



Facility Name & ID Number WATERFRONT TERRACE

# 0028076 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**III. STATISTICAL DATA**

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

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

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	722	2	4,396	5,120	8
9	SNF/PED					9
10	ICF	31,761	1,919		33,680	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,483	1,921	4,396	38,800	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.09%**

**D. How many bed-hold days during this year were paid by the Department?**  
0 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)**  
NONE

**F. Does the facility maintain a daily midnight census?** YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 04/01/83

**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 3,794

Medicare Intermediary MUTUAL OF OMAHA

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	186,944	22,467	8,668	218,079		218,079	0	218,079		1
2	Food Purchase		159,152		159,152	0	159,152	(679)	158,473		2
3	Housekeeping	0	21,248	117,670	138,918		138,918	0	138,918		3
4	Laundry	75	21,945	82,629	104,649	0	104,649	0	104,649		4
5	Heat and Other Utilities			79,889	79,889		79,889	1,005	80,894		5
6	Maintenance	62,430	70,441	11,844	144,715		144,715	10,828	155,543		6
7	Other (specify):*			16,227	16,227		16,227	583	16,810		7
8	<b>TOTAL General Services</b>	<b>249,449</b>	<b>295,253</b>	<b>316,927</b>	<b>861,629</b>	<b>0</b>	<b>861,629</b>	<b>11,737</b>	<b>873,366</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		2,100	2,100		2,100	0	2,100		9
10	Nursing and Medical Records	1,358,239	79,755	3,856	1,441,850		1,441,850	(2,784)	1,439,066		10
10a	Therapy	0	1,351	391	1,742		1,742	0	1,742		10a
11	Activities	124,014	7,493	1,860	133,367		133,367	0	133,367		11
12	Social Services	29,272		1,782	31,054		31,054	0	31,054		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			530	530		530	0	530		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,511,525</b>	<b>88,599</b>	<b>10,519</b>	<b>1,610,643</b>	<b>0</b>	<b>1,610,643</b>	<b>(2,784)</b>	<b>1,607,859</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	96,354		115,000	211,354		211,354	(10,124)	201,230		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			71,613	71,613		71,613	2,714	74,327		19
20	Dues, Fees, Subscriptions & Promotions			88,051	88,051		88,051	(49,779)	38,272		20
21	Clerical & General Office Expenses	151,313	22,526	299,972	473,811		473,811	(238,620)	235,191		21
22	Employee Benefits & Payroll Taxes			466,310	466,310	0	466,310	0	466,310		22
23	Inservice Training & Education			1,755	1,755		1,755	0	1,755		23
24	Travel and Seminar			0	0		0	170	170		24
25	Other Admin. Staff Transportation			8,043	8,043		8,043	(1,993)	6,050		25
26	Insurance-Prop.Liab.Malpractice			92,271	92,271		92,271	3,807	96,078		26
27	Other (specify):*			55,778	55,778		55,778	(25,435)	30,343		27
28	<b>TOTAL General Administration</b>	<b>247,667</b>	<b>22,526</b>	<b>1,198,793</b>	<b>1,468,986</b>	<b>0</b>	<b>1,468,986</b>	<b>(319,260)</b>	<b>1,149,726</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,008,641</b>	<b>406,378</b>	<b>1,526,239</b>	<b>3,941,258</b>	<b>0</b>	<b>3,941,258</b>	<b>(310,307)</b>	<b>3,630,951</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,364
	REPAIRS & MAINTENANCE	304
		0
		8,668
3	<b>HOUSEKEEPING</b>	
	CONTRACTED HOUSEKEEPING SERVICE	117,670
		0
		117,670
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	4,183
	CONTRACTED LAUNDRY SERVICE	78,446
		0
		82,629
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	61,212
	ELECTRICITY	7,663
	WATER	11,014
	CABLE TV - LOBBY	0
		0
		79,889
6	<b>MAINTENANCE</b>	
	GROUND MAINTENANCE	1,146
	PAINTING & DECORATING	398
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,209
	ELEVATOR MAINTENANCE & REPAIR	2,320
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,771
	FIRE SERVICE	0
		0
		0
		0
		11,844
7	<b>OTHER</b>	
	SCAVENGER	16,227
	SECURITY SERVICE	0
		0
		0
		16,227
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,100
		2,100

