Nurse Aide Training			0				90	90		13
14	Program Transportation			1,000	1,000		1,000	0	1,000		14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,173,115	54,659	22,109	1,249,883		1,249,883	(577)	1,249,306		16
	C. General Administration										
17	Administrative	79,813		120,000	199,813		199,813	11,338	211,151		17
18	Directors Fees			0				0			18
19	Professional Services			30,237	30,237		30,237	3,198	33,435		19
20	Dues, Fees, Subscriptions & Promotions			76,843	76,843		76,843	(49,143)	27,700		20
21	Clerical & General Office Expense	102,186	15,473	178,123	295,782		295,782	(112,592)	183,190		21
22	Employee Benefits & Payroll Taxes			317,810	317,810	21,539	339,349	(1,282)	338,067		22
23	Inservice Training & Education			0				0			23
24	Travel and Seminar			2,829	2,829		2,829	473	3,302		24
25	Other Admin. Staff Transportation			6,800	6,800		6,800	22	6,822		25
26	Insurance-Prop.Liab.Malpractice			64,811	64,811		64,811	553	65,364		26
27	Other (specify):*			0				14,226	14,226		27
28	TOTAL General Administration	181,999	15,473	797,453	994,925	21,539	1,016,464	(133,207)	883,257		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,673,592	313,843	917,389	2,904,824		2,904,824	(112,946)	2,791,878		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.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			100,717	100,717		100,717	16,491	117,208		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			24,040	24,040		24,040	230,387	254,427		32
33	Real Estate Taxes			82,615	82,615		82,615	1,374	83,989		33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)			34
35	Rent-Equipment & Vehicles			6,961	6,961		6,961	5,717	12,678		35
36	Other (specify):*							0			36
37	TOTAL Ownership			675,534	675,534		675,534	(207,232)	468,302		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		31,566	44,851	76,417		76,417	(1,838)	74,579		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			64,782	64,782		64,782	0	64,782		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		31,566	109,633	141,199		141,199	(1,838)	139,361		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,673,592	345,409	1,702,556	3,721,557	0	3,721,557	(322,016)	3,399,541		45

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

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2000

Ending: 2/31/2000

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	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Program:				3
4 Non-Patient Meals		2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space		34		6
7 Sale of Supplies to Non-Patients		10		7
8 Laundry for Non-Patients		4		8
9 Non-Straightline Depreciation	7,624	30		9
10 Interest and Other Investment Income	(2,376)	32		10
11 Discounts, Allowances, Rebates & Refunds	(3,106)	2		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(482)	2		13
14 Non-Care Related Interest	0	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)		25		16
17 Non-Care Related Fees	(83)	20		17
18 Fines and Penalties		21		18
19 Entertainment	0	20		19
20 Contributions	(3,177)	20		20
21 Owner or Key-Man Insurance	0	22		21
22 Special Legal Fees & Legal Retainers	(287)	19		22
23 Malpractice Insurance for Individuals		26		23
24 Bad Debt	0	27		24
25 Fund Raising, Advertising and Promotional	(46,473)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees		13		27
28 Yellow Page Advertising	0	20		28
29 Other-Attach Schedule	15,915			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,445)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(289,571)		34
35 Other- Attach Schedule	0		35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (289,571)		36
(sum of SUBTOTALS)			
37 TOTAL ADJUSTMENTS (A) and (B)	\$ (322,016)		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 Exceptional Care Program		X			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Print Preview

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Num WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

