

		FOR BHF USE					

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**2013  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2013)**

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><b>I. IDPH License ID Number:</b> <u>0046979</u></p> <p><b>Facility Name:</b> <u>EASTSIDE TERRACE</u></p> <p><b>Address:</b> <u>3850 EAST FULTON</u> <u>DECATUR</u> <u>62521</u> Number City Zip Code</p> <p><b>County:</b> <u>MACON</u></p> <p><b>Telephone Number:</b> <u>(217) 330-7094</u> Fax # ( )</p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>01/01/92</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b> Name: <u>PATRICK E. BELL, CPA</u> Telephone Number: <u>(217) 465-6494</u> Email Address: _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/13</u> to <u>12/31/13</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="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Angela Barr-Cornell</u> (Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>President</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Patrick E. Bell</u> <u>CPA</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>LARSSON WOODYARD &amp; HENSON, LLP</u> <u>702 E. Court Street, Paris, IL 61944</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u></td> </tr> <tr> <td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Angela Barr-Cornell</u> (Date) _____	Paid Preparer	(Title) <u>President</u>	(Signed) _____	(Print Name and Title) <u>Patrick E. Bell</u> <u>CPA</u>	(Firm Name & Address) <u>LARSSON WOODYARD &amp; HENSON, LLP</u> <u>702 E. Court Street, Paris, IL 61944</u>		(Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE

# 0046979 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,201			5,201	13
14	TOTALS	5,201			5,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

D. How many bed-hold days during this year were paid by the Department? 69 (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 JANUARY 1, 1992

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/01/92 NO

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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
	<b>A. General Services</b>										
1	Dietary	12,848	2,310	1,128	16,286		16,286	16,286		1	
2	Food Purchase		27,647		27,647		27,647	(536)	27,111	2	
3	Housekeeping	732	677		1,409		1,409		1,409	3	
4	Laundry									4	
5	Heat and Other Utilities			12,475	12,475		12,475	107	12,582	5	
6	Maintenance	7,229	1,100	3,819	12,148		12,148	200	12,348	6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	20,809	31,734	17,422	69,965		69,965	(229)	69,736	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,500	7,500		7,500		7,500	9	
10	Nursing and Medical Records	160,460	1,819	356	162,635	(1,743)	160,892		160,892	10	
10a	Therapy									10a	
11	Activities		1,945	1,200	3,145		3,145		3,145	11	
12	Social Services			96	96		96		96	12	
13	CNA Training					1,743	1,743		1,743	13	
14	Program Transportation			5,373	5,373		5,373		5,373	14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	160,460	3,764	14,525	178,749		178,749		178,749	16	
	<b>C. General Administration</b>										
17	Administrative	31,407			31,407		31,407		31,407	17	
18	Directors Fees									18	
19	Professional Services			5,266	5,266		5,266		5,266	19	
20	Dues, Fees, Subscriptions & Promotions			482	482		482		482	20	
21	Clerical & General Office Expenses	2,498	895	22,265	25,658		25,658	(18,621)	7,037	21	
22	Employee Benefits & Payroll Taxes			25,274	25,274		25,274	3,714	28,988	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			234	234		234		234	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			4,036	4,036		4,036		4,036	26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	33,905	895	57,557	92,357		92,357	(14,907)	77,450	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	215,174	36,393	89,504	341,071		341,071	(15,136)	325,935	29	

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT  
 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 (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	
	<b>D. Ownership</b>											
30	Depreciation			2,875	2,875	2,875	7,047	9,922				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			8,340	8,340	8,340		8,340				33
34	Rent-Facility & Grounds			51,000	51,000	51,000	(17,000)	34,000				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>State Income Tax</b>			8,150	8,150	8,150	(8,150)					36
37	<b>TOTAL Ownership</b>			70,365	70,365	70,365	(18,103)	52,262				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,234	38,234	38,234		38,234				42
43	Other (specify):* <b>Resident Supplies</b>		1,871		1,871	1,871	(1,871)					43
44	<b>TOTAL Special Cost Centers</b>		1,871	38,234	40,105	40,105	(1,871)	38,234				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	215,174	38,264	198,103	451,541	451,541	(35,110)	416,431				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE