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	3,856
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		3,856
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	391
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		391
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,860
		0
		1,860
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,782
		0
		1,782
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	530
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	115,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,276
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	66,337
		0
		71,613
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	48,406
	EMPLOYEE WANT ADS XIX F	24,176
	CONTRIBUTIONS VI 20 XIX F	320
	DUES & SUBSCRIPTIONS XIX F	5,940
	LICENSES & PERMITS XIX F	3,348
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,691
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	4,170
	PATIENT BACKGROUND CHECKS XIX F	0
		88,051
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	12,856
	EQUIPMENT REPAIR & MAINTENANCE	16,079
	OUTSIDE CLERICAL SERVICES	246,770
	PENALTIES / OVERDRAFT CHARGES VI 18	525
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	23,742
	MESSENGER SERVICE	0
		0
		299,972

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	153,089
	UNEMPLOYMENT COMPENSATION XIX D	67,198
	WORKERS COMPENSATION INSURANC XIX D	60,843
	HOSPITALIZATION INSURANCE XIX D	161,422
	EMPLOYEE BENEFITS - OTHER XIX D	19,042
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	4,716
		0
		466,310
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,755
		1,755
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,043
		8,043
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	92,271
		92,271
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	55,778
		55,778

GRAND TOTAL COLUMN 3 OTHER

1,526,239

WATERFRONT TERRACE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	159,152	PATIENT MEALS	116400
LESS SALES TAX	(679)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	158,473	TOTAL MEALS/YEAR	116400
TOTAL PATIENT CENSUS	38,800	NET FOOD	158473
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	116400
	-----		
TOTAL PATIENT MEALS	116400	COST PER MEAL	1.36
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

WATERFRONT TERRACE

#0028076

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	
	<b>D. Ownership</b>											
30	Depreciation			72,933	72,933		72,933	68,323	141,256			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			59,029	59,029		59,029	94,765	153,794			32
33	Real Estate Taxes			111,653	111,653		111,653	3,086	114,739			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)	0			34
35	Rent-Equipment & Vehicles			6,531	6,531		6,531	5,579	12,110			35
36	Other (specify):*				0		0	0	0			36
37	<b>TOTAL Ownership</b>			711,347	711,347	0	711,347	(289,448)	421,899			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		125,575	254,546	380,121		380,121	(686)	379,435			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	<b>TOTAL Special Cost Centers</b>	0	125,575	319,151	444,726	0	444,726	(686)	444,040			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,008,641	531,953	2,556,737	5,097,331	0	5,097,331	(600,441)	4,496,890			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:

01/01/2006

Ending:

12/31/2006

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	53,634	30		9
10	Interest and Other Investment Income	(11,703)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(679)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(525)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,011)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(254)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,778)	27		24
25	Fund Raising, Advertising and Promotional	(48,406)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(44,895)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (110,617)		\$ 0	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(489,824)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (489,824)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (600,441)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY

48	49	50	51	52
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WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (41,926)	21	1
2	MARKETING TRAVEL	(2,969)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(44,895)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number WATERFRONT TERRACE

