

		FOR OHF USE				

LL 1

**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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: <u>04/01/83</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> <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>01/01/2001</u> to <u>12/31/2001</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 data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>MARSHALL MAUER</u></td> </tr> <tr> <td data-bbox="1144 828 1281 885"></td> <td data-bbox="1281 828 1921 885">(Title) <u>TREASURER</u></td> </tr> <tr> <td data-bbox="1144 885 1281 1039">Paid Preparer</td> <td data-bbox="1281 885 1921 1039">(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 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	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 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
<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 _____																														
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 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																														

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF			842	842	8
9	SNF/PED					9
10	ICF	38,561	950	445	39,956	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,561	950	1,287	40,798	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.72%

D. How many bed-hold days during this year were paid by Public Aid?
1,450 (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 04/01/83 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 842

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	165,956	19,394	7,840	193,190		193,190	0	193,190		1
2	Food Purchase		173,797		173,797	(35,058)	138,739	(1,441)	137,298		2
3	Housekeeping	71,843	32,915	0	104,758		104,758	0	104,758		3
4	Laundry	46,468	13,262	1,144	60,874		60,874	0	60,874		4
5	Heat and Other Utilities			59,952	59,952		59,952	748	60,700		5
6	Maintenance	69,476	19,927	9,051	98,454		98,454	16,150	114,604		6
7	Other (specify):*			13,442	13,442		13,442	1,139	14,581		7
8	TOTAL General Services	353,743	259,295	91,429	704,467	(35,058)	669,409	16,596	686,005		8
B. Health Care and Programs											
9	Medical Director	0		2,400	2,400		2,400	0	2,400		9
10	Nursing and Medical Records	1,150,233	67,745	5,855	1,223,833		1,223,833	(3,706)	1,220,127		10
10a	Therapy	0		6,950	6,950		6,950	0	6,950		10a
11	Activities	110,842	7,983	3,398	122,223		122,223	0	122,223		11
12	Social Services	0		2,835	2,835		2,835	0	2,835		12
13	Nurse Aide Training			0	0		0	117	117		13
14	Program Transportation			425	425		425	0	425		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,261,075	75,728	21,863	1,358,666	0	1,358,666	(3,589)	1,355,077		16
C. General Administration											
17	Administrative	84,658		120,000	204,658		204,658	28,188	232,846		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			40,051	40,051		40,051	4,411	44,462		19
20	Dues, Fees, Subscriptions & Promotions			56,941	56,941		56,941	(27,435)	29,506		20
21	Clerical & General Office Expenses	105,938	17,267	200,314	323,519		323,519	(199,760)	123,759		21
22	Employee Benefits & Payroll Taxes			340,858	340,858	35,058	375,916	0	375,916		22
23	Inservice Training & Education			965	965		965	0	965		23
24	Travel and Seminar			0	0		0	834	834		24
25	Other Admin. Staff Transportation			7,265	7,265		7,265	106	7,371		25
26	Insurance-Prop.Liab.Malpractice			93,255	93,255		93,255	3,370	96,625		26
27	Other (specify):*			3,931	3,931		3,931	19,637	23,568		27
28	TOTAL General Administration	190,596	17,267	863,580	1,071,443	35,058	1,106,501	(170,649)	935,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,805,414	352,290	976,872	3,134,576	0	3,134,576	(157,642)	2,976,934		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.

Facility Name & ID Number

WATERFRONT TERRACE

#0028076

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			96,760	96,760		96,760	30,753	127,513			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			20,015	20,015		20,015	212,909	232,924			32
33	Real Estate Taxes			73,218	73,218		73,218	1,762	74,980			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)	0			34
35	Rent-Equipment & Vehicles			13,481	13,481		13,481	7,211	20,692			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			664,675	664,675	0	664,675	(208,566)	456,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		13,374	46,034	59,408		59,408	(466)	58,942			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			64,605	64,605		64,605	0	64,605			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	13,374	110,639	124,013	0	124,013	(466)	123,547			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,805,414	365,664	1,752,186	3,923,264	0	3,923,264	(366,674)	3,556,590			45

