

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

<p>I. IDPH License ID Number: <u>0028076</u></p> <p>Facility Name: <u>WATERFRONT TERRACE</u></p> <p>Address: <u>7750 SOUTH SHORE DRIVE</u> <u>CHICAGO</u> <u>60649</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u></p> <p>HFS ID Number: <u>36-3230699</u></p> <p>Date of Initial License for Current Owners: <u>04/01/1983</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <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>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARSHALL MAUER</u> (Date) _____</td> </tr> <tr> <td>(Title) <u>TREASURER</u></td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARSHALL MAUER</u> (Date) _____	(Title) <u>TREASURER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>76</u>	Intermediate (ICF)	<u>76</u>	<u>27,740</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	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	<u>1,355</u>	<u>24</u>	<u>5,437</u>	<u>6,816</u>	8
9	SNF/PED					9
10	ICF	<u>29,540</u>	<u>1,848</u>	<u>209</u>	<u>31,597</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,895</u>	<u>1,872</u>	<u>5,646</u>	<u>38,413</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.19%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/01/1983

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/1983 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 16 and days of care provided 5,413

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	198,633	23,746	10,093	232,472		232,472		232,472		1
2	Food Purchase		183,144		183,144		183,144	(841)	182,303		2
3	Housekeeping		18,602	120,010	138,612		138,612		138,612		3
4	Laundry		17,872	86,364	104,236		104,236		104,236		4
5	Heat and Other Utilities			97,938	97,938		97,938	958	98,896		5
6	Maintenance	63,730	91,745	15,297	170,772		170,772	14,076	184,848		6
7	Other (specify):*			22,528	22,528		22,528	639	23,167		7
8	TOTAL General Services	262,363	335,109	352,230	949,702		949,702	14,832	964,534		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	1,460,889	80,114	3,796	1,544,799		1,544,799	(745)	1,544,054		10
10a	Therapy		809		809		809		809		10a
11	Activities	112,160	9,123	1,350	122,633		122,633		122,633		11
12	Social Services			2,727	2,727		2,727		2,727		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,573,049	90,046	9,073	1,672,168		1,672,168	(745)	1,671,423		16
	C. General Administration										
17	Administrative	111,275		60,000	171,275		171,275	72,939	244,214		17
18	Directors Fees										18
19	Professional Services			72,763	72,763		72,763	4,914	77,677		19
20	Dues, Fees, Subscriptions & Promotions			65,802	65,802		65,802	(40,197)	25,605		20
21	Clerical & General Office Expenses	135,365	19,680	355,969	511,014		511,014	(298,038)	212,976		21
22	Employee Benefits & Payroll Taxes			421,392	421,392		421,392		421,392		22
23	Inservice Training & Education			1,680	1,680		1,680		1,680		23
24	Travel and Seminar							261	261		24
25	Other Admin. Staff Transportation			9,593	9,593		9,593	(286)	9,307		25
26	Insurance-Prop.Liab.Malpractice			65,081	65,081		65,081	1,967	67,048		26
27	Other (specify):*			17,932	17,932		17,932	21,017	38,949		27
28	TOTAL General Administration	246,640	19,680	1,070,212	1,336,532		1,336,532	(237,423)	1,099,109		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,082,052	444,835	1,431,515	3,958,402		3,958,402	(223,336)	3,735,066		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,364
	REPAIRS & MAINTENANCE	1,729
		0
		10,093
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICE	120,010
		0
		120,010
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	6,358
	CONTRACTED LAUNDRY SERVICE	80,006
		86,364
5	HEAT & OTHER UTILITIES	
	GAS HEAT	50,801
	ELECTRICITY	35,813
	WATER	11,324
	CABLE TV - LOBBY	0
		0
		97,938
6	MAINTENANCE	
	GROUNDS MAINTENANCE	439
	PAINTING & DECORATING	977
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,038
	ELEVATOR MAINTENANCE & REPAIR	4,808
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,035
	FIRE SERVICE	0
		0
		0
		0
		0
		15,297
7	OTHER	
	SCAVENGER	22,528
	SECURITY SERVICE	0
		0
		0
		22,528
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	1,200
		1,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	3,776
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	20
		0
		0
		3,796
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,350
		0
		1,350
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,727
		0
		2,727
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	60,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,009
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	67,754
		0
		72,763
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	37,451
	EMPLOYEE WANT ADS XIX F	12,443
	CONTRIBUTIONS VI 20 XIX F	1,978
	DUES & SUBSCRIPTIONS XIX F	6,664
	LICENSES & PERMITS XIX F	3,002
	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	1,504
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,760
	PATIENT BACKGROUND CHECKS XIX F	0
		65,802
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	15,515
	OUTSIDE CLERICAL SERVICES	315,220
	PENALTIES / OVERDRAFT CHARGES VI 18	6,707
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,527
	MESSENGER SERVICE	0
		0
		355,969