# 0028076 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(679)	0	0	0	0	0	0	0	0	0	0	(679)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,005	0	0	0	0	0	0	0	0	1,005	5
6	Maintenance	0	0	4,886	5,942	0	0	0	0	0	0	0	10,828	6
7	Other (specify):*	0	0	0	0	583	0	0	0	0	0	0	583	7
8	<b>TOTAL General Services</b>	<b>(679)</b>	<b>0</b>	<b>5,891</b>	<b>5,942</b>	<b>583</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11,737</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(2,784)	0	0	0	0	0	(2,784)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,784)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,784)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(115,000)	0	104,876	0	0	0	0	0	0	0	(10,124)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(254)	2,000	968	0	0	0	0	0	0	0	0	2,714	19
20	Fees, Subscriptions & Promotions	(50,417)	0	638	0	0	0	0	0	0	0	0	(49,779)	20
21	Clerical & General Office Expenses	(42,451)	(246,770)	43,833	6,768	0	0	0	0	0	0	0	(238,620)	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	170	0	0	0	0	0	0	0	0	170	24
25	Other Admin. Staff Transportation	(2,969)	0	976	0	0	0	0	0	0	0	0	(1,993)	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,807	0	0	0	0	0	0	0	0	3,807	26
27	Other (specify):*	(55,778)	0	8,185	0	22,158	0	0	0	0	0	0	(25,435)	27
28	<b>TOTAL General Administration</b>	<b>(151,869)</b>	<b>(359,770)</b>	<b>58,577</b>	<b>111,644</b>	<b>22,158</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(319,260)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(152,548)</b>	<b>(359,770)</b>	<b>64,468</b>	<b>117,586</b>	<b>22,741</b>	<b>(2,784)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(310,307)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	53,634	6,425	8,264	0	0	0	0	0	0	0	0	68,323	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,703)	104,049	2,419	0	0	0	0	0	0	0	0	94,765	32
33	Real Estate Taxes	0	0	3,086	0	0	0	0	0	0	0	0	3,086	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	5,579	0	0	0	0	0	0	0	0	5,579	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>41,931</b>	<b>(350,727)</b>	<b>19,348</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(289,448)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(686)	0	0	0	0	0	(686)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(686)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(686)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(110,617)</b>	<b>(710,497)</b>	<b>83,816</b>	<b>117,586</b>	<b>22,741</b>	<b>(3,470)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(600,441)</b>	<b>45</b>

**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
<b>SCHEDULE ATTACHED</b>		<b>SCHEDULE ATTACHED</b>		<b>SCHEDULE ATTACHED</b>		

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 <b>MANAGEMENT FEE</b>	\$ 115,000	<b>DYNAMIC HEALTHCARE CONSULTANT</b>		\$	\$ (115,000)	1
2	V	21 <b>BOOKKEEPING SERVICES</b>	246,770	" "			(246,770)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 <b>RENT</b>	461,201	<b>WATERFRONT TERRACE ASSOCIATES</b>			(461,201)	7
8	V	30 <b>DEPRECIATION</b>		" "		6,425	6,425	8
9	V	19 <b>ACCOUNTING &amp; LEGAL</b>		" "		2,000	2,000	9
10	V	32 <b>INTEREST</b>		" "		104,049	104,049	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 822,971			\$ 112,474	\$ * (710,497)	14