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

Print Summary												SUMMARY		
Operating Expenses		PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS		
A. General Services		5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,588)	0	0	0	0	0	0	0	0	0	0	(3,588)	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	584	0	0	0	0	0	0	0	0	584	5
6	Maintenance	17,197	0	2,984	3,172	0	0	0	0	0	0	0	23,353	6
7	Other (specify):*	0	0	84	0	405	0	0	0	0	0	0	489	7
8	TOTAL General Services	13,609	0	3,652	3,172	405	0	0	0	0	0	0	20,838	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	(667)	0	0	0	0	0	(667)	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	Nurse Aide Training	0	0	90	0	0	0	0	0	0	0	0	90	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 Program	0	0	90	0	0	(667)	0	0	0	0	0	(577)	16
C. General Administration														
17	Administrative	0	(120,000)	0	131,338	0	0	0	0	0	0	0	11,338	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(287)	2,075	1,410	0	0	0	0	0	0	0	0	3,198	19
20	Fees, Subscriptions & Promotions	(49,733)	0	590	0	0	0	0	0	0	0	0	(49,143)	20
21	Clerical & General Office Expenses	0	(150,845)	35,283	2,970	0	0	0	0	0	0	0	(112,592)	21
22	Employee Benefits & Payroll Taxes	(1,282)	0	0	0	0	0	0	0	0	0	0	(1,282)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	473	0	0	0	0	0	0	0	0	473	24
25	Other Admin. Staff Transportation	0	0	22	0	0	0	0	0	0	0	0	22	25
26	Insurance-Prop.Liab.Malpractice	0	0	553	0	0	0	0	0	0	0	0	553	26
27	Other (specify):*	0	0	4,677	0	9,549	0	0	0	0	0	0	14,226	27
28	TOTAL General Administration	(51,302)	(268,770)	43,008	134,308	9,549	0	0	0	0	0	0	(133,207)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,693)	(268,770)	46,750	137,480	9,954	(667)	0	0	0	0	0	(112,946)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Numbr WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

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

Print Summary

	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	7,624	6,424	2,443	0	0	0	0	0	0	0	0	16,491	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,376)	230,998	1,765	0	0	0	0	0	0	0	0	230,387	32
33	Real Estate Taxes	0	0	1,374	0	0	0	0	0	0	0	0	1,374	33
34	Rent-Facility & Grounds	0	(461,201)	0	0	0	0	0	0	0	0	0	(461,201)	34
35	Rent-Equipment & Vehicles	0	0	5,717	0	0	0	0	0	0	0	0	5,717	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	5,248	(223,779)	11,299	0	0	0	0	0	0	0	0	(207,232)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,838)	0	0	0	0	0	(1,838)	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 Cent	0	0	0	0	0	(1,838)	0	0	0	0	0	(1,838)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(32,445)	(492,549)	58,049	137,480	9,954	(2,505)	0	0	0	0	0	(322,016)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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%	\$ 584	\$ 584
16	V	6 REPAIRS & MAINT.		" " "	100.00%	2,984	2,984
17	V	7 EMP. BEN. - GEN. SERVICES		" " "	100.00%	84	84
18	V	13 NURSES AIDE TRAINING		" " "	100.00%	90	90
19	V	19 PROFESSIONAL FEES		" " "	100.00%	1,410	1,410
20	V	20 DUES AND SUBSCRIPTION		" " "	100.00%	590	590
21	V	21 CLERICAL & GENERAL		" " "	100.00%	35,283	35,283
22	V	24 SEMINARS AND TRAVEL		" " "	100.00%	473	473
23	V	25 ADMIN. STAFF TRANS		" " "	100.00%	22	22
24	V	26 INSURANCE		" " "	100.00%	553	553
25	V	27 EMP BEN. - GEN ADMIN.		" " "	100.00%	4,677	4,677
26	V	30 DEPRECIATION		" " "	100.00%	2,443	2,443
27	V	32 INTEREST		" " "	100.00%	1,765	1,765
28	V	33 REAL ESTATE TAXES		" " "	100.00%	1,374	1,374
29	V	35 EQUIPMENT RENTAL		" " "	100.00%	5,717	5,717
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 58,049	\$ * 58,049

Sum_6A

584
2984
84
90
1410
590
35283
473
22
553
4677
2443
1765
1374
5717

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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. [X] 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.

Table with 8 columns: 1 Schedule V, 2 Line, 3 Cost Per General Ledger, 4 Amount, 5 Cost to Related Organization, 6 Percent of Ownership, 7 Operating Cost of Related Organization, 8 Difference: Adjustments for Related Organization Costs (7 minus 4). Rows include items like MAINT. CMP. - D. NEHMER, NURSING CMP. - SUE G., etc.