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	157,348
	UNEMPLOYMENT COMPENSATION XIX D	45,782
	WORKERS COMPENSATION INSURANC XIX D	58,815
	HOSPITALIZATION INSURANCE XIX D	140,180
	EMPLOYEE BENEFITS - OTHER XIX D	15,079
	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	4,188
		0
		421,392
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,680
		1,680
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,593
		9,593
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	65,081
		65,081
27	OTHER	
	BAD DEBTS VI 24	17,932
		17,932

GRAND TOTAL COLUMN 3 OTHER

1,431,515

**WATERFRONT TERRACE
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	183,144
LESS SALES TAX	<u>(841)</u>
NET FOOD	182,303

TOTAL PATIENT CENSUS	38,413
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	115,239

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	115,239
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	115,239

NET FOOD	182,303
DIVIDE TOTAL MEALS/YEAR	<u>115,239</u>

COST PER MEAL	1.58
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number WATERFRONT TERRACE

#0028076

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			76,172	76,172		76,172	75,535	151,707			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,387	72,387		72,387	68,196	140,583			32
33	Real Estate Taxes			112,687	112,687		112,687	3,386	116,073			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)				34
35	Rent-Equipment & Vehicles			5,830	5,830		5,830	7,288	13,118			35
36	Other (specify):*											36
37	TOTAL Ownership			728,277	728,277		728,277	(306,796)	421,481			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,974	398,197	573,171		573,171	(274)	572,897			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		174,974	462,802	637,776		637,776	(274)	637,502			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,082,052	619,809	2,622,594	5,324,455		5,324,455	(530,406)	4,794,049			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:

01/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	66,598	30		9
10	Interest and Other Investment Income	(11,331)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(841)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,707)	21		18
19	Entertainment		20		19
20	Contributions	(3,482)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,932)	27		24
25	Fund Raising, Advertising and Promotional	(37,451)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(33,895)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,041)		\$	30

BHF 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)	(485,365)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (485,365)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (530,406)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING TRAVEL	\$ (1,680)	25	1
2	MARKETING SALARY	(32,203)	21	2
3	COLLECTION FEES	(12)	19	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	(33,895)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning:

01/01/2007

Ending: 12/31/2007

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	(841)	0	0	0	0	0	0	0	0	0	0	(841)	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	958	0	0	0	0	0	0	0	0	958	5
6	Maintenance	0	0	7,508	6,568	0	0	0	0	0	0	0	14,076	6
7	Other (specify):*	0	0	0	0	639	0	0	0	0	0	0	639	7
8	TOTAL General Services	(841)	0	8,466	6,568	639	0	0	0	0	0	0	14,832	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	(745)	0	0	0	0	0	(745)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(745)	0	0	0	0	0	(745)	16
	C. General Administration													
17	Administrative	0	(60,000)	0	132,939	0	0	0	0	0	0	0	72,939	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12)	2,214	2,712	0	0	0	0	0	0	0	0	4,914	19
20	Fees, Subscriptions & Promotions	(40,933)	0	736	0	0	0	0	0	0	0	0	(40,197)	20
21	Clerical & General Office Expenses	(38,910)	(315,220)	48,893	7,199	0	0	0	0	0	0	0	(298,038)	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	261	0	0	0	0	0	0	0	0	261	24
25	Other Admin. Staff Transportation	(1,680)	0	1,394	0	0	0	0	0	0	0	0	(286)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,967	0	0	0	0	0	0	0	0	1,967	26
27	Other (specify):*	(17,932)	0	10,014	0	28,935	0	0	0	0	0	0	21,017	27
28	TOTAL General Administration	(99,467)	(373,006)	65,977	140,138	28,935	0	0	0	0	0	0	(237,423)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(100,308)	(373,006)	74,443	146,706	29,574	(745)	0	0	0	0	0	(223,336)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE# 0028076