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

Facility Name & ID Number WATERFRONT TERRACE# 0028076Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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 CONSULTANT		\$ 1,005	\$	1,005	15
16	V	6 REPAIR & MAINT.		"		4,886		4,886	16
17	V	19 PROFESSIONAL FEES		"		968		968	17
18	V	20 DUES AND SUBSCRIPTION		"		638		638	18
19	V	21 CLERICAL & GENERAL		"		43,833		43,833	19
20	V	24 SEMINARS AND TRAVEL		"		170		170	20
21	V	25 AUTO EXPENSE		"		976		976	21
22	V	26 INSURANCE		"		3,807		3,807	22
23	V	27 EMP. BEN.- GEN, ADMIN.		"		8,185		8,185	23
24	V	30 DEPRECIATION		"		8,264		8,264	24
25	V	32 INTEREST		"		2,419		2,419	25
26	V	33 REAL ESTATE TAXES		"		3,086		3,086	26
27	V	35 EQUIPMENT RENTAL		"		5,579		5,579	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 83,816	\$ *	83,816	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP.- D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 5,942	\$	5,942	15
16	V	10 DON SALARY - NON OWNER		"					16
17	V	17 ADMIN CMP.- M. MAUER		"		16,161		16,161	17
18	V	17 ADMIN CMP.- M. AARON		"		18,388		18,388	18
19	V	17 ADMIN CMP.- F. AARON		"		10,399		10,399	19
20	V	17 ADMIN CMP.- S. GOLDSTEIN		"					20
21	V	17 ADMIN CMP.- S. KOPLIN		"		10,590		10,590	21
22	V	17 ADMIN CMP.- D. MAGAFAS		"		11,429		11,429	22
23	V	17 ADMIN CMP.- S. LEVY		"		15,446		15,446	23
24	V	17 ADMIN CMP.- HOWARD ALTER		"		12,000		12,000	24
25	V	17 ADMIN CMP.- NON-OWNER		"		10,463		10,463	25
26	V	21 CLERICAL. CMP. - S. AARON		"		6,768		6,768	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 117,586	\$ *	117,586	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 583	\$	583	15
16	V	17 DON SALARY - NON OWNER		"					16
17	V	27 EMP. BEN. - M. MAUER		"		1,155		1,155	17
18	V	27 EMP. BEN. - M. AARON		"		1,824		1,824	18
19	V	27 EMP. BEN. - F. AARON		"		7,367		7,367	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		"					20
21	V	27 EMP. BEN. - S. KOPLIN		"		3,354		3,354	21
22	V	27 EMP. BEN. - D. MAGAFAS		"		2,014		2,014	22
23	V	27 EMP. BEN. - S. LEVY		"		1,586		1,586	23
24	V	27 EMP. BEN. - H. ALTER		"		1,101		1,101	24
25	V	27 EMP. BEN. - NON-OWNER		"		2,378		2,378	25
26	V	27 EMP. BEN. - S. AARON				1,379		1,379	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 22,741	\$ *	22,741	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 MEDICAL SUPPLIES	\$ 24,791	LINCOLN MEDICAL SUPPLIES, INC		\$ 22,007	\$ (2,784)
16	V	39 ANCILLARY SERVICES	6,112	" "		5,426	(686)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,903			\$ 27,433	\$ * (3,470)

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

Facility Name &amp; ID Number

WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	ADMINISTRATION				SCHEDULE ATTACHED		SALARY	\$ 16,161	17-7	1
2	MAURICE AARON	ADMINISTRATION						SALARY	18,388	17-7	2
3	FRED AARON	ADMINISTRATION						SALARY	10,399	17-7	3
4	FRED AARON	ADMINISTRATION						SALARY	20,500	17-7	4
5	SHARON AARON	CLERICAL						SALARY	6,768	17-7	5
6	HOWARD ALTER	ADMINISTRATOR						SALARY	12,000	17-7	6
7	HOWARD ALTER	ADMINISTRATOR						SALARY	96,354	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 180,570		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: **01/01/2006**

Ending: **2/31/2006**

**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 CONSULTANTS  
 Street Address 3359 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	408,951	12	\$ 10,593	\$ 38,800	\$ 1,005	1
2	6	REPAIR & MAINT.	"	408,951	12	51,500	38,800	4,886	2
3	19	PROFESSIONAL FEES	"	408,951	12	10,199	38,800	968	3
4	20	DUES AND SUBSCRIPTION	"	408,951	12	6,724	38,800	638	4
5	21	CLERICAL & GENERAL	"	408,951	12	461,999	356,210	43,833	5
6	24	SEMINARS AND TRAVEL	"	408,951	12	1,791	38,800	170	6
7	25	AUTO EXPENSE	"	408,951	12	10,284	38,800	976	7
8	26	INSURANCE	"	408,951	12	40,124	38,800	3,807	8
9	27	EMP. BEN.- GEN, ADMIN.	"	408,951	12	86,265	38,800	8,185	9
10	30	DEPRECIATION	"	408,951	12	87,103	38,800	8,264	10
11	32	INTEREST	"	408,951	12	25,499	38,800	2,419	11
12	33	REAL ESTATE TAXES	"	408,951	12	32,525	38,800	3,086	12
13	35	EQUIPMENT RENTAL	"	408,951	12	58,806	38,800	5,579	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					\$ 883,412	\$ 356,210	\$ 83,816	25