Sum_6B

3172
25606
32752
19205
20637
6021
6769
7451
2435
10462
2970

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

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- 1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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%	\$ 405	\$ 405
16	V 15	EMP. BEN. - SUE G.		" " "	100.00%		
17	V 27	EMP. BEN. - M. MAUER		" " "	100.00%	715	715
18	V 27	EMP. BEN. - M. AARON		" " "	100.00%	831	831
19	V 27	EMP. BEN. - F. AARON		" " "	100.00%	2,369	2,369
20	V 27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%		
21	V 27	EMP. BEN. - S. KOPLIN		" " "	100.00%	1,282	1,282
22	V 27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	1,114	1,114
23	V 27	EMP. BEN. - E. CASSON		" " "	100.00%		
24	V 27	EMP. BEN. - S. BOGEN		" " "	100.00%		
25	V 27	EMP. BEN. - S. LEVY		" " "	100.00%	1,021	1,021
26	V 27	EMP. BEN. - A. STEINER		" " "	100.00%	404	404
27	V 27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,407	1,407
28	V 27	EMP. BEN. - S. AARON		" " "	100.00%	406	406
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$		\$	9,954	\$ * 9,954

Sum_6C

405

715

831

2369

20

1282

1114

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

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39

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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 10a	THERAPY	\$ 7,411	DYNAMIC REHAB CONSULTANTS LLC	100.00%	\$ 7,411	\$
16	V 22	EMPLOYEE BENEFITS		" " "	100.00%		
17	V 39	ANCILLARY SERVICES	40,293	" " "	100.00%	40,293	
18	V				100.00%		
19	V				100.00%		
20	V 10	NURSING & MEDICAL SUPP	5,529	PHARMCOR LLC	100.00%	5,529	
21	V 11	ACTIVITIES		" "	100.00%		
22	V 22	EMPLOYEE BENEFITS		" "	100.00%		
23	V 39	ANCILLARY EXPENSE	16,417	" "	100.00%	16,417	
24	V				100.00%		
25	V				100.00%		
26	V 20	DUES, FEES & SUBSCRIPTION		LINCOLN MEDICAL SUPPLIES, INC.	100.00%		
27	V 10	MEDICAL SUPPLIES	2,534	" " "	100.00%	1,867	(667)
28	V 39	ANCILLARY EXPENSE	6,985	" " "	100.00%	5,147	(1,838)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 79,169			\$ 76,664	\$ * (2,505)

Sum_6D

-667
-1838

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

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	ABE STERN		ADMINISTRAT	25%				CONSULT	\$ 20,637	17-7	1
2	MARSHALL MAUER		ADMINISTRAT	25%				SALARY	25,606	17-7	2
3	MAURICE AARON		ADMINISTRAT	25%				SALARY	32,752	17-7	3
4	FRED AARON		ADMINISTRAT	0.00				SALARY	19,205	17-7	4
5	SHARON AARON		CLERICAL	0.00				SALARY	2,970	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 101,170		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 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 REI

** 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

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2000

Ending: 1/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS 707,726	15	\$ 10,055	\$	41,117	\$ 584	1
2	6	REPAIRS & MAINT	" " 707,726	15	51,362	16,071	41,117	2,984	2
3	7	EMP. BEN. - GEN. SVC.	" " 707,726	15	1,448		41,117	84	3
4	13	NURSES AIDE TRAINING	" " 707,726	15	1,550		41,117	90	4
5	19	PROFESSIONAL FEES	" " 707,726	15	24,272		41,117	1,410	5
6	20	DUES & SUBSCRIPTIONS	" " 707,726	15	10,163		41,117	590	6
7	21	CLERICAL & GENERAL	" " 707,726	15	607,305	465,093	41,117	35,283	7
8	24	SEMINARS & TRAVEL	" " 707,726	15	8,134		41,117	473	8
9	25	ADMIN. STAFF TRANS.	" " 707,726	15	372		41,117	22	9
10	26	INSURANCE	" " 707,726	15	9,517		41,117	553	10
11	27	EMP. BEN. - GEN. ADMIN.	" " 707,726	15	80,498		41,117	4,677	11
12	30	DEPRECIATION	" " 707,726	15	42,057		41,117	2,443	12
13	32	INTEREST	" " 707,726	15	30,386		41,117	1,765	13
14	33	REAL ESTATE TAXES	" " 707,726	15	23,654		41,117	1,374	14
15	35	EQUIPMENT RENTAL	" " 707,726	15	98,401		41,117	5,717	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 999,174	\$ 481,164		\$ 58,049	25