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	66,598	6,425	2,512	0	0	0	0	0	0	0	0	75,535	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,331)	76,653	2,874	0	0	0	0	0	0	0	0	68,196	32
33	Real Estate Taxes	0	0	3,386	0	0	0	0	0	0	0	0	3,386	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	7,288	0	0	0	0	0	0	0	0	7,288	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	55,267	(378,123)	16,060	0	0	0	0	0	0	0	0	(306,796)	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	(274)	0	0	0	0	0	(274)	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	(274)	0	0	0	0	0	(274)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(45,041)	(751,129)	90,503	146,706	29,574	(1,019)	0	0	0	0	0	(530,406)	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
<u>SCHEDULED ATTACHED</u>		<u>SCHEDULED ATTACHED</u>		<u>SCHEDULED ATTACHED</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 <u>MANAGEMENT FEE</u>	\$ 60,000	<u>DYNAMIC HEALTHCARE CONSULTANT</u>		\$	\$ (60,000)	1
2	V	21 <u>BOOKKEEPING SERVICES</u>	315,220	" "			(315,220)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 <u>RENT</u>	461,201	<u>WATERFRONT TERRACE ASSOCIATES</u>			(461,201)	7
8	V	30 <u>DEPRECIATION</u>		" "		6,425	6,425	8
9	V	19 <u>ACCOUNTING & LEGAL</u>		" "		2,214	2,214	9
10	V	32 <u>INTEREST</u>		" "		76,653	76,653	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 836,421			\$ 85,292	\$ * (751,129)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANT	100.00%	\$ 958	\$	958	15
16	V	6 REPAIR & MAINT.		"		7,508		7,508	16
17	V	19 PROFESSIONAL FEES		"		2,712		2,712	17
18	V	20 DUES AND SUBSCRIPTION		"		736		736	18
19	V	21 CLERICAL & GENERAL		"		48,893		48,893	19
20	V	24 SEMINARS AND TRAVEL		"		261		261	20
21	V	25 AUTO EXPENSE		"		1,394		1,394	21
22	V	26 INSURANCE		"		1,967		1,967	22
23	V	27 EMP. BEN.- GEN, ADMIN.		"		10,014		10,014	23
24	V	30 DEPRECIATION		"		2,512		2,512	24
25	V	32 INTEREST		"		2,874		2,874	25
26	V	33 REAL ESTATE TAXES		"		3,386		3,386	26
27	V	35 EQUIPMENT RENTAL		"		7,288		7,288	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		\$			\$ 90,503	\$ *	90,503	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	100.00%	\$ 6,568	\$	6,568	15
16	V	10 DON SALARY - NON OWNER		"					16
17	V	17 ADMIN CMP.- M. MAUER		"		17,826		17,826	17
18	V	17 ADMIN CMP.- M. AARON		"		20,381		20,381	18
19	V	17 ADMIN CMP.- F. AARON		"		19,050		19,050	19
20	V	17 ADMIN CMP.- S. GOLDSTEIN		"					20
21	V	17 ADMIN CMP.- S. KOPLIN		"		23,850		23,850	21
22	V	17 ADMIN CMP.- D. MAGAFAS		"		11,961		11,961	22
23	V	17 ADMIN CMP.- HOWARD ALTER		"		12,000		12,000	23
24	V	17 ADMIN CMP.- NON-OWNER		"		11,087		11,087	24
25	V	17 ADMIN CMP.- CFO NON-OWNER		"		16,784		16,784	25
26	V	21 CLERICAL. CMP. - S. AARON		"		7,199		7,199	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		\$			\$ 146,706	\$ *	146,706	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 639	\$	639	15
16	V	17 DON SALARY - NON OWNER		"					16
17	V	27 EMP. BEN. - M. MAUER		"		1,300		1,300	17
18	V	27 EMP. BEN. - M. AARON		"		1,710		1,710	18
19	V	27 EMP. BEN. - F. AARON		"		8,779		8,779	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		"					20
21	V	27 EMP. BEN. - S. KOPLIN		"		8,629		8,629	21
22	V	27 EMP. BEN. - D. MAGAFAS		"		997		997	22
23	V	27 EMP. BEN. - H. ALTER		"		1,120		1,120	23
24	V	27 EMP. BEN. - NON-OWNER		"		2,715		2,715	24
25	V	27 EMP. BEN. - CFO NON-OWNER		"		2,170		2,170	25
26	V	27 EMP. BEN. - S. AARON				1,515		1,515	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		\$			\$ 29,574	\$ *	29,574	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	\$ 25,566	LINCOLN MEDICAL SUPPLIES, INC		\$ 24,821	\$ (745)
16	V	39 ANCILLARY SERVICES	9,385	" "		9,111	(274)
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		\$ 34,951			\$ 33,932	\$ * (1,019)