# 0046979

Report Period Beginning: 01/01/13

Ending: 12/31/13

**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	(1,378)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(536)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,150)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Resident Supplies	(1,871)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (12,435)</b>		<b>\$</b>	<b>30</b>

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)			34
35	Other- Attach Schedule	(22,675)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (22,675)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (35,110)</b>		<b>37</b>

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

EASTSIDE TERRACE

ID# 0046979

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Personal Supplies	\$ (1,871)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(1,871)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number EASTSIDE TERRACE# 0046979

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	(536)	0	0	0	0	0	0	0	0	0	0	(536)	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	107	0	0	0	0	0	0	0	0	0	107	5
6	Maintenance	0	200	0	0	0	0	0	0	0	0	0	200	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(536)</b>	<b>307</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>0</b>	<b>(229)</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	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(500)	(18,121)	0	0	0	0	0	0	0	0	0	(18,621)	21
22	Employee Benefits & Payroll Taxes	0	3,714	0	0	0	0	0	0	0	0	0	3,714	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(500)</b>	<b>(14,407)</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>0</b>	<b>(14,907)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(1,036)</b>	<b>(14,100)</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>0</b>	<b>(15,136)</b>	<b>29</b>



STATE OF ILLINOIS

Summary B

Facility Name & ID Number EASTSIDE TERRACE

# 0046979

Report Period Beginning:

01/01/13 Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(1,378)	8,425	0	0	0	0	0	0	0	0	0	7,047	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(17,000)	0	0	0	0	0	0	0	0	0	(17,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* <b>State Income Tax</b>	(8,150)	0	0	0	0	0	0	0	0	0	0	(8,150)	36
37	<b>TOTAL Ownership</b>	<b>(9,528)</b>	<b>(8,575)</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>0</b>	<b>(18,103)</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	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):* <b>Resident Supplies</b>	(1,871)	0	0	0	0	0	0	0	0	0	0	(1,871)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,871)</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>0</b>	<b>0</b>	<b>(1,871)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(12,435)</b>	<b>(22,675)</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>0</b>	<b>(35,110)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Angela Barr-Cornell	100%	South Side Manor	Decatur	Alpha Omega	Oveido, FL	Central Office
Angela Barr-Cornell	100%	Montgomery Terrace	Nokomis	Alpha Omega	Oveido, FL	Central Office
Angela Barr-Cornell	100%	James R Thompson House	Decatur	Alpha Omega	Oveido, FL	Central Office
Angela Barr-Cornell	100%	Lincoln House	Lincoln	Alpha Omega	Oveido, FL	Central Office
Angela Barr-Cornell	100%	East Side Terrace	Decatur	Alpha Omega	Oveido, FL	Central Office

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	34 Building Rent	\$ 17,000	Angela Barr-Cornell		\$	(17,000)	1
2	V	30 Depreciation Expense				7,173	7,173	2
3	V	21 Central Office	19,680	Angela Barr-Cornell			(19,680)	3
4	V	5 Utilities				107	107	4
5	V	6 Maintenance				200	200	5
6	V	21 Office Expense				1,559	1,559	6
7	V	22 Employee Insurance				3,714	3,714	7
8	V	30 Depreciation Expense				1,252	1,252	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 36,680			\$ 14,005	\$ * (22,675)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE # 0046979 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	Angela Barr-Cornell	Owner	Admin. Mgmt	100.00	83,860	8	20.00		\$ 20,965	17-1	1
2	Jason Cornell	Son	Admin. Mgmt		17,696	8	20.00		4,424	17-1	2
3	Cara Ebbeler	Daughter	Consultant		4,800	8	20.00		1,200	11-3	3
4	Cara Ebbeler	Daughter	Clerical		3,890						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,589		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE

# 0046979

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Angela Barr-Cornell  
 Street Address 80 Ellington Place  
 City / State / Zip Code Oviedo, FL 32765  
 Phone Number ( )  
 Fax Number ( )

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

EASTSIDE TERRACE

# 0046979

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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		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							\$	\$			\$					
2																
3	N/A															
4																
5																
	<b>Working Capital</b>															
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$					
	<b>B. Non-Facility Related*</b>															
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$					

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2012 report.		\$	<b>8,300</b>	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.)		\$	<b>8,340</b>	2											
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>40</b>	3											
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>8,300</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6											
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>8,340</b>	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2008	<u>9,105</u>	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2012 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2012 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2009	<u>8,298</u>	9												
	2010	<u>8,236</u>	10												
	2011	<u>8,280</u>	11												
	2012	<u>8,340</u>	12												

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT





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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 EASTSIDE TERRACE

# 0046979 Report Period Beginning:

01/01/13 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,400 B. General Construction Type: Exterior RBB & B/Vinyl Frame Wood Number of Stories 1

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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Per 93 Audit</u>			\$ <u>44,534</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>44,534</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Landscaping	1991		525		10			525	9
10	Carpet	1992		361		7			361	10
11	Landscaping	1992		2,285		15			2,285	11
12	Carpet	1993		294		10			294	12
13	Blacktop	1993		1,100		10			1,100	13
14	Carpet	1993		1,561		10			1,561	14
15	Carpet	1995		3,704		10			3,704	15
16	Carpet	1997		998		10			998	16
17	Bathroom Vinyl & Installation	1997		360		10			360	17
18	Vinyl Flooring	1998		652		10			652	18
19	Bathroom Vinyl	1999		344		10			344	19
20	Water Heater	2000		425		10			425	20
21	Fencing	2003		3,555	105	20	178	73	3,085	21
22	Deck Add On	2007		2,113		15	106	106	2,113	22
23	Fire Alarm Panel	2007		2,317		20	116	116	2,317	23
24	Air Conditioner	2009		1,989		10	199	199	1,989	24
25	Flooring	2010		1,094		20	55	55	1,094	25
26	Flooring	2010		1,115		20	56	56	1,115	26
27										27
28	Central Office						1,252	1,252		28
29										29
30	Related Party Rent Depn						7,026	7,026		30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE

# 0046979

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 24,792	\$ 105		\$ 8,988	\$ 8,883	\$ 24,322	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	2,770	2,770	168	(2,602)		2,770	72
73	Fully Depreciated Assets	17,689		619	619		17,689	73
74	Related Party Depreciation			147	147			74
75	TOTALS	\$ 20,459	\$ 2,770	\$ 934	\$ (1,836)		\$ 20,459	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transportation	1991 Chevy Pickup	1992	\$ 16,519	\$	\$	\$		\$ 16,519	76
77	Transportation	2005 Chevy Van	2005	16,409					16,409	77
78										78
79										79
80	TOTALS			\$ 32,928	\$	\$	\$		\$ 32,928	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)	\$ 122,713	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,875	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,922	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,047	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 77,709	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Alfred Kreckman, Dewey Barr, Angela Barr-Cornell  
 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:	<u>1991</u>	<u>16</u>	<u>01/01/92</u>	\$ <u>51,000</u>	<u>15</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>16</b>		\$ <b>51,000</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 06/10/13  
 Ending 06/10/18

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2014</u>	\$ <u>51,000</u>
13.	<u>12/31/2015</u>	\$ <u>51,000</u>
14.	<u>12/31/2016</u>	\$ <u>51,000</u>

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE # 0046979 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**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 checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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)		330		330
4	Clinical Wages (b)		660		660
5	In-House Trainer Wages (c)		753		753
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,743	\$	\$ 1,743
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,743		

**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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$		\$									1
2	Licensed Speech and Language Development Therapist		hrs														2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist		hrs														4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy	N/A	# of prescripts														9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify):																13
14	TOTAL			\$		\$		\$			\$			\$			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.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number **EASTSIDE TERRACE**