[Print Previe](#)

ANTS

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	\$ 54,000	\$ 54,000	2	\$ 3,172	1
2	10	NURSING - SUE G.	" "	40	1	32,209	32,209		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	14	435,842	435,842	2	25,606	3
4	17	ADMIN. CMP. - M. AARON	" "	45	14	558,156	558,156	3	32,752	4
5	17	ADMIN. CMP. - F. AARON	" "	50	7	160,040	160,040	6	19,205	5
6	17	ADMIN. CMP. - A. STERN	" "	8	14	351,664		0	20,637	6
7	17	ADMIN. CMP. - S. GOLDST	" "	50	3	179,079	179,079		0	7
8	17	ADMIN. CMP. - S. KOPLIN	" "	45	10	67,732	67,732	4	6,021	8
9	17	ADMIN. CMP. - D. MAGAF	" "	45	10	82,127	82,127	4	6,769	9
10	17	ADMIN. CMP. - E. CASSON	" "	45	2	47,882	47,882		0	10
11	17	ADMIN. CMP. - S. BOGEN	" "	45	3	119,320	119,320		0	11
12	17	ADMIN. CMP. - S. LEVY	" "	55	14	126,974	126,974	3	7,451	12
13	17	ADMIN. CMP. - A. STEINER	" "	45	14	41,511	41,511	3	2,435	13
14	17	ADMIN. CMP. - NON-OWNI	" "	45	14	178,292	178,292	3	10,462	14
15	21	CLERICAL CMP. - S. AARO	" "	40	14	50,548	50,548	2	2,970	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,485,376	\$ 2,133,712		\$ 137,480	25

ANTS

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	14	\$ 6,887	2	\$ 405	1
2	15	EMP BEN - SUE G.	" "	40	1	2,883		0	2
3	27	EMP BEN - M. MAUER	" "	40	14	12,175	2	715	3
4	27	EMP BEN - M. AARON	" "	45	14	14,155	3	831	4
5	27	EMP BEN - F. AARON	" "	50	7	19,744	6	2,369	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	18,514		0	6
7	27	EMP BEN - S. KOPLIN	" "	45	10	14,423	4	1,282	7
8	27	EMP BEN - D. MAGAFAS	" "	45	10	13,516	4	1,114	8
9	27	EMP BEN - E. CASSON	" "	45	2	10,284		0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	3	7,029		0	10
11	27	EMP BEN - S. LEVY	" "	55	14	17,400	3	1,021	11
12	27	EMP BEN - A. STEINER	" "	45	14	6,891	3	404	12
13	27	EMP BEN - NON-OWNER	" "	45	14	23,984	3	1,407	13
14	27	EMP BEN - S. AARON	" "	40	14	6,917	2	406	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 174,802	\$	\$ 9,954	25

ANTS

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	DYNAMIC REHAB CONSULTANTS				\$	\$		\$	1
2	10a THERAPY	DIRECT ALLOCATION						7,411	2
3	22 EMPLOYEE BENEFITS	" "							3
4	39 ANCILLARY SERVICES	" "						40,293	4
5									5
6									6
7	PHARCOR LLC								7
8	10 NURSING & MEDICAL SUP	DIRECT ALLOCATION						5,529	8
9	22 EMPLOYEE BENEFIT	" "							9
10	39 ANCILLARY EXPENSE	" "						16,417	10
11									11
12									12
13	LINCOLN MEDICAL SUPPLIES								13
14	20 DUES, FEES & SUBSCRIPT	DIRECT ALLOCATION							14
15	10 MEDICAL SUPPLIES	" "						1,867	15
16	39 ANCILLARY EXPENSE	" "						5,147	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 76,664	25

LC

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PHARMCOR, LLC.

Street Address 3116 S. OAK PARK

City / State / Zip Code BERWYN, IL 60402

Phone Number (708) 795 - 7701

Fax Number ((

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	SUCCESS BANK		X	MORTGAGE	\$43,437.00	10/99	\$ 3,050,000	\$ 2,825,454	11/09	7.75	\$ 230,998	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	SUCCESS NATL BANK		X	WORKING CAPITAL				107,669		PRIME+	24,040	6								
7												7								
8	RELATED PARTY	X									1,765	8								
9	TOTAL Facility Related				\$43,437.00		\$ 3,050,000	\$ 2,933,123			\$ 256,803	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,050,000	\$ 2,933,123			\$ 256,803	15								

* 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.)