Facility Name & ID Number WATERFRONT TERRACE

# 0028076 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 CONSULTANTS  
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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	12	\$ 54,933	\$ 54,933	4	\$ 5,942	1
2	10	DON DALARY - NON OWNER	" "	40	12	74,145	74,145		0	2
3	17	ADMIN CMP.- M. MAUER	" "	40	12	170,000	170,000	4	16,161	3
4	17	ADMIN CMP.- M. AARON	" "	40	12	170,000	170,000	4	18,388	4
5	17	ADMIN CMP.- F. AARON	" "	47	12	57,500	57,500	9	10,399	5
6	17	ADMIN CMP.- S. GOLDSTEIN	" "	45	12	27,199	27,199		0	6
7	17	ADMIN CMP.- S. KOPLIN	" "	40	12	71,067	71,067	6	10,590	7
8	17	ADMIN CMP.- D. MAGAFAS	" "	45	12	105,603	105,603	5	11,429	8
9	17	ADMIN CMP.- S. LEVY	" "	45	12	162,480	162,480	4	15,446	9
10	17	ADMIN CMP.- HOWARD ALTER	" "	40	12	12,000	12,000	40	12,000	10
11	17	ADMIN CMP.- NON-OWNER	" "	45	12	96,679	96,679	5	10,463	11
12	21	CLERICAL. CMP. - S. AARON	" "	40	12	71,245	71,245	4	6,768	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					\$ 1,072,851	\$ 1,072,851		\$ 117,586	25

Facility Name & ID Number WATERFRONT TERRACE

# 0028076 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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	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	12	\$ 5,392	4	\$ 583	1
2	17	EMP. BEN. - DON NON OWNER	" "	40	12	15,214		0	2
3	27	EMP. BEN. - M. MAUER	" "	40	12	12,149	4	1,155	3
4	27	EMP. BEN. - M. AARON	" "	40	12	16,867	4	1,824	4
5	27	EMP. BEN. - F. AARON	" "	47	12	40,734	9	7,367	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	31,524		0	6
7	27	EMP. BEN. - S. KOPLIN	" "	40	12	22,507	6	3,354	7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	12	18,613	5	2,014	8
9	27	EMP. BEN. - S. LEVY	" "	45	12	16,678	4	1,586	9
10	27	EMP. BEN. - H. ALTER	" "	40	12	1,101	40	1,101	10
11	27	EMP. BEN. - NON-OWNER	" "	45	12	21,972	5	2,378	11
12	27	EMP. BEN. - S. AARON		40	12	14,514	4	1,379	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					\$ 217,265		\$ 22,741	25

Facility Name & ID Number WATERFRONT TERRACE

# 0028076 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	LINCOLN MEDICAL SUPPLIES				\$	\$		\$	1
2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						22,007	2
3	39 ANCILLARY SERVICES	" "						5,426	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				\$	\$		\$ 27,433	25

Facility Name & ID Number

WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	BANK FINANCIAL		X	MORTGAGE	\$43,437.00	10/99	\$ 3,050,000	\$ 1,168,209	11/09	7.7500	\$ 104,049	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	BANK FINANCIAL		X	WORKING CAPITAL				604,018			48,571	6					
7			X	INSURANCE FINANCING							2,021	7					
8		X		WORKING CAPITAL							8,437	8					
9	<b>TOTAL Facility Related</b>				\$43,437.00		\$ 3,050,000	\$ 1,772,227			\$ 163,078	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0			\$ 0	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 3,050,000	\$ 1,772,227			\$ 163,078	15					

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2005 report.		\$	<b>112,000</b>	<b>1</b>
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.)		\$	<b>110,653</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,347)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>113,000</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>111,653</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>80,252</b>	<b>8</b>
	<b>2002</b>	<b>81,152</b>	<b>9</b>
	<b>2003</b>	<b>107,158</b>	<b>10</b>
	<b>2004</b>	<b>109,538</b>	<b>11</b>
	<b>2005</b>	<b>110,653</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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 2005 TAX BILL.**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 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 2005 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 2005.

(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>109,903.27</u>	\$ <u>109,903.27</u>
2. <u>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>749.84</u>	\$ <u>749.84</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>110,653.11</u>	\$ <u>110,653.11</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES       X       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

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

Facility Name &amp; ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	118	1983		\$ 1,508,000	\$ 0	35	\$ 43,086	\$ 43,086	\$ 1,023,293	4
5										5
6										6
7										7
8	RELATED PARTY			42,087	1,079		1,202	123	16,033	8
	Improvement Type**									
9	ROOF	1983		21,787	0	10			21,787	9
10	LEASEHOLD IMPROVEMENT	1985		950	0	15			950	10
11	LEASEHOLD IMPROVEMENT	1986		3,800	0	10			3,800	11
12	LEASEHOLD IMPROVEMENT	1986		1,005	0	15			1,005	12
13	ROOF	1990		13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING	1990		20,776	660	15	660		19,953	14
15	LEASEHOLD IMPROVEMENT	1991		7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT	1991		1,491	47	15	47		1,297	16
17	LEASEHOLD IMPROVEMENT	1992		18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT	1992		1,097	35	15	35		907	18
19	LEASEHOLD IMPROVEMENT	1993		7,742	246	31.5	246		3,372	19
20	LEASEHOLD IMPROVEMENT	1993		3,426	88	39	88		1,184	20
21	LEASEHOLD IMPROVEMENT	1994		25,007	642	39	642		7,997	21
22	ELEVATOR REPAIR	1995		1,500	38	39	38		454	22
23	SPRINKLER REPAIR	1995		4,154	107	39	107		1,261	23
24	BOILER REPAIR, WATER PUMP, ALARM	1996		6,033	154	39	154		1,650	24
25	FENCING	1996		756	50	15	50		525	25
26	NURSE STATION	1996		5,300	136	39	136		1,377	26
27	HANDRAILS	1996		3,735	96	39	96		964	27
28	PARKING LOT REPAVING	1997		14,968	998	15	998		8,578	28
29	TUCKPOINTING, ROOF REPAIR	1997		25,814	662	39	662		6,206	29
30	DRAPERY	1997		14,754	378	39	378		3,536	30
31	DOORS & SIGNS	1997		8,428	216	39	216		2,025	31
32	AIR HANDLER REPAIR & PUMPS	1997		17,005	436	39	436		4,088	32
33	REMODELING	1997		59,133	1,517	39	1,517		14,380	33
34	NURSE STATION	1997		5,106	131	39	131		1,228	34
35										35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## 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	\$	\$ 9,700	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		1,398	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		791	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		1,734	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		432	41
42	REMODELING	1998	21,934	562	39	562		4,730	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		2,881	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		831	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		4,539	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		3,739	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		2,177	47
48	FIRE ALARM	1999	10,286	264	39	264		2,032	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		6,988	49
50	BOILER WORK	1999	7,345	189	39	189		1,446	50
51	CABLE WORK	1999	433	11	39	11		86	51
52	CARPET	1999	18,828	483	39	483		3,667	52
53	ELEVATOR WORK	1999	2,017	52	39	52		399	53
54	AIR CONDITIONING	1999	7,350	189	39	189		1,474	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		1,745	55
56	ROOF WORK	1999	2,187	56	39	56		422	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		11,205	57
58	WINDOWS	1999	5,513	142	39	142		1,074	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		6,210	59
60	RELATED PARTY - NURSE STATION	1999	19,656	504	39	504		3,759	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		33,745	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		4,208	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		663	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		2,429	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		766	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		2,460	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		19,062	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		638	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		626	69
70	TOTAL (lines 4 thru 69)		\$ 2,507,455	\$ 27,398		\$ 69,349	\$ 41,951	\$ 1,325,529	70