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

Facility Name & ID Number

WATERFRONT TERRACE

#

0028076

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 17,826	17-7	1
2	MAURICE AARON	ADMINISTRATION						SALARY	20,381	17-7	2
3	FRED AARON	ADMINISTRATION						SALARY	19,050	17-7	3
4	FRED AARON	ADMINISTRATION						SALARY	13,500	17-3	4
5	SHARON AARON	CLERICAL						SALARY	7,199	21-7	5
6	HOWARD ALTER	ADMINISTRATOR						SALARY	12,000	17-7	6
7	HOWARD ALTER	ADMINISTRATOR						SALARY	111,275	17-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 201,231		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: **01/01/2007**

Ending: **2/31/2007**

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	388,610	11	\$ 9,690	38,413	\$ 958	1
2	6	REPAIR & MAINT.	"	388,610	11	75,959	38,413	7,508	2
3	19	PROFESSIONAL FEES	"	388,610	11	27,437	38,413	2,712	3
4	20	DUES AND SUBSCRIPTION	"	388,610	11	7,442	38,413	736	4
5	21	CLERICAL & GENERAL	"	388,610	11	494,636	380,513	48,893	5
6	24	SEMINARS AND TRAVEL	"	388,610	11	2,640	38,413	261	6
7	25	AUTO EXPENSE	"	388,610	11	14,104	38,413	1,394	7
8	26	INSURANCE	"	388,610	11	19,903	38,413	1,967	8
9	27	EMP. BEN.- GEN, ADMIN.	"	388,610	11	101,305	38,413	10,014	9
10	30	DEPRECIATION	"	388,610	11	25,409	38,413	2,512	10
11	32	INTEREST	"	388,610	11	29,080	38,413	2,874	11
12	33	REAL ESTATE TAXES	"	388,610	11	34,252	38,413	3,386	12
13	35	EQUIPMENT RENTAL	"	388,610	11	73,733	38,413	7,288	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					\$ 915,590	\$ 380,513	\$ 90,503	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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	11	\$ 58,010	\$ 58,010	5	\$ 6,568	1
2	10	DON DALARY - NON OWNER	" "	40	11	73,306	73,306			2
3	17	ADMIN CMP.- M. MAUER	" "	40	11	180,000	180,000	4	17,826	3
4	17	ADMIN CMP.- M. AARON	" "	40	11	180,000	180,000	5	20,381	4
5	17	ADMIN CMP.- F. AARON	" "	45	11	95,250	95,250	9	19,050	5
6	17	ADMIN CMP.- S. GOLDSTEIN	" "	45	11	37,505	37,505			6
7	17	ADMIN CMP.- S. KOPLIN	" "	30	11	71,549	71,549	10	23,850	7
8	17	ADMIN CMP.- D. MAGAFAS	" "	50	11	105,666	105,666	6	11,961	8
9	17	ADMIN CMP.- HOWARD ALTER	" "	40	11	12,000	12,000	40	12,000	9
10	17	ADMIN CMP.- NON-OWNER	" "	45	11	97,823	97,823	5	11,087	10
11	17	ADMIN CMP.- CFO NON-OWNER	" "	45	11	169,480	169,480	4	16,784	11
12	21	CLERICAL. CMP. - S. AARON	" "	40	11	72,716	72,716	4	7,199	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					\$ 1,153,305	\$ 1,153,305		\$ 146,706	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	11	\$ 5,643	5	\$ 639	1
2	17	EMP. BEN. - DON NON OWNER	" "	40	11	19,251			2
3	27	EMP. BEN. - M. MAUER	" "	40	11	13,131	4	1,300	3
4	27	EMP. BEN. - M. AARON	" "	40	11	15,105	5	1,710	4
5	27	EMP. BEN. - F. AARON	" "	45	11	43,896	9	8,779	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	11	34,284			6
7	27	EMP. BEN. - S. KOPLIN	" "	30	11	25,887	10	8,629	7
8	27	EMP. BEN. - D. MAGAFAS	" "	50	11	8,807	6	997	8
9	27	EMP. BEN. - H. ALTER	" "	40	11	1,120	40	1,120	9
10	27	EMP. BEN. - NON-OWNER	" "	45	11	23,953	5	2,715	10
11	27	EMP. BEN. - CFO NON-OWNER	" "	45	11	21,910	4	2,170	11
12	27	EMP. BEN. - S. AARON	" "	40	11	15,300	4	1,515	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					\$ 228,287	\$	\$ 29,574	25