Facility Name & ID Number: **WATERFRONT TERRACE**

0028076 Report Period Beginning: **01/01/2000** Ending: **12/31/2000**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	85,000	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.)	\$	82,615	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,385)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	85,000	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 used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 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	\$	82,615	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	78,229	8
	1996	80,154	9
	1997	81,723	10
	1998	83,174	11
	1999	82,615	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.			
	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number: WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

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

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

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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	NURSING HOME	37,824	1983	\$ 100,000	1
2					2
3	TOTALS	37,824		\$ 100,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

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Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2000(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8					25,772	661		736	75	5,400	8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		LEASEHOLD IMPROVEMENT		1983	21,787	0	10	0		21,787	9
10		LEASEHOLD IMPROVEMENT		1985	950	0	15			950	10
11		LEASEHOLD IMPROVEMENT		1986	3,800	160	10	0	(160)	3,800	11
12		LEASEHOLD IMPROVEMENT		1986	1,005	42	15	67	25	962	12
13		LEASEHOLD IMPROVEMENT		1990	13,634	433	10	685	252	13,634	13
14		LEASEHOLD IMPROVEMENT		1990	20,776	660	15	1,385	725	14,543	14
15		LEASEHOLD IMPROVEMENT		1991	7,956	253	10	796	543	7,592	15
16		LEASEHOLD IMPROVEMENT		1991	1,491	47	15	99	52	911	16
17		LEASEHOLD IMPROVEMENT		1992	18,033	572	10	1,803	1,231	15,326	17
18		LEASEHOLD IMPROVEMENT		1992	1,097	35	15	73	38	621	18
19		LEASEHOLD IMPROVEMENT		1993	7,742	246	31.5	246		1,896	19
20		LEASEHOLD IMPROVEMENT		1993	3,426	88	39	88		656	20
21		LEASEHOLD IMPROVEMENT		1994	25,007	642	39	642		4,146	21
22		ELEVATOR REPAIR		1995	1,500	38	39	38		224	22
23		SPRINKLER REPAIR		1995	4,154	107	39	107		619	23
24		BOILER REPAIR, WATER PUMP, ALARM		1996	6,033	154	39	154		726	24
25		FENCING		1996	756	50	15	50		225	25
26		NURSE STATION		1996	5,300	136	39	136		561	26
27		HANDRAILS		1996	3,735	96	39	96		388	27
28		PARKING LOT REPAVING		1997	14,968	998	15	998		3,492	28
29		TUCKPOINTING, ROOF REPAIR		1997	25,814	662	39	662		2,234	29
30		DRAPERY		1997	14,754	378	39	378		1,268	30
31		DOORS & SIGNS		1997	8,428	216	39	216		729	31
32		AIR HANDLER REPAIR & PUMPS		1997	17,005	436	39	436		1,472	32
33		REMODELING		1997	59,133	1,516	39	1,516		5,279	33
34		NURSE STATION		1997	5,106	131	39	131		442	34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 8,757		\$ 11,538	\$ 2,781	\$ 109,883	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Report Period Beginning:

01/01/2000(Ending: 12/31/2000

Facility Name & ID Numbe WATERFRONT TERRACE

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
			Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4			1983		\$ 1,508,000	\$ 0	35	\$ 43,086	\$ 43,086	\$ 764,777	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		FLOOR TILES, HANDRAILS, BUMPERGUARDS		1998	44,786	1,148	39	1,148		2,812	9
10		RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNETS		1998	6,419	165	39	165		408	10
11		SPRINKLER WORK, ALARMS, SECURITY DOOR		1998	3,636	93	39	93		233	11
12		CUBICLE CURTAINS, WINDOW TREATMENTS		1998	8,000	205	39	205		504	12
13		BEAUTY SALON STATION		1998	2,042	52	39	52		120	13
14		REMODELING		1998	21,934	562	39	562		1,358	14
15		FENCING, LANDSCAPING		1998	5,089	339	15	339		847	15
16		GENERATOR, ELEVATOR REPAIR		1998	3,825	98	39	98		243	16
17		TUCKPOINTING, ROOF WORK		1998	21,000	538	39	538		1,310	17
18		ANTENNA & INSTALLATION		1998	17,323	444	39	444		1,075	18
19		LIGHT FIXTURES, ARTWORK		1998	10,050	258	39	258		625	19
20		FIRE ALARM		1999	10,286	264	39	264		448	20
21		BATHROOMS REMODELING		1999	35,657	914	39	914		1,504	21
22		BOILER WORK		1999	7,345	188	39	188		317	22
23		CABLE WORK		1999	433	11	39	11		20	23
24		CARPET		1999	18,828	483	39	483		769	24
25		ELEVATOR WORK		1999	2,017	52	39	52		87	25
26		AIR CONDITIONING		1999	7,350	188	39	188		343	26
27		LIGHT AND MIRRORS		1999	9,093	233	39	233		347	27
28		ROOF WORK		1999	2,187	56	39	56		86	28
29		ROOMS IMPROVEMENTS		1999	59,493	1,525	39	1,525		2,057	29
30		WINDOWS		1999	5,513	141	39	141		227	30
31		RELATED PARTY - NURSE CALL SYSTEM		1999	32,456	832	39	832		1,214	31
32		RELATED PARTY - NURSE STATION		1999	19,656	504	39	504		735	32
33		RELATED PARTY - DRYWALL, PAINT, FLOORING		1999	176,452	4,524	39	4,524		6,601	33
34		RELATED PARTY - FIRE SYSTEM DAMPERS		1999	22,000	564	39	564		824	34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 14,381		\$ 57,467	\$ 43,086	\$ 789,891	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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01/01/2000 Ending: 12/31/2000

Facility Name & ID Numbe WATERFRONT TERRACE

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		NURSE CALL SYSTEM		2000	2,778	50	27.5	50		50	9
10		BATHROOM REMODEL		2000	10,080	227	27.5	227		227	10
11		FIRE ALARM REPAIR		2000	3,170	76	27.5	76		76	11
12		WALLTILE/FLOORING/KICK PLATES/BASEBOARD		2000	10,242	227	27.5	227		227	12
13		DRYWALL & CEILING REPAIR		2000	79,500	1,716	27.5	1,716		1,716	13
14		1ST FLOOR REMODEL		2000	2,698	50	27.5	50		50	14
15		DOOR/DOORBELL INTERCOM/PAGER		2000	2,640	50	27.5	50		50	15
16		EXHAUST FAN		2000	890	25	27.5	25		25	16
17		HOT WATER HEATER		2000	1,100	27	27.5	27		27	17
18		OVERBED LIGHTS		2000	3,093	76	27.5	76		76	18
19		WINDOW TREATMENTS/CUBICLE CURTAINS		2000	11,247	1,607	20	281	(1,326)	281	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		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 4,131		\$ 2,805	\$ (1,326)	\$ 2,805	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Report Period Beginning:

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01/01/200(Ending: 12/31/2000

Facility Name & ID Numbe **WATERFRONT TERRACE**

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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0028076

Report Period Beginning:

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Facility Name & ID Numbe WATERFRONT TERRACE

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 436,683	\$ 67,411	\$ 39,393	\$ (28,018)		\$ 287,106	37
38	Current Year Purchases	88,364	13,121	4,418	(8,703)		7,223	38
39	Fully Depreciated Assets	229,948					229,948	39
40	RELATED PARTY	15,107	1,605	1,433	(172)		6,752	40
41	TOTALS	\$ 770,102	\$ 82,137	\$ 45,244	\$ (36,893)		\$ 531,029	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RELATED PARTY			\$ 924	\$ 178	\$ 154	\$ (24)		\$ 154	42
43										43
44										44
45										45
46	TOTALS			\$ 924	\$ 178	\$ 154	\$ (24)		\$ 154	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 109,584	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 117,208	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 7,624	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,433,762	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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 \$ 3,576 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>HOWARD ALTER</u>	<u>TOYOTA CAMRY</u>	\$ <u>325.00</u>	\$ <u>4,400</u>	17
18		<u>2001HONDA</u>	<u>414.00</u>	<u>828</u>	18
19	<u>PAYROLL DEDUCTION</u>			<u>(1,843)</u>	19
20					20
21	TOTAL		\$ <u>739.00</u>	\$ <u>3,385</u>	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.