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

Facility Name &amp; ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,507,455	\$ 27,398		\$ 69,349	\$ 41,951	\$ 1,325,529	1
2	EXHAUST FAN	2000	890	32	27.5	32		217	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		267	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		748	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247	458	7	458		10,641	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		1,565	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		1,277	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		1,172	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		1,267	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		503	10
11	AC UNIT	2001	786	28	27.5	28		156	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		1,150	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		677	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		311	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		501	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		243	16
17	GENERATOR REPAIRS	2003	71,609	2,604	27.5	2,604		9,005	17
18	DECK & FENCE	2004	10,197	680	15	680		1,700	18
19	A/C REPAIR	2004	2,200	80	27.5	80		196	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		401	20
21	WATER HEATER	2004	6,937	252	27.5	252		620	21
22	NURSE CALL STATION	2004	585	21	27.5	21		52	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		112	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		1,998	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		888	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		1,031	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		684	27
28	ROOF REPAIRS	2005	726	26	27.5	26		38	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		233	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		54	30
31	ROOF REPAIRS	2006	8,575	143	27.5	143		143	31
32	SHOWER ROOM RENOVATION	2006	3,100	52	27.5	52		52	32
33	FLOORING/CARPETING	2006	32,977	550	27.5	550		550	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,806,954	\$ 37,768		\$ 79,719	\$ 41,951	\$ 1,363,981	34

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

Facility Name & ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,806,954	\$ 37,768		\$ 79,719	\$ 41,951	\$ 1,363,981	1
2	CIRCULATION PUMP	2006	2,045	34	27.5	34		34	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	118	27.5	118		118	3
4	WALLCOVERINGS/BLINDS	2006	67,180	1,120	27.5	1,120		1,120	4
5	DOORS	2006	15,104	252	27.5	252		252	5
6	MONITORING CAMERAS	2006	5,530	92	27.5	92		92	6
7	DIESEL GENERATOR	2006	72,592	1,210	27.5	1,210		1,210	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	62	27.5	62		62	8
9	PLUMBING PIPING VALVES	2006	1,643	27	27.5	27		27	9
10	AIR CONDITIONERS	2006	2,480	41	27.5	41		41	10
11	SINK/IRON RAILING	2006	1,483	25	27.5	25		25	11
12	WALL/GATE MACHINE ROOM	2006	2,960	49	27.5	49		49	12
13	ALARM SYSTEM REPAIRS	2006	2,985	50	27.5	50		50	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,991,784	\$ 40,848		\$ 82,799	\$ 41,951	\$ 1,367,061	34

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 578,638	\$ 34,413	\$ 53,372	\$ 18,959		\$ 363,644	71
72	Current Year Purchases	17,279	3,456	864	(2,592)		864	72
73	Fully Depreciated Assets	344,941			0		344,941	73
74	RELATED PARTY	48,496	7,186	4,221	(2,965)			74
75	TOTALS	\$ 989,354	\$ 45,055	\$ 58,457	\$ 13,402		\$ 709,449	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				\$ 14,935	\$ 1,719	\$	\$ (1,719)		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 14,935	\$ 1,719	\$ 0	\$ (1,719)		\$ 0	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)	\$ 4,096,073	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,622	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 141,256	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 53,634	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,076,510	85

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

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

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 3,822 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>2001 HONDA</u>	\$ <u>429.00</u>	\$ <u>2,709</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>429.00</u>	\$ <u>2,709</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	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	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 124,703	\$		\$ 124,703	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,550			4,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			125,293			125,293	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				97,768		97,768	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, XRAY Other (specify): <b>RENTALS</b>						27,807		27,807	13
14	<b>TOTAL</b>			\$		\$ 254,546	\$ 125,575		\$ 380,121	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,080,329		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,546		6
7	Other Prepaid Expenses	8,729		7
8	Accounts Receivable (owners or related parties)	39,962		8
9	Other(specify): <u>RE TAX ESCROW</u>	85,190		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,266,756	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,150,459		15
16	Equipment, at Historical Cost	955,781		16
17	Accumulated Depreciation (book methods)	(1,159,113)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>DEPOSIT</u>	50,598		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 997,725	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,264,481	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 636,526	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	604,018		29
30	Accrued Salaries Payable	158,086		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,792		31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,000		32
33	Accrued Interest Payable	6,838		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,538,260	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,538,260	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 726,221	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,264,481	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>720,566</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>720,566</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>5,655</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>5,655</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>726,221</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,912,865	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,912,865	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,418	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 178,418	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	11,703	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,703	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,102,986	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	861,629	31
32	Health Care	1,610,643	32
33	General Administration	1,468,986	33
	<b>B. Capital Expense</b>		
34	Ownership	711,347	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	380,121	35
36	Provider Participation Fee	64,605	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,097,331	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	5,655	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 5,655	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,885	2,147	\$ 70,133	\$ 32.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,509	1,484	44,036	29.67	3
4	Licensed Practical Nurses	29,763	32,969	701,175	21.27	4
5	CNAs & Orderlies	53,116	57,576	520,843	9.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,023	23,914	11.82	9
10	Activity Assistants	8,299	8,946	100,100	11.19	10
11	Social Service Workers	2,000	2,080	29,272	14.07	11
12	Dietician					12
13	Food Service Supervisor	1,056	1,217	18,597	15.28	13
14	Head Cook	5,695	6,356	61,588	9.69	14
15	Cook Helpers/Assistants	10,074	10,627	106,759	10.05	15
16	Dishwashers					16
17	Maintenance Workers	4,018	4,332	62,430	14.41	17
18	Housekeepers					18
19	Laundry	8	8	75	9.38	19
20	Administrator	1,933	2,135	96,354	45.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,544	8,163	151,313	18.54	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	2,004	2,161	22,052	10.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,808	142,224	\$ 2,008,641 *	\$ 14.12	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	\$ 8,364	1-3	35
36	Medical Director	2,100	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	3,856	10-3	39
40	Physical Therapy Consultant	391	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	39	11-3	44
45	Social Service Consultant	33	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	72	\$ 18,353	49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
HOWARD ALTER	ADMINISTRATOR		\$ 96,354	Workers' Compensation Insurance	\$ 60,843	IDPH License Fee	\$ 1,760	
				Unemployment Compensation Insurance	67,198	Advertising: Employee Recruitment	24,176	
				FICA Taxes	153,089	Health Care Worker Background Check	4,170	
				Employee Health Insurance	161,422	(Indicate # of checks performed _____)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,011	
				EMPLOYEE BENEFITS - OTHER	19,042	MARKETING/ADV/PROMO	48,406	
						LICENSES/DUES/SUBSCRIPTIONS	7,528	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 96,354			MGMT CO ALLOC	638	
(List each licensed administrator separately.)						TRUST/FRANCHISE/CONTRIB/ETC	(2,011)	
				CHICAGO HEAD TAX	4,716	Less: Public Relations Expense	( 0 )	
						Non-allowable advertising	(48,406)	
						Yellow page advertising	( 0 )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 466,310	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 38,272	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEE			\$ 115,000				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 115,000				Seminar Expense	0
(Attach a copy of any management service agreement)							MGMT CO ALLOC	170
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount				TOTAL	\$ 170
SEE SCHEDULE ATTACHED			71,613					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 71,613					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number WATERFRONT TERRACE

# 0028076

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$5,271
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,373 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 64,605  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ 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