# **0046979**

Report Period Beginning: **01/01/13**

Ending:

**12/31/13**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/13** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 18,986	\$ 891,899	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	39,405	183,909	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,473	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 58,391</b>	<b>\$ 1,077,281</b>	<b>10</b>
<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	24,793	315,765	15
16	Equipment, at Historical Cost	53,386	248,732	16
17	Accumulated Depreciation (book methods)	(77,709)	(522,479)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 470</b>	<b>\$ 42,018</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 58,861</b>	<b>\$ 1,119,299</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 10,239	\$ 59,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,494	41,260	30
31	Accrued Taxes Payable (excluding real estate taxes)	200	1,655	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,300	45,050	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,150	33,452	35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 35,383</b>	<b>\$ 180,497</b>	<b>38</b>
<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 (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 35,383</b>	<b>\$ 180,497</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 23,478</b>	<b>\$ 938,802</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 58,861</b>	<b>\$ 1,119,299</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 386,655	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 386,655	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	172,899	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	(19,432)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Intercompany Transfers</u>	(516,644)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (363,177)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 23,478	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 624,243	1	
2	Discounts and Allowances for all Levels	( )	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 624,243	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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>	\$	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***		25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>OTHER</b>	197	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 197	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 624,440	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	69,965	31	
32	Health Care	178,749	32	
33	General Administration	92,357	33	
<b>B. Capital Expense</b>				
34	Ownership	70,365	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,871	35	
36	Provider Participation Fee	38,234	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 451,541	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	172,899	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 172,899	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 518,543	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SOCIAL SECURITY</u>	102,978	47
48	Other-(specify) <u>INCOME CREDITS</u>	2,722	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 624,243	49

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **EASTSIDE TERRACE**

# **0046979**

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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
2	Assistant Director of Nursing				2
3	Registered Nurses	388	13,744	35.42	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	11,921	115,953	9.31	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	1,490	12,848	8.62	15
16	Dishwashers				16
17	Maintenance Workers	384	7,229	17.38	17
18	Housekeepers	91	732	8.04	18
19	Laundry				19
20	Administrator	993	31,407	31.63	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	159	2,498	15.71	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,920	30,763	14.79	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	17,346	215,174 *	11.91	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	24	\$ 1,128	1-3 35
36	Medical Director	Mo Fee	7,500	9-3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Mo Fee	1,200	11-3 44
45	Social Service Consultant	3	96	12-3 45
46	Other(specify) <u>Dental</u>	Per Visit	356	10-3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	27	\$ 10,280	49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **EASTSIDE TERRACE**

# **0046979**

Report Period Beginning: **01/01/13**

Ending: **12/31/13**

**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	
Angela Barr-Cornell	Admin	100	\$ 20,965	Workers' Compensation Insurance	\$ 6,849	IDPH License Fee	\$	
Anna Brackenbush	Admin	0	5,968	Unemployment Compensation Insurance	2,382	Advertising: Employee Recruitment	50	
Jason Cornell	Admin	0	4,474	FICA Taxes	16,379	Health Care Worker Background Check	78	
				Employee Health Insurance	3,714	(Indicate # of checks performed <u>2</u> )		
				Employee Meals		Patient Background Checks	2 32	
				Illinois Municipal Retirement Fund (IMRF)*		License & Fees	202	
				Simple IRA	(336)	Dues & Subscriptions	120	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 31,407					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 28,988	Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$		
Larsson Woodyard & Henson	Accounting		\$ 5,266				Out-of-State Travel	\$
							In-State Travel	120
							Seminar Expense	
							Red Cross-CPR & First Aid Training	114
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,266	TOTAL			(agree to Sch. V, line 24, col. 8)	
					\$	TOTAL		\$ 234

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8	N/A											
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number EASTSIDE TERRACE

# 0046979

Report Period Beginning:

01/01/13

Ending:

12/31/13

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (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. \$ 38,234  
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? N/A
- (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. \$ NONE Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ N/A
- (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. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
  - 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? YES
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.