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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 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	21,159	30		9
10	Interest and Other Investment Income	(1,854)	32		10
11	Discounts, Allowances, Rebates & Refunds	(815)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(626)	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	0	20		17
18	Fines and Penalties	(100)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,600)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(37)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,931)	27		24
25	Fund Raising, Advertising and Promotional	(25,857)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(62,449)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,110)		\$ 0	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)	(289,564)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (289,564)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (366,674)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 7642	6	1
2	MARKETING SALARY	(70,091)	21	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	(62,449)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,441)	0	0	0	0	0	0	0	0	0	0	(1,441)	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	748	0	0	0	0	0	0	0	0	748	5
6	Maintenance	7,642	0	3,875	4,633	0	0	0	0	0	0	0	16,150	6
7	Other (specify):*	0	0	800	0	339	0	0	0	0	0	0	1,139	7
8	TOTAL General Services	6,201	0	5,423	4,633	339	0	0	0	0	0	0	16,596	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(3,706)	0	0	0	0	0	(3,706)	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	117	0	0	0	0	0	0	0	0	117	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	117	0	0	(3,706)	0	0	0	0	0	(3,589)	16
	C. General Administration													
17	Administrative	0	(120,000)	0	148,188	0	0	0	0	0	0	0	28,188	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(37)	2,765	1,683	0	0	0	0	0	0	0	0	4,411	19
20	Fees, Subscriptions & Promotions	(28,457)	0	1,022	0	0	0	0	0	0	0	0	(27,435)	20
21	Clerical & General Office Expenses	(70,191)	(175,720)	41,613	4,538	0	0	0	0	0	0	0	(199,760)	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	834	0	0	0	0	0	0	0	0	834	24
25	Other Admin. Staff Transportation	0	0	106	0	0	0	0	0	0	0	0	106	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,370	0	0	0	0	0	0	0	0	3,370	26
27	Other (specify):*	(3,931)	0	6,711	0	16,857	0	0	0	0	0	0	19,637	27
28	TOTAL General Administration	(102,616)	(292,955)	55,339	152,726	16,857	0	0	0	0	0	0	(170,649)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(96,415)	(292,955)	60,879	157,359	17,196	(3,706)	0	0	0	0	0	(157,642)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE# 0028076 Report Period Beginning:01/01/2001 Ending:12/31/2001

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	21,159	6,424	3,170	0	0	0	0	0	0	0	0	30,753 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,854)	212,949	1,814	0	0	0	0	0	0	0	0	212,909 32
33	Real Estate Taxes	0	0	1,762	0	0	0	0	0	0	0	0	1,762 33
34	Rent-Facility & Grounds	0	(461,201)	0	0	0	0	0	0	0	0	0	(461,201) 34
35	Rent-Equipment & Vehicles	0	0	7,211	0	0	0	0	0	0	0	0	7,211 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	19,305	(241,828)	13,957	0	0	0	0	0	0	0	0	(208,566) 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	(466)	0	0	0	0	0	(466) 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	(466)	0	0	0	0	0	(466) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(77,110)	(534,783)	74,836	157,359	17,196	(4,172)	0	0	0	0	0	(366,674) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING FEES	\$ 175,720	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ (175,720)	1
2	V	17	MANAGEMENT FEES	120,000	" " "		(120,000)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V	34	RENT	461,201	WATERFRONT TERRACE ASSOCIATES	100.00%	(461,201)	9
10	V	30	DEPRECIATION		" " "		6,424	10
11	V	19	ACCOUNTING & LEGAL		" " "		2,765	11
12	V	32	INTEREST		" " "		212,949	12
13	V							13
14	Total		\$ 756,921			\$ 222,138	\$ * (534,783)	14

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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%	\$ 748	\$ 748
16	V	6 REPAIRS & MAINT.		" " "	100.00%	3,875	3,875
17	V	7 EMP. BEN. - GEN. SERVICES		" " "	100.00%	800	800
18	V	13 NURSES AIDE TRAINING		" " "	100.00%	117	117
19	V	19 PROFESSIONAL FEES		" " "	100.00%	1,683	1,683
20	V	20 DUES AND SUBSCRIPTION		" " "	100.00%	1,022	1,022
21	V	21 CLERICAL & GENERAL		" " "	100.00%	41,613	41,613
22	V	24 SEMINARS AND TRAVEL		" " "	100.00%	834	834
23	V	25 ADMIN. STAFF TRANS		" " "	100.00%	106	106
24	V	26 INSURANCE		" " "	100.00%	3,370	3,370
25	V	27 EMP BEN. - GEN ADMIN.		" " "	100.00%	6,711	6,711
26	V	30 DEPRECIATION		" " "	100.00%	3,170	3,170
27	V	32 INTEREST		" " "	100.00%	1,814	1,814
28	V	33 REAL ESTATE TAXES		" " "	100.00%	1,762	1,762
29	V	35 EQUIPMENT RENTAL		" " "	100.00%	7,211	7,211
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 74,836	\$ * 74,836