Facility Name & ID Number WATERFRONT TERRACE

0028076 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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						24,821	2
3	39 ANCILLARY SERVICES	" "						9,111	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				\$	\$		\$ 33,932	25

Facility Name & ID Number

WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	BANK FINANCIAL		X	MORTGAGE	\$43,437.00	10/99	\$ 3,050,000	\$ 808,046	11/09	7.7500	\$ 76,653	1						
2												2						
3												3						
4	RELATED PARTY											2,874						
5	INSURANCE FINANCING		X									1,101						
Working Capital																		
6	BANK FINANCIAL		X	LINE OF CREDIT		10/07	1,000,000	855,111	10/08	8.2500	61,286	6						
7	WOODBIDGE	X		WORKING CAPITAL				75,000			3,750	7						
8	WINDMILL	X		WORKING CAPITAL				125,000			6,250	8						
9	TOTAL Facility Related				\$43,437.00		\$ 4,050,000	\$ 1,863,157			\$ 151,914	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,050,000	\$ 1,863,157			\$ 151,914	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 2006 report.	\$	113,000	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.)	\$	111,687	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,313)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	114,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	112,687	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	81,152	8
	2003	107,158	9
	2004	109,538	10
	2005	110,653	11
	2006	111,687	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>110,676.55</u>	\$ <u>110,676.55</u>
2. <u>21-30-412-038-0000</u>	<u>NURSING HOME</u>	\$ <u>1,010.67</u>	\$ <u>1,010.67</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>111,687.22</u>	\$ <u>111,687.22</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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:

A. Land.

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	35	\$ 43,086	\$ 43,086	\$ 1,066,379	4
5										5
6										6
7										7
8	RELATED PARTY			43,849	1,124	35	1,253	129	17,957	8
	Improvement Type**									
9	ROOF	1983		21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT	1985		950		15			950	10
11	LEASEHOLD IMPROVEMENT	1986		3,800		10			3,800	11
12	LEASEHOLD IMPROVEMENT	1986		1,005		15			1,005	12
13	ROOF	1990		13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING	1990		20,776	660	15	660		20,613	14
15	LEASEHOLD IMPROVEMENT	1991		7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT	1991		1,491	47	15	47		1,344	16
17	LEASEHOLD IMPROVEMENT	1992		18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT	1992		1,097	35	15	35		942	18
19	LEASEHOLD IMPROVEMENT	1993		7,742	246	31.5	246		3,618	19
20	LEASEHOLD IMPROVEMENT	1993		3,426	88	39	88		1,272	20
21	LEASEHOLD IMPROVEMENT	1994		25,007	642	39	642		8,639	21
22	ELEVATOR REPAIR	1995		1,500	38	39	38		492	22
23	SPRINKLER REPAIR	1995		4,154	107	39	107		1,368	23
24	BOILER REPAIR, WATER PUMP, ALARM	1996		6,033	154	39	154		1,804	24
25	FENCING	1996		756	50	15	50		575	25
26	NURSE STATION	1996		5,300	136	39	136		1,513	26
27	HANDRAILS	1996		3,735	96	39	96		1,060	27
28	PARKING LOT REPAVING	1997		14,968	998	15	998		9,576	28
29	TUCKPOINTING, ROOF REPAIR	1997		25,814	662	39	662		6,868	29
30	DRAPERY	1997		14,754	378	39	378		3,914	30
31	DOORS & SIGNS	1997		8,428	216	39	216		2,241	31
32	AIR HANDLER REPAIR & PUMPS	1997		17,005	436	39	436		4,524	32
33	REMODELING	1997		59,133	1,517	39	1,517		15,897	33
34	NURSE STATION	1997		5,106	131	39	131		1,359	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 & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 10,848	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		1,563	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		884	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		1,939	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		484	41
42	REMODELING	1998	21,934	562	39	562		5,292	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		3,220	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		929	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	539	39	539		5,078	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		4,183	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	258	39	258		2,435	47
48	FIRE ALARM	1999	10,286	264	39	264		2,296	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		7,902	49
50	BOILER WORK	1999	7,345	189	39	189		1,635	50
51	CABLE WORK	1999	433	11	39	11		97	51
52	CARPET	1999	18,828	483	39	483		4,150	52
53	ELEVATOR WORK	1999	2,017	52	39	52		451	53
54	AIR CONDITIONING	1999	7,350	189	39	189		1,663	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		1,978	55
56	ROOF WORK	1999	2,187	56	39	56		478	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,523	39	1,523		12,728	57
58	WINDOWS	1999	5,513	142	39	142		1,216	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	832	39	832		7,042	59
60	RELATED PARTY - NURSE STATION	1999	19,656	505	39	505		4,264	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		38,269	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		4,772	62
63	NURSE CALL SYSTEM	2000	2,778	101	27.5	101		764	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		2,796	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		881	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	373	27.5	373		2,833	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		21,953	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		736	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		722	69
70	TOTAL (lines 4 thru 69)		\$ 2,509,217	\$ 27,444		\$ 69,401	\$ 41,957	\$ 1,395,601	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:

01/01/2007 Ending: 12/31/2007

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		\$ 2,509,217	\$ 27,444		\$ 69,401	\$ 41,957	\$ 1,395,601	1
2	EXHAUST FAN	2000	890	32	27.5	32		249	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		307	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		860	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247		7	458	458	11,099	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		1,836	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		1,502	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		1,379	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		1,490	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		592	10
11	AC UNIT	2001	786	28	27.5	28		184	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	184	27.5	184		1,334	12
13	ELEVATOR REPAIR	2002	6,244	227	27.5	227		904	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		401	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		646	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		313	16
17	GENERATOR REPAIRS	2003	30,936	1,125	27.5	1,125		10,130	17
18	DECK & FENCE	2004	10,197	680	15	680		2,380	18
19	A/C REPAIR	2004	2,200	80	27.5	80		276	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	163	27.5	163		564	20
21	WATER HEATER	2004	6,937	252	27.5	252		872	21
22	NURSE CALL STATION	2004	585	21	27.5	21		73	22
23	GENERATOR REPAIRS	2004	1,250	46	27.5	46		158	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	1,370	27.5	1,370		3,368	24
25	BOILER, PLUMBING & PIPING	2005	16,751	609	27.5	609		1,497	25
26	NURSE CALL SYSTEM	2005	19,432	707	27.5	707		1,738	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	469	27.5	469		1,153	27
28	ROOF REPAIRS	2005	726	26	27.5	26		64	28
29	ELECTRIC WIRING	2005	4,400	160	27.5	160		393	29
30	CUBICLE CURTAINS	2005	1,020	37	27.5	37		91	30
31	ROOF REPAIRS	2006	8,575	312	27.5	312		455	31
32	SHOWER ROOM RENOVATION	2006	3,100	113	27.5	113		165	32
33	FLOORING/CARPETING	2006	32,977	1,199	27.5	1,199		1,749	33
34	TOTAL (lines 1 thru 33)		\$ 2,768,043	\$ 36,756		\$ 79,171	\$ 42,415	\$ 1,443,823	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:

01/01/2007 Ending: 12/31/2007

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 12B, Carried Forward		\$ 2,768,043	\$ 36,756		\$ 79,171	\$ 42,415	\$ 1,443,823	1
2	CIRCULATION PUMP	2006	2,045	74	27.5	74		108	2
3	FIRE SPRINKLER SYSTEM REPAIRS	2006	7,102	258	27.5	258		376	3
4	WALLCOVERINGS/BLINDS	2006	67,180	2,443	27.5	2,443		3,563	4
5	DOORS	2006	15,104	549	27.5	549		801	5
6	MONITORING CAMERAS	2006	5,530	201	27.5	201		293	6
7	DIESEL GENERATOR	2006	72,592	2,640	27.5	2,640		3,850	7
8	EXIT SIGNS/FRONT SIGN	2006	3,726	135	27.5	135		197	8
9	PLUMBING PIPING VALVES	2006	1,643	60	27.5	60		87	9
10	AIR CONDITIONERS	2006	2,480	90	27.5	90		131	10
11	SINK/IRON RAILING	2006	1,483	54	27.5	54		79	11
12	WALL/GATE MACHINE ROOM	2006	2,960	108	27.5	108		157	12
13	ALARM SYSTEM REPAIRS	2006	2,985	109	27.5	109		159	13
14	PUMPS & CONTROL PANEL	2007	15,172	253	27.5	253		253	14
15	WALLCOVERING & VINYL	2007	24,279	405	27.5	405		405	15
16	AIR CONDITIONERS	2007	13,918	232	27.5	232		232	16
17	FIRE ALARM SYSTEM & SECURITY CAMERAS	2007	97,529	1,626	27.5	1,626		1,626	17
18	ELEVATOR WORK	2007	77,074	1,285	27.5	1,285		1,285	18
19	DOORS & FRAMES	2007	18,896	315	27.5	315		315	19
20	SIGNAGE	2007	2,403	40	27.5	40		40	20
21	BOILER WORK	2007	1,835	30	27.5	30		3	21
22	BASEMENT & THERAPY-WALLPAPER,PAINT,FLOORING	2007	23,221	387	27.5	387		387	22
23	ELECTRICAL WORK	2007	4,730	79	27.5	79		79	23
24	PLUMBING WORK	2007	2,752	46	27.5	46		46	24
25	CABLING OF BUILDING	2007	19,000	316	27.5	316		316	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,253,682	\$ 48,491		\$ 90,906	\$ 42,415	\$ 1,458,611	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	\$ 569,108	\$ 23,375	\$ 53,512	\$ 30,137	10 YRS	\$ 388,213	71
72	Current Year Purchases	54,974	10,995	2,749	(8,246)	10 YRS	2,749	72
73	Fully Depreciated Assets	371,750					371,750	73
74	RELATED PARTY	33,762	331	2,244	1,913		26,723	74
75	TOTALS	\$ 1,029,594	\$ 34,701	\$ 58,505	\$ 23,804		\$ 789,435	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			2002	\$ 14,925	\$ 860		\$ (860)		\$ 14,925	76
77				17,044	1,057	2,296	1,239		11,305	77
78										78
79										79
80	TOTALS			\$ 31,969	\$ 1,917	\$ 2,296	\$ 379		\$ 26,230	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)	\$ 4,415,245	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 85,109	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,707	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 66,598	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,274,276	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: N/A