Print Preview

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Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

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

<p>1. HAVE YOU TRAINED AIDES 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 TRAINED 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 AIDE _____</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 AIDE _____</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 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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Facility Name & ID Number WATERFRONT TERRACE# 0028076 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
									Units	Cost		
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 15,185	\$		\$	15,185	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,409				3,409	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	39-3	hrs			21,700				21,700	4	
5	Physician Care	39-3	visits			151				151	5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39-2	# of prescripts					23,586		23,586	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Exceptional Care Program										12	
13	RADIOLOGY, LAB & RENTALS Other (specify):	39 - 2 & 3				4,406		7,980		12,386	13	
14	TOTAL			\$		\$ 44,851	\$	31,566	\$	76,417	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 nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

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

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	736,599	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	28,384	6
7	Other Prepaid Expenses	2,740	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): RE ESCROW	29,103	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 796,826	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cost	723,134	15
16	Equipment, at Historical Cost	754,994	16
17	Accumulated Depreciation (book methods)	(618,338)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify): DEPOSITS	425	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 860,215	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,657,041	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 250,840	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	180,741	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,392	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,000	32
33	Accrued Interest Payable	954	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	DUE TO SUCCESS NATL BANK	107,669	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 642,596	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 642,596	\$ 46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,014,445	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,657,041	\$ 48

*(See instructions.)

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Facility Name & ID Number WATERFRONT TERRACE# 0028076Report Period Beginning 1/01/2000Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 680,922	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(5,471)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 675,451	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	538,994	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	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 338,994	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,014,445	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,191,543	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,191,543	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,526	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 63,526	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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**	2,376	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,376	26
E. Other Revenue (specify):***			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	3,106	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,106	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,260,551	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 660,016	31
32	Health Care	1,249,883	32
33	General Administration	994,925	33
B. Capital Expense			
34	Ownership	675,534	34
C. Ancillary Expense			
35	Special Cost Centers	76,417	35
36	Provider Participation Fee	64,782	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,721,557	40
41	Income before Income Taxes (line 30 minus line 40)**	538,994	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 538,994	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,397	2,578	\$ 69,441	\$ 26.94	1
2	Assistant Director of Nursing	1,258	1,182	24,508	20.73	2
3	Registered Nurses	1,470	1,500	28,716	19.14	3
4	Licensed Practical Nurses	28,319	31,201	488,690	15.66	4
5	Nurse Aides & Orderlies	58,008	61,474	425,133	6.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,942	2,030	21,879	10.78	9
10	Activity Assistants	10,428	10,820	79,192	7.32	10
11	Social Service Workers					11
12	Dietician	1,659	1,889	21,829	11.56	12
13	Food Service Supervisor					13
14	Head Cook	3,515	3,764	33,130	8.80	14
15	Cook Helpers/Assistants	12,649	13,336	93,480	7.01	15
16	Dishwashers					16
17	Maintenance Workers	4,937	5,176	60,097	11.61	17
18	Housekeepers	10,701	11,075	65,827	5.94	18
19	Laundry	5,823	6,678	44,115	6.61	19
20	Administrator	2,038	2,225	79,813	35.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,276	6,708	102,186	15.23	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	830	830	6,236	7.51	31
32	Other Health Care(specify)					32
33	Other(specify CARE PLAN)	1,595	1,734	29,320	16.91	33
34	TOTAL (lines 1 - 33)	153,845	164,200	\$ 1,673,592 *	\$ 10.19	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	191	\$ 7,680	1-3	35
36	Medical Director	MONTHLY	2,400	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	96	1,558	10-3	39
40	Physical Therapy Consultant	152	5,303	10a-3	40
41	Occupational Therapy Consultant	37	1,286	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	24	823	10a-3	43
44	Activity Consultant	77	3,385	11-3	44
45	Social Service Consultant	119	6,334	12-3	45
46	Other(specify)				46
47			0		47
48					48
49	TOTAL (lines 35 - 48)	696	\$ 28,769		49

C. CONTRACT NURSES

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

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