* 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. CMP. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 4,633	\$ 4,633
16	V	10 NURSING CMP - SUE G.		" " "	100.00%		
17	V	17 ADMIN. CMP. - M. MAUER		" " "	100.00%	28,715	28,715
18	V	17 ADMIN. CMP. - M. AARON		" " "	100.00%	38,834	38,834
19	V	17 ADMIN. CMP. - F. AARON		" " "	100.00%	27,690	27,690
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%		
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "	100.00%	8,255	8,255
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	9,325	9,325
23	V	17 ADMIN. CMP. - E. CASSON		" " "	100.00%		
24	V	17 ADMIN. CMP. - S. BOGEN		" " "	100.00%		
25	V	17 ADMIN. CMP. - S. LEVY		" " "	100.00%	10,057	10,057
26	V	17 ADMIN. CMP. - H. ALTER		" " "	100.00%	9,000	9,000
27	V	17 ADMIN. CMP. - NON-OWNER		" " "	100.00%	16,312	16,312
28	V	21 CLERICAL CMP. - S. AARON		" " "	100.00%	4,538	4,538
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 157,359	\$ * 157,359

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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%	\$ 339	\$ 339
16	V	15 EMP. BEN. - SUE G.		" " "	100.00%		
17	V	27 EMP. BEN. - M. MAUER		" " "	100.00%	1,833	1,833
18	V	27 EMP. BEN. - M. AARON		" " "	100.00%	2,677	2,677
19	V	27 EMP. BEN. - F. AARON		" " "	100.00%	3,182	3,182
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "	100.00%		
21	V	27 EMP. BEN. - S. KOPLIN		" " "	100.00%	1,892	1,892
22	V	27 EMP. BEN. - D. MAGAFAS		" " "	100.00%	2,007	2,007
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%	1,396	1,396
26	V	27 EMP. BEN. - H. ALTER		" " "	100.00%	1,068	1,068
27	V	27 EMP. BEN. - NON-OWNER		" " "	100.00%	2,193	2,193
28	V	27 EMP. BEN. - S. AARON		" " "	100.00%	609	609
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 17,196	\$ * 17,196

* 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	10a THERAPY	\$ 6,950	DYNAMIC REHAB CONSULTANTS LLC	100.00%	\$ 6,950	\$
16	V	19 PROFESSIONAL FEES		" " "	100.00%		
17	V	22 EMPLOYEE BENEFITS		" " "	100.00%		
18	V	39 ANCILLARY SERVICES	44,360	" " "	100.00%	44,360	
19	V						
20	V	10 NURSING & MEDICAL SUPP	5,405	PHARMCOR LLC	100.00%	5,405	
21	V	19 PROFESSIONAL FEES		" "	100.00%		
22	V	21 CLERICAL & GENERAL	277	" "	100.00%	277	
23	V	22 EMPLOYEE BENEFITS		" "	100.00%		
24	V	39 ANCILLARY EXPENSE	6,563		100.00%	6,563	
25	V						
26	V						
27	V	10 MEDICAL SUPPLIES	17,902	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	14,196	(3,706)
28	V	39 ANCILLARY EXPENSE	2,251	" " "	100.00%	1,785	(466)
29	V			" " "			
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 83,708			\$ 79,536	\$ * (4,172)

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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		ADMINISTRATIVE	25%		SCHEDULE ATTACHED		SALARY	\$ 28,715	17-8	1
2	MAURICE AARON		ADMINISTRATIVE	25%				SALARY	38,834	17-8	2
3	FRED AARON		ADMINISTRATIVE	0.00				SALARY	27,690	17-8	3
4											4
5	SHARON AARON		CLERICAL	0.00				SALARY	4,538	21-8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 99,777		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: 01/01/2001 Ending: 2/31/2001

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 CONSULTANTS
 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	TOTAL PATIENT DAYS	577,359	14	\$ 10,580	\$	40,798	\$ 748	1
2	6 REPAIRS & MAINT	" "	577,359	14	54,834	37,633	40,798	3,875	2
3	7 EMP. BEN. - GEN. SVC.	" "	577,359	14	11,326		40,798	800	3
4	13 NURSES AIDE TRAINING	" "	577,359	14	1,650		40,798	117	4
5	19 PROFESSIONAL FEES	" "	577,359	14	23,811		40,798	1,683	5
6	20 DUES & SUBSCRIPTIONS	" "	577,359	14	14,469		40,798	1,022	6
7	21 CLERICAL & GENERAL	" "	577,359	14	588,891	487,646	40,798	41,613	7
8	24 SEMINARS & TRAVEL	" "	577,359	14	11,803		40,798	834	8
9	25 ADMIN. STAFF TRANS.	" "	577,359	14	1,502		40,798	106	9
10	26 INSURANCE	" "	577,359	14	47,685		40,798	3,370	10
11	27 EMP.BEN. - GEN. ADMIN.	" "	577,359	14	94,969		40,798	6,711	11
12	30 DEPRECIATION	" "	577,359	14	44,866		40,798	3,170	12
13	32 INTEREST	" "	577,359	14	25,667		40,798	1,814	13
14	33 REAL ESTATE TAXES	" "	577,359	14	24,936		40,798	1,762	14
15	35 EQUIPMENT RENTAL	" "	577,359	14	102,054		40,798	7,211	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,059,043	\$ 525,279		\$ 74,836	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 CONSULTANTS
 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	13	\$ 62,194	\$ 62,194	3	\$ 4,633	1
2	10	NURSING - SUE G.	" "	40	13	45,894	45,894		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	13	398,821	398,821	3	28,715	3
4	17	ADMIN. CMP. - M. AARON	" "	45	13	521,536	521,536	3	38,834	4
5	17	ADMIN. CMP. - F. AARON	" "	45	13	191,700	191,700	7	27,690	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	50	13	161,003	161,003		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	45	13	71,993	71,993	5	8,255	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	13	81,938	81,938	5	9,325	8
9	17	ADMIN. CMP. - E. CASSON	" "	38	13	47,846	47,846		0	9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	13	96,858	96,858		0	10
11	17	ADMIN. CMP. - S. LEVY	" "	55	13	139,807	139,807	4	10,057	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	13	9,000	9,000	40	9,000	12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	13	219,069	219,069	3	16,312	13
14	21	CLERICAL CMP. - S. AARON	" "	40	13	63,022	63,022	3	4,538	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,110,681	\$ 2,110,681		\$ 157,359	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 CONSULTANTS
 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	13	\$ 4,545	\$ 3	\$ 339	1
2	15	EMP BEN - SUE G.	" "	40	13	3,924		0	2
3	27	EMP BEN - M. MAUER	" "	40	13	25,461	3	1,833	3
4	27	EMP BEN - M. AARON	" "	45	13	35,957	3	2,677	4
5	27	EMP BEN - F. AARON	" "	45	13	22,028	7	3,182	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	13	20,193		0	6
7	27	EMP BEN - S. KOPLIN	" "	45	13	16,504	5	1,892	7
8	27	EMP BEN - D. MAGAFAS	" "	45	13	17,632	5	2,007	8
9	27	EMP BEN - E. CASSON	" "	38	13	11,976		0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	13	6,849		0	10
11	27	EMP BEN - S. LEVY	" "	55	13	19,408		1,396	11
12	27	EMP BEN - H. ALTER	" "	40	13	1,068	40	1,068	12
13	27	EMP BEN - NON-OWNER	" "	45	13	29,449	3	2,193	13
14	27	EMP BEN - S. AARON	" "	40	13	8,457	3	609	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 223,451	\$	\$ 17,196	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 LLC
 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>DYNAMIC REHAB CONSULTANTS</u>				\$	\$			1
2	<u>10a THERAPY</u>	<u>DIRECT ALLOCATION</u>						6,950	2
3	<u>19 PROFESSIONAL FEES</u>	" "							3
4	<u>22 EMPLOYEE BENEFITS</u>	" "							4
5	<u>39 ANCILLARY SERVICES</u>	" "						44,360	5
6									6
7									7
8	<u>PHARCOR LLC</u>								8
9	<u>10 NURSING & MEDICAL SUPPLY</u>	<u>DIRECT ALLOCATION</u>						5,405	9
10	<u>19 PROFESSIONAL FEES</u>	" "							10
11	<u>21 CLERICAL & GENERAL</u>	" "						277	11
12	<u>22 EMPLOYEE BENEFIT</u>	" "							12
13	<u>39 ANCILLARY EXPENSE</u>	" "						6,563	13
14									14
15									15
16	<u>LINCOLN MEDICAL SUPPLIES</u>								16
17	<u>10 MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>						14,196	17
18	<u>39 ANCILLARY EXPENSE</u>	" "						1,785	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 79,536	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	\$ 2,600,211	11/09	7.7500	\$ 212,949	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	SUCCESS BANK		X	WORKING CAPITAL				467,886		PRIME +	20,015	6							
7												7							
8	RELATED PARTY	X									1,814	8							
9	TOTAL Facility Related				\$43,437.00		\$ 3,050,000	\$ 3,068,097			\$ 234,778	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14							
15	TOTALS (line 9+line14)						\$ 3,050,000	\$ 3,068,097			\$ 234,778	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: **01/01/2001** Ending: **12/31/2001****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 2000 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.)			\$	78,218	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(6,782)	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	80,000	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 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.			\$	73,218	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	80,154	8	FOR OHF USE ONLY	
		1997	81,723	9		
		1998	83,174	10	13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
		1999	82,615	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2000	78,218	12	15	LESS REFUND FROM LINE 6 \$ 15
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-412-045-0000</u>	<u>NURSING HOME</u>	\$ <u>77,423.16</u>	\$ <u>77,423.16</u>
2. <u>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>794.69</u>	\$ <u>794.69</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>78,217.85</u>	\$ <u>78,217.85</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 NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2001 Ending:

12/31/2001

X. BUILDING AND GENERAL INFORMATION:

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

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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			1983		\$ 1,508,000	\$ 0	35	\$ 43,086	\$ 43,086	\$ 807,863	4
5											5
6											6
7											7
8					31,346	804		896	92	7,463	8
		Improvement Type**									
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	1,029	12
13		LEASEHOLD IMPROVEMENT	1990		13,634	433	10	685	252	14,319	13
14		LEASEHOLD IMPROVEMENT	1990		20,776	660	15	1,385	725	15,928	14
15		LEASEHOLD IMPROVEMENT	1991		7,956	253	10	796	543	8,388	15
16		LEASEHOLD IMPROVEMENT	1991		1,491	47	15	99	52	1,010	16
17		LEASEHOLD IMPROVEMENT	1992		18,033	572	10	1,803	1,231	17,129	17
18		LEASEHOLD IMPROVEMENT	1992		1,097	35	15	73	38	694	18
19		LEASEHOLD IMPROVEMENT	1993		7,742	246	31.5	246		2,142	19
20		LEASEHOLD IMPROVEMENT	1993		3,426	88	39	88		744	20
21		LEASEHOLD IMPROVEMENT	1994		25,007	642	39	642		4,788	21
22		ELEVATOR REPAIR	1995		1,500	38	39	38		262	22
23		SPRINKLER REPAIR	1995		4,154	107	39	107		726	23
24		BOILER REPAIR, WATER PUMP, ALARM	1996		6,033	154	39	154		880	24
25		FENCING	1996		756	50	15	50		275	25
26		NURSE STATION	1996		5,300	136	39	136		697	26
27		HANDRAILS	1996		3,735	96	39	96		484	27
28		PARKING LOT REPAVING	1997		14,968	998	15	998		4,390	28
29		TUCKPOINTING, ROOF REPAIR	1997		25,814	662	39	662		2,896	29
30		DRAPERY	1997		14,754	378	39	378		1,646	30
31		DOORS & SIGNS	1997		8,428	216	39	216		945	31
32		AIR HANDLER REPAIR & PUMPS	1997		17,005	436	39	436		1,908	32
33		REMODELING	1997		59,133	1,517	39	1,517		6,795	33
34		NURSE STATION	1997		5,106	131	39	131		573	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:

01/01/2001 Ending: 12/31/2001

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	
	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	\$	\$ 3,960		37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNETS	1998	6,419	165	39	165		573		38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		326		39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		709		40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		172		41
42	REMODELING	1998	21,934	562	39	562		1,920		42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		1,186		43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		341		44
45	TUCKPOINTING, ROOF WORK	1998	21,000	538	39	538		1,848		45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		1,519		46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	259	39	259		883		47
48	FIRE ALARM	1999	10,286	264	39	264		712		48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		2,418		49
50	BOILER WORK	1999	7,345	188	39	188		505		50
51	CABLE WORK	1999	433	11	39	11		31		51
52	CARPET	1999	18,828	483	39	483		1,252		52
53	ELEVATOR WORK	1999	2,017	52	39	52		139		53
54	AIR CONDITIONING	1999	7,350	188	39	188		531		54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		580		55
56	ROOF WORK	1999	2,187	56	39	56		142		56
57	ROOMS IMPROVEMENTS	1999	59,493	1,525	39	1,525		3,582		57
58	WINDOWS	1999	5,513	141	39	141		368		58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	833	39	833		2,046		59
60	RELATED PARTY - NURSE STATION	1999	19,656	504	39	504		1,239		60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		11,125		61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		1,388		62
63	NURSE CALL SYSTEM	2000	2,778	103	27.5	103		151		63
64	BATHROOM REMODEL	2000	10,080	367	27.5	367		594		64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		191		65
66	WALLTILE/FLOORING/KICK PLATES/BASEBOARD	2000	10,242	372	27.5	372		599		66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		4,607		67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		148		68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		146		69
70	TOTAL (lines 4 thru 69)		\$ 2,496,714	\$ 27,326		\$ 73,210	\$ 45,884	\$ 976,542		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:

01/01/2001 Ending: 12/31/2001

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,496,714	\$ 27,326		\$ 73,210	\$ 45,884	\$ 976,542	1
2	EXHAUST FAN	2000	890	32	27.5	32		57	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		67	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		188	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247	2,754	7	2,754		3,035	5
6	ROOF REPAIRS	2001	7,445	210	27.5	210		210	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	152	27.5	152		152	7
8	OUTLETS, TRANSFERSWITCH	2001	5,686	137	27.5	137		137	8
9	VALVES, BASEMENT REPAIR	2001	6,136	152	27.5	152		152	9
10	LIGHT FIXTURES	2001	2,450	58	27.5	58		58	10
11	AC UNIT	2001	786	14	27.5	14		14	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,541,727	\$ 30,987		\$ 76,871	\$ 45,884	\$ 980,612	34

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

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 523,931	\$ 69,281	\$ 46,450	\$ (22,831)		\$ 216,808	71
72	Current Year Purchases	23,383	3,720	1,169	(2,551)		1,169	72
73	Fully Depreciated Assets	231,063			0		231,063	73
74	RELATED PARTY	18,616	2,150	1,776	(374)		9,989	74
75	TOTALS	\$ 796,993	\$ 75,151	\$ 49,395	\$ (25,756)		\$ 459,029	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			\$ 3,978	\$ 216	\$ 1,247	\$ 1,031		\$ 1,434	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 3,978	\$ 216	\$ 1,247	\$ 1,031		\$ 1,434	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)	\$ 3,442,698	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,354	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 127,513	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,159	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,441,075	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? YES NO
 If NO, see instructions.

		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>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</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: \$ 3,704 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>ADMINISTRATIVE</u>	<u>TOYOTA CAMRY</u>	\$ <u>565.00</u>	\$ <u>6,780</u>	17
18		<u>2001 HONDA</u>	<u>414.00</u>	<u>4,968</u>	18
19	<u>PAYROLL DEDUCTION</u>			<u>(1,971)</u>	19
20					20
21	TOTAL		\$ <u>979.00</u>	\$ <u>9,777</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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1 Drop-outs	2 Completed	3 Contract	4 Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (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.

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				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 18,331	\$	\$	18,331	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,673			1,673	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			24,605			24,605	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				10,239		10,239	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Med Supp, Lab, Rentals and other Other (specify): services	39-2 & 3					4,560		4,560	13
14	TOTAL			\$		\$ 44,609	\$ 14,799	\$	59,408	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(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)	1,112,354		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	35,504		6
7 Other Prepaid Expenses	3,893		7
8 Accounts Receivable (owners or related parties)	15,675		8
9 Other(specify): RE TAX ESCROW	33,504		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,200,930	\$ 0	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	751,817		15
16 Equipment, at Historical Cost	778,377		16
17 Accumulated Depreciation (book methods)	(715,097)		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 (spe DEPOSITS)	1,025		22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 816,122	\$ 0	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,017,052	\$ 0	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 214,635	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	467,886		29
30 Accrued Salaries Payable	209,542		30
31 Accrued Taxes Payable (excluding real estate taxes)	16,306		31
32 Accrued Real Estate Taxes(Sch.IX-B)	80,000		32
33 Accrued Interest Payable	1,748		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 990,117	\$ 0	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)	\$ 0	\$ 0	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 990,117	\$ 0	46
47 TOTAL EQUITY(page 18, line 24)	\$ 1,026,935	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,017,052	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,014,445	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(8,022)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,006,423	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	426,512	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	(406,000)	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)	\$ 20,512	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,026,935	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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	\$ 4,295,190	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,295,190	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	51,917	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 51,917	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)	\$ 0	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,854	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,854	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	815	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 815	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,349,776	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	704,467	31
32	Health Care	1,358,666	32
33	General Administration	1,071,443	33
B. Capital Expense			
34	Ownership	664,675	34
C. Ancillary Expense			
35	Special Cost Centers	59,408	35
36	Provider Participation Fee	64,605	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,923,264	40
41	Income before Income Taxes (line 30 minus line 40)**	426,512	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 426,512	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.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

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	2,310	2,579	\$ 72,429	\$ 28.08	1
2	Assistant Director of Nursing	53	53	1,122	21.17	2
3	Registered Nurses	1,139	1,102	22,155	20.10	3
4	Licensed Practical Nurses	28,723	31,831	540,874	16.99	4
5	Nurse Aides & Orderlies	59,942	63,419	473,462	7.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,994	2,113	21,522	10.19	9
10	Activity Assistants	11,337	11,889	89,320	7.51	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,657	1,921	23,777	12.38	13
14	Head Cook	4,930	5,255	47,956	9.13	14
15	Cook Helpers/Assistants	11,820	12,448	94,223	7.57	15
16	Dishwashers					16
17	Maintenance Workers	4,997	5,291	69,476	13.13	17
18	Housekeepers	10,789	11,056	71,843	6.50	18
19	Laundry	5,846	6,691	46,468	6.94	19
20	Administrator	1,885	2,274	84,658	37.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,925	6,389	105,938	16.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,519	1,558	13,148	8.44	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coor</u>	1,398	1,530	27,043	17.68	33
34	TOTAL (lines 1 - 33)	156,264	167,399	\$ 1,805,414 *	\$ 10.79	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	\$ 7,680	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	600	10-3	37
38	Nurse Consultant	T	1,728	10-3	38
39	Pharmacist Consultant	H	3,527	10-3	39
40	Physical Therapy Consultant	L	2,750	10a-3	40
41	Occupational Therapy Consultant	Y	4,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,398	11-3	44
45	Social Service Consultant	E	2,835	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,118		49

C. CONTRACT NURSES

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
HOWARD ALTER	ADMIN		\$ 84,658	Workers' Compensation Insurance	\$ 37,663	IDPH License Fee	\$ 200	
			0	Unemployment Compensation Insurance	24,737	Advertising: Employee Recruitment	19,287	
				FICA Taxes	137,030	Health Care Worker Background Check	1,279	
				Employee Health Insurance	114,389	(Indicate # of checks performed _____)		
				Employee Meals	35,058	MARKETING/ADV/PROMO	25,857	
				Illinois Municipal Retirement Fund (IMRF)*		RELATED PARTY	1,022	
				EMPLOYEE BENEFITS - OTHER	22,161	CONTRIBUTIONS	2,600	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	5,930	
				PENSION/PROFIT SHARING PLANS	0	LICENSES & PERMITS	1,788	
				CHICAGO HEAD TAX	4,878	CONTRIBUTIONS	(2,600)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(25,857)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 84,658	TOTAL (agree to Schedule V,	\$ 375,916	TOTAL (agree to Sch. V,	\$ 29,506	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 120,000				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,000				Seminar Expense	0
(Attach a copy of any management service agreement)							RELATED PARTY	834
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
HEALTH DATA SYSTEM	DATA PROCESSING		2,252	TOTAL		\$	line 24, col. 8)	\$ 834
DART CHART SYSTEM	MEDICARE CONSULTNT		10,440					
SACHNOFF & WEAVER	LEGAL		4,348					
FINKEL, MARTWICK & COLES	LEGAL		669					
KRUPNICK, BOKOR, KAGDA	ACCOUNTING		14,717					
FROST, RUTTENBERG	ACCOUNTING		3,075					
ECONOCARE	PURCHASING CONS		2,124					
FOX RIVER FOODS	PURCHASING CONS		1,000					
PERSONNEL PLANNERS	UC CONSULTANT		1,389					
BRENDA COHEN	COLLECTION		37					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 40,051					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
													Improvement Type
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1996	\$ 8,009	5	\$ 1,602	\$ 1,602	\$ 1,602	\$ 800	\$	\$	\$	\$	\$
2	PAINT/DECORATING	1998	30,058	3	5,010	10,020	10,020	5,008					
3	PAINT/DECORATING	1999	5,502	3		917	1,834	1,834	917				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 43,569		\$ 6,612	\$ 12,539	\$ 13,456	\$ 7,642	\$ 917	\$	\$	\$	\$

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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. IL COUNCIL ON LONG TERM CARE \$5,180
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,374 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 _____ 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 of Public Aid during this cost report period. \$ 64,605
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 35,058 Has any meal income been offset against related costs? _____ 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,680
	REPAIRS & MAINTENANCE	160
		0
		7,840
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,144
		0
		1,144
5	HEAT & OTHER UTILITIES	
	GAS HEAT	43,678
	ELECTRICITY	9,025
	WATER	7,249
	CABLE TV - LOBBY	0
		0
		59,952
6	MAINTENANCE	
	GROUNDS MAINTENANCE	320
	PAINTING & DECORATING	259
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,101
	ELEVATOR MAINTENANCE & REPAIR	3,371
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,000
	FIRE SERVICE	0
		0
		0
		0
		9,051
7	OTHER	
	SCAVENGER	13,442
	SECURITY SERVICE	0
		13,442
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,400
		2,400

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	600
	PHARMACY CONSULTANT XVIII B 39-2	3,527
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,728
		0
		0
		5,855
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	2,750
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	4,200
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		6,950
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,398
		0
		3,398
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,835
		0
		2,835
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	425
17		ADMINISTRATIVE	
	XIX B	MANAGEMENT FEES	120,000
18		DIRECTORS FEES	0
19		PROFESSIONAL SERVICES	
	XIX C	DATA PROCESSING	2,252
	XIX C	ADMINISTRATIVE CONSULTANTS	0
	XIX C	PROFESSIONAL FEES	37,799
			0
			40,051
20		FEES,SUBSCRIPTIONS,PROMOTIONS	
	VI 19 XIX F	ENTERTAINMENT & MARKETING	0
	VI 25 XIX F	ADV & PROMO-NON PATIENT RELATED	25,857
	XIX F	EMPLOYEE WANT ADS	19,287
	VI 20 XIX F	CONTRIBUTIONS	0
	XIX F	DUES & SUBSCRIPTIONS	5,930
	XIX F	LICENSES & PERMITS	1,988
	XIX F	PUBLIC RELATIONS-PATIENT RELATED	0
	VI 28 XIX F	ADVERTISING-YELLOW PAGES	0
	VI 17 XIX F	TRUST FEES / FRANCHISE TAX / ETC	0
	VI 20 XIX F	CONTRIBUTIONS - POLITICAL	2,600
	XIX F	HEALTH CARE WORKER BACKGROUND CHEC	1,279
			56,941
21		CLERICAL & GENERAL OFFICE EXPENSES	
		BANK CHARGES	690
		EQUIPMENT REPAIR & MAINTENANCE	4,856
		OUTSIDE CLERICAL SERVICES	175,720
	VI 18	PENALTIES	100
		HOME OFFICE EXPENSE	0
		THEFT & DAMAGE LOSS	0
		TELEPHONE	18,948
		MESSENGER SERVICE	0
			0
			200,314

LINE	SCHED REF		TOTAL
22		EMPLOYEE BENEFITS & PAYROLL TAXES	
	XIX D	FICA TAXES	137,030
	XIX D	UNEMPLOYMENT COMPENSATION	24,737
	XIX D	WORKERS COMPENSATION INSURANC	37,663
	XIX D	HOSPITALIZATION INSURANCE	114,389
	XIX D	EMPLOYEE BENEFITS - OTHER	22,161
	XIX D	EMPLOYEE PHYSICAL EXAMS	0
	VI 21/XIX D	INSURANCE - EXECUTIVE LIFE	0
	XIX D	PENSION/PROFIT SHARING PLANS	0
	XIX D	CHICAGO HEAD TAX	4,878
			340,858
23		INSERVICE TRAINING & EDUCATION	
		EDUCATION & SEMINARS	965
			965
24		TRAVEL & SEMINARS	
	XIX G	EDUCATION & SEMINARS	0
	XIX G	TRAVEL	0
			0
			0
25		ADMIN. STAFF TRANSPORTATION	
		TRANSPORTATION - STAFF	7,265
			7,265
26		INSURANCE - PROP. LIAB & MALPRACTICE	
		GENERAL INSURANCE	93,255
			93,255
27		OTHER	
	VI 24	BAD DEBTS	3,931
			0
			3,931

GRAND TOTAL COLUMN 3 OTHER

976,872

WATERFRONT TERRACE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	173,797
LESS SALES TAX	(626)

NET FOOD	173,171
TOTAL PATIENT CENSUS	40,798
TIME 3 MEALS PER DAY	3

TOTAL PATIENT MEALS	122394
ADD # EMPLOYEE MEALS/DAY	85
TIME # DAYS	365

TOTAL EMPLOYEE MEALS	31025

PATIENT MEALS	122394
ADD EMPLOYEE MEALS	31025

TOTAL MEALS/YEAR	153419
NET FOOD	173171
DIVIDE TOTAL MEALS/YEAR	153419
COST PER MEAL	1.13
TIME EMPLOYEE MEALS	31025

EMPLOYEE MEAL RECLASSIFICATION	35058
	=====