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

If NO, see instructions. YES NO

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

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: \$ 3,411 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>2,419</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,419</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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 199,750	\$		\$ 199,750	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,681			2,681	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			195,766			195,766	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				143,973		143,973	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED SUPPLIES, LAB, RENTALS Other (specify): RADIOLOGY						31,001		31,001	13
14	TOTAL			\$		\$ 398,197	\$ 174,974		\$ 573,171	14

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

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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 <u>251,000</u>)	1,376,275		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,972		6
7	Other Prepaid Expenses	20,470		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX ESCROW</u>	119,794		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,548,511	\$	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	1,451,268		15
16	Equipment, at Historical Cost	1,010,754		16
17	Accumulated Depreciation (book methods)	(1,235,285)		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): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,226,737	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,775,248	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 543,098	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	855,111		29
30	Accrued Salaries Payable	177,917		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,770		31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,000		32
33	Accrued Interest Payable	6,854		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)	\$ 1,713,750	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,713,750	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,061,498	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,775,248	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 726,224	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 726,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	335,274	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 335,274	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,061,498	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,488,254	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,488,254	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	160,144	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 160,144	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,331	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,331	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,659,729	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	949,702	31
32	Health Care	1,672,168	32
33	General Administration	1,336,532	33
	B. Capital Expense		
34	Ownership	728,277	34
	C. Ancillary Expense		
35	Special Cost Centers	573,171	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,324,455	40
41	Income before Income Taxes (line 30 minus line 40)**	335,274	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 335,274	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: 01/01/2007

Ending: 12/31/2007

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	1,925	2,166	\$ 73,059	\$ 33.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,625	1,625	48,493	29.84	3
4	Licensed Practical Nurses	30,313	34,786	757,368	21.77	4
5	CNAs & Orderlies	52,201	56,891	530,499	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,067	2,430	25,134	10.34	9
10	Activity Assistants	8,355	8,952	87,026	9.72	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,695	1,950	31,077	15.94	13
14	Head Cook	5,582	6,144	62,075	10.10	14
15	Cook Helpers/Assistants	9,841	10,618	105,481	9.93	15
16	Dishwashers					16
17	Maintenance Workers	4,397	4,500	63,730	14.16	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,915	2,191	111,275	50.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,256	7,640	135,365	17.72	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	1,927	2,139	23,037	10.77	31
32	Other Health Care(specify)	1,174	1,276	28,433	22.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,273	143,308	\$ 2,082,052 *	\$ 14.53	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	\$ 8,364	1-3	35
36	Medical Director	O	1,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	20	10-3	38
39	Pharmacist Consultant	H	3,776	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,350	11-3	44
45	Social Service Consultant	E	2,727	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,437		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		\$ 111,275	Workers' Compensation Insurance	\$ 58,815	IDPH License Fee	\$ 2,095	
				Unemployment Compensation Insurance	45,782	Advertising: Employee Recruitment	12,443	
				FICA Taxes	157,348	Health Care Worker Background Check	2,760	
				Employee Health Insurance	140,180	(Indicate # of checks performed _____)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,482	
				EMPLOYEE BENEFITS - OTHER	15,079	MARKETING/ADV/PROMO	37,451	
						LICENSES/DUES/SUBSCRIPTIONS	7,571	
						MGMT CO ALLOC	736	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 111,275	CHICAGO HEAD TAX	4,188	TRUST/FRANCHISE/CONTRIB/ETC	(3,482)	
(List each licensed administrator separately.)						Less: Public Relations Expense	(0)	
						Non-allowable advertising	(37,451)	
						Yellow page advertising	(0)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 421,392	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,605	
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			\$ 60,000				Out-of-State Travel	\$
							In-State Travel	0
							RELATED PARTY	261
							Seminar Expense	0
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 60,000				Entertainment Expense	()
(Attach a copy of any management service agreement)				TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 261
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			72,763					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 72,763					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE

0028076

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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 _____ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees