

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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>0023036</u></p> <p>Facility Name: <u>Bayside Terrace</u></p> <p>Address: <u>1100 South Lewis</u> <u>Waukegan</u> <u>60085</u> Number City Zip Code</p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>(847) 244-8196</u> Fax # <u>(847) 244-7647</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>00/00/76</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>Steve Lavenda</u> Telephone Number: <u>(847) 282-6300</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	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>01/01/15</u> to <u>12/31/15</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" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>STEVEN N LAVENDA CPA</u> <u>Partner</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>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) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>STEVEN N LAVENDA CPA</u> <u>Partner</u>		(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
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Facility Name & ID Number Bayside Terrace

0023036 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 N/A

	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	168	Intermediate (ICF)	168	61,320	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	53,719	467		54,186	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,719	467		54,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.37%

D. How many bed-hold days during this year were paid by the Department? None (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 11/03/1976

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ 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 N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	337,270	41,665	8,196	387,131		387,131		387,131		1
2	Food Purchase		343,548		343,548		343,548	(29)	343,519		2
3	Housekeeping	149,738	30,137		179,875		179,875		179,875		3
4	Laundry	26,357	41,297		67,654		67,654		67,654		4
5	Heat and Other Utilities			123,109	123,109		123,109	447	123,556		5
6	Maintenance	59,380	114	103,707	163,201		163,201	2,745	165,946		6
7	Other (specify):*										7
8	TOTAL General Services	572,745	456,761	235,012	1,264,518		1,264,518	3,163	1,267,681		8
	B. Health Care and Programs										
9	Medical Director			11,700	11,700		11,700		11,700		9
10	Nursing and Medical Records	1,396,253	55,516	10,956	1,462,725		1,462,725		1,462,725		10
10a	Therapy										10a
11	Activities	198,344	16,568		214,912		214,912		214,912		11
12	Social Services	276,581	7,677	7,802	292,060		292,060		292,060		12
13	CNA Training										13
14	Program Transportation			6,399	6,399		6,399		6,399		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,871,178	79,761	36,857	1,987,796		1,987,796		1,987,796		16
	C. General Administration										
17	Administrative	157,582		375,863	533,445		533,445	(250,863)	282,582		17
18	Directors Fees										18
19	Professional Services			121,690	121,690		121,690	(270)	121,420		19
20	Dues, Fees, Subscriptions & Promotions			55,300	55,300		55,300	(32,428)	22,872		20
21	Clerical & General Office Expenses	270,310	22,572	180,498	473,380		473,380	(168,561)	304,819		21
22	Employee Benefits & Payroll Taxes			595,747	595,747		595,747	(957)	594,790		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,695	3,695		3,695	(1,796)	1,899		24
25	Other Admin. Staff Transportation			4,614	4,614		4,614		4,614		25
26	Insurance-Prop.Liab.Malpractice			160,331	160,331		160,331	294	160,625		26
27	Other (specify):*							16,343	16,343		27
28	TOTAL General Administration	427,892	22,572	1,497,738	1,948,202		1,948,202	(438,238)	1,509,964		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,871,815	559,094	1,769,607	5,200,516		5,200,516	(435,075)	4,765,441		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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			10,546	10,546		10,546	37,099	47,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,429	9,429		9,429	(4,354)	5,075			32
33	Real Estate Taxes			142,617	142,617		142,617		142,617			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(218,870)	21,130			34
35	Rent-Equipment & Vehicles			12,389	12,389		12,389	716	13,105			35
36	Other (specify):*											36
37	TOTAL Ownership			414,981	414,981		414,981	(185,409)	229,572			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			72,344	72,344		72,344	(72,344)				41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			72,344	72,344		72,344	(72,344)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,871,815	559,094	2,256,932	5,687,841		5,687,841	(692,828)	4,995,013			45

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

Bayside TerraceID# 0023036Report Period Beginning: 01/01/15Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Expense	\$ (72,344)	41	1
2	Misc. Income	(331)	21	2
3	Bank Charges	(2,577)	21	3
4	Out of State Seminars	(1,796)	24	4
5	Out of Period Legal Fees	(505)	19	5
6	Non-Care Depreciation	(1,177)	30	6
7	Additional R&M	2,745	06	7
8	Annual Filing Fees - Bldg. Co	(250)	21	8
9	Accounting Fees - Bldg. Co	(5,975)	19	9
10	Sate Replacement Tax - Bldg. Co	(1,204)	21	10
11	Professional Fees - Bldg. Co.	(6,000)	19	11
12	Non-Allowable Expense	(48,346)	21	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	(137,760)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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													1
2	Food Purchase	(29)											(29)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			447									447	5
6	Maintenance	2,745											2,745	6
7	Other (specify):*													7
8	TOTAL General Services	2,716		447									3,163	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(39,525)	(125,336)	(86,002)							(250,863)	17
18	Directors Fees													18
19	Professional Services	(12,480)	11,975		94	141							(270)	19
20	Fees, Subscriptions & Promotions	(32,428)											(32,428)	20
21	Clerical & General Office Expenses	(171,055)	1,454	1,040									(168,561)	21
22	Employee Benefits & Payroll Taxes	(957)											(957)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,796)											(1,796)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			294									294	26
27	Other (specify):*				12,471	3,872							16,343	27
28	TOTAL General Administration	(218,716)	13,429	(38,191)	(112,771)	(81,989)							(438,238)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(216,000)	13,429	(37,744)	(112,771)	(81,989)							(435,075)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bayside Terrace# 0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	33,943	3,127	29									37,099	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,354)											(4,354)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(240,000)	21,130									(218,870)	34
35	Rent-Equipment & Vehicles			716									716	35
36	Other (specify):*													36
37	TOTAL Ownership	29,589	(236,873)	21,875									(185,409)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(72,344)											(72,344)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(72,344)											(72,344)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(258,755)	(223,444)	(15,869)	(112,771)	(81,989)							(692,828)	45

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
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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 Rental Income	\$ 240,000	Bayside Terrace Realty, LLC	100.00%	\$	(240,000)	1
2	V	33 Rental Income-R/E Tax Reimb	146,400	Bayside Terrace Realty, LLC	100.00%	3,783	(142,617)	2
3	V			Bayside Terrace Realty, LLC	100.00%			3
4	V	33 R/E Taxes		Bayside Terrace Realty, LLC	100.00%	146,400	146,400	4
5	V	33 R/E Taxes - Prior Year	3,783	Bayside Terrace Realty, LLC	100.00%		(3,783)	5
6	V	21 Annual Filing Fee		Bayside Terrace Realty, LLC	100.00%	250	250	6
7	V	19 Accounting Fees		Bayside Terrace Realty, LLC	100.00%	5,975	5,975	7
8	V	30 Depreciation		Bayside Terrace Realty, LLC	100.00%	3,127	3,127	8
9	V	21 State Replacement Tax		Bayside Terrace Realty, LLC	100.00%	1,204	1,204	9
10	V	19 Professional Fees		Bayside Terrace Realty, LLC	100.00%	6,000	6,000	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 390,183			\$ 166,739	\$ * (223,444)	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	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%	\$ 447	\$	447	15
16	V	19 PROFESSIONAL FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%				16
17	V	21 CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,040		1,040	17
18	V	26 INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	294		294	18
19	V	30 DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	29		29	19
20	V	34 RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	21,130		21,130	20
21	V	35 EQUIPMENT RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	716		716	21
22	V								22
23	V								23
24	V	6 ADM. COMP.- M. ROSENBAUM		A.H.B. D/B/A ABH MANAGEMENT	100.00%				24
25	V	17 ADM. COMP.- IVY FISHMAN		A.H.B. D/B/A ABH MANAGEMENT	100.00%				25
26	V	17 SALARY - A. ROSENBAUM		A.H.B. D/B/A ABH MANAGEMENT	100.00%				26
27	V	21 CLERICAL COMP		A.H.B. D/B/A ABH MANAGEMENT	100.00%				27
28	V	27 EMP. BEN.-DIRECT ALLOC.		A.H.B. D/B/A ABH MANAGEMENT	100.00%				28
29	V								29
30	V								30
31	V								31
32	V	17 HOME OFFICE	39,525	A.H.B. D/B/A ABH MANAGEMENT	100.00%			(39,525)	32
33	V	21 HOME OFFICE CLERICAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%				33
34	V	22 HOME OFFICE BENEFITS		A.H.B. D/B/A ABH MANAGEMENT	100.00%				34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 39,525			\$ 23,656	\$ *	(15,869)	39

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

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	17 ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 50,000	\$ 50,000
16	V	19 PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	94	94
17	V	27 EMPLOYEE BENEFITS		KARLA BISHOP, INC.	100.00%	12,471	12,471
18	V						
19	V						
20	V						
21	V	17 MANAGEMENT FEES	175,336	KARLA BISHOP, INC.	100.00%		(175,336)
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		\$ 175,336			\$ 62,565	\$ * (112,771)

* 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	17 ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 75,000	\$ 75,000
16	V	19 PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	141	141
17	V	27 EMPLOYEE BENEFITS		HEALTH RESOURCE, INC.	100.00%	3,872	3,872
18	V						
19	V	17 MANAGEMENT FEES	161,002	HEALTH RESOURCE, INC.	100.00%		(161,002)
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		\$ 161,002			\$ 79,013	\$ * (81,989)

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	\$ *	39

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

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	\$ *	39

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

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	\$ *	39

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

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	ALAN ROSENBAUM FAMILY TRUST	1.270%	ABBOTT HOUSE LLC	HIGHLAND PARK	BAYSIDE TERRACE REALTY, LLC		BUILDING CO.	1
2	ANN BERMAN KAPLAN REVOCABLE TRUST	2.701%	HILLCREST RETIREMENT VILLAGE, LTD.	ROUND LAKE BEACH	KARLA BISHOP, INC.	LAKE BLUFF	MANAGEMENT CO.	2
3	BETTE C. HORSTMAN TRUST	0.847%			A.H.B. D/B/A ABH MANAGEMEN	HIGHLAND PARK	HOME OFFICE	3
4	CAROL F. GUTSTEIN TRUST	2.860%			HEALTH RESOURCE, INC.	HIGHLAND PARK	MANAGEMENT CO.	4
5	CAROL SPIELMAN TRUST	3.602%						5
6	CHRISTINE G. GARBER REV. TRUST	1.801%						6
7	EARL L ROSENBAUM DECLARATION TRUST	40.112%						7
8	EDWARD F. VLACK III	0.847%						8
9	ELEANOR SINGLETON	0.847%						9
10	ELIEZER SILVER	0.900%						10
11	ELIZABETH O'LAVIN	0.847%						11
12	HEALTH RESOURCE, INC.	1.000%						12
13	HOWARD M. SILBERMAN REVOCABLE TRUST	3.602%						13
14	ILA ROSENBAUM	0.338%						14
15	IVY FISHMAN FAMILY TRUST	1.270%						15
16	JOYCE L. MAZUREK TRUST	4.502%						16
17	JUDY ROSENBAUM	2.701%						17
18	KARLA BISHOP, INC.	13.445%						18
19	KATHLEEN HANKS	0.847%						19
20	LAWRENCE JUTOVSKY TRUST	1.801%						20
21	MARY LYNN KAULFERS	0.847%						21
22	MICHAEL HARRIS	2.701%						22
23	MITCHELL ROSENBAUM	0.338%						23
24	PAUL ROSENBAUM	0.338%						24
25	RALPH ROSENBAUM	0.338%						25
26	SHARON NUDELMAN DECLARATION TRUST	2.701%						26
27	SOLOMON GUTSTEIN TRUST	2.542%						27
28	SONDRA GOLD	1.351%						28
29	YEHUDAH SILVER	0.900%						29
30	JUDITH JUTOVSKY TRUST DTD 10/02/02	1.801%						30

Facility Name & ID Number

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Report Period Beginning:

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12/31/15

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	Karla Bishop	Gen. Partner	Administrative	0%	See Attached	10	25.00%	Alloc. Salary	\$ 50,000	17 - 7	1	
2	Earl Rosenbaum	Gen. Partner	Administrative	0%	See Attached	15	37.50%	Alloc. Salary	75,000	17 - 7	2	
3	Jack Bishop	Relative	Maintenance	0%		40		Salary	57,931	6 - 1	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 182,931		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 Bayside Terrace

0023036

Report Period Beginning:

01/01/15

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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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENT
 Street Address 600 CENTRAL AVENUE
 City / State / Zip Code HIGHLAND PARK, IL 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

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.

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	PATIENT DAYS	136,463	3	\$ 1,125	\$ 54,186	\$ 447	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	136,463	3		54,186		2
3	21	CLERICAL AND GENERAL	PATIENT DAYS	136,463	3	2,619	54,186	1,040	3
4	26	INSURANCE	PATIENT DAYS	136,463	3	740	54,186	294	4
5	30	DEPRECIATION	PATIENT DAYS	136,463	3	72	54,186	29	5
6	34	RENT	PATIENT DAYS	136,463	3	53,215	54,186	21,130	6
7	35	EQUIPMENT RENT	PATIENT DAYS	136,463	3	1,803	54,186	716	7
8									8
9									9
10	6	ADM. COMP.- M. ROSENBAUM	AVG. HOURS WORKED		1				10
11	17	ADM. COMP.- IVY FISHMAN	AVG. HOURS WORKED	40	1	5,000			11
12	17	SALARY - A. ROSENBAUM	AVG. HOURS WORKED	40	1				12
13	21	CLERICAL COMP	AVG. HOURS WORKED	40	1				13
14	27	EMP. BEN.-DIRECT ALLOC.	DIRECT		2	14,378			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 78,952	\$	\$ 23,656	25

Facility Name & ID Number Bayside Terrace

0023036 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 KARLA BISHOP, INC.
 Street Address 271 RIVERS DRIVE
 City / State / Zip Code LAKE BLUFF, IL. 60044
 Phone Number (847)432-7262
 Fax Number (847)432-6095

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	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED 40	3	\$ 200,000	\$ 200,000	10	\$ 50,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 40	3	375		10	94	2
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 40	3	49,883		10	12,471	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				\$ 250,258	\$ 200,000		\$ 62,565	25

Facility Name & ID Number Bayside Terrace

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Report Period Beginning:

01/01/15

Ending: 12/31/15

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 HEALTH RESOURCE, INC.
 Street Address P.O. BOX 1275
 City / State / Zip Code HIGHLAND PARK, IL. 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

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	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED 40	3	\$ 200,000	\$ 200,000	15	\$ 75,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 40	3	375		15	141	2
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 40	3	10,325		15	3,872	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				\$ 210,700	\$ 200,000		\$ 79,013	25

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number **Bayside Terrace**

0023036 Report Period Beginning: **01/01/15** Ending: **12/31/15**

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Lake Forest Bank & Trust					300,000			5,751	6									
7	Auto Loan					2,304			355	7									
8										8									
9	TOTAL Facility Related					\$ 302,304			\$ 6,106	9									
B. Non-Facility Related*																			
10	Interest Income		X						(4,354)	10									
11	Other Interest		X						3,323	11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$			\$ (1,031)	14									
15	TOTALS (line 9+line14)					\$ 302,304			\$ 5,075	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.)

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

* 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

		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 2014 report.		\$	146,000		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.)		\$	142,217		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,783)		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	146,400		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.		\$	142,617		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>114,284</u>	<u>8</u>	FOR BHF USE ONLY	
	2011	<u>108,459</u>	<u>9</u>	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>135,573</u>	<u>10</u>	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>133,054</u>	<u>11</u>	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>142,217</u>	<u>12</u>	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2015 Accrual = \$142,217 x 1.03 = \$146,000					

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bayside Terrace COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0023036
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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>08-32-107-012</u>	<u>Long Term Care Property</u>	\$ <u>142,216.78</u>	\$ <u>142,216.78</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>142,216.78</u></u>	\$ <u><u>142,216.78</u></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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Bayside Terrace

0023036 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,360 B. General Construction Type: Exterior Brick Frame _____ 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).

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>104,671</u>		<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	104,671		\$ 100,000	3

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	168	1976	1976	\$ 1,082,366	\$		\$	\$	\$ 1,082,366	4
5		1986	1986	630,167	3,127	35	18,005	14,878	534,175	5
6		1986	1986	121,200					121,200	6
7										7
8										8
Improvement Type**										
9	Various		1986	2,654		20			2,654	9
10	Various		1994	1,255		20			1,255	10
11	Various		1997	13,727		20	179	179	3,403	11
12	Various		1998	12,230		20				12
13	Various		1999	21,922		20	123	123	2,085	13
14	Various		2000	18,159		20			18,159	14
15	Various		2001	38,470		20	732	732	10,980	15
16	Various		2002	7,035		20			7,035	16
17	Various		2003	5,358		20	37	37	5,358	17
18	Various		2004	13,804		20			13,304	18
19	Various		2005	1,634		20			1,634	19
20	Various		2007	67,925		20	305	305	64,520	20
21	Various		2008	29,876		20	622	622	21,846	21
22	Various		2009	3,490		20	175	175	1,151	22
23	Various		2010	8,707		20	721	721	4,021	23
24	Various		2011	26,433		20	1,634	1,634	7,633	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		467,942			7,936	7,936	441,726	67
68		3,584	29		80	51	3,041	68
69			9,369			(9,369)		69
70		\$ 2,577,938	\$ 12,525		\$ 30,548	\$ 18,023	\$ 2,347,546	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,577,938	\$ 12,525		\$ 30,548	\$ 18,023	\$ 2,347,546	1
2	Concrete Patio	2013	6,602		20	660	660	1,651	2
3	Concrete Patio (Southwest)	2013	7,360		20	736	736	1,779	3
4	Interior Doors	2013	2,900		20	290	290	701	4
5	Fire Wall (C Wing)	2013	4,336		20	434	434	976	5
6	New Roof	2013	15,776		20	1,578	1,578	3,550	6
7	Walk-In Freezer Compressor	2014	2,545		20	127	127	212	7
8	Ac Unit Condenser	2014	2,580		20	129	129	215	8
9	Reinstall Annunciator	2014	2,618		20	131	131	175	9
10	Hot Water Heater	2015	7,088		20	40	40	40	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	TOTAL (lines 1 thru 33)		\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	34

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	
1		\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	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	TOTAL (lines 1 thru 33)	\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	34

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

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	
1		\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	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	TOTAL (lines 1 thru 33)	\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	34

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	
1		\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	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	TOTAL (lines 1 thru 33)	\$ 2,629,742	\$ 12,525		\$ 34,672	\$ 22,147	\$ 2,356,842	34

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	1977	1,498		20			1,498	9
10	Various	1978	7,531		20			7,531	10
11	Various	1979	14,356		20			14,356	11
12	Various	1980	4,020		20			4,020	12
13	Various	1981	11,197		20			11,197	13
14	Various	1982	16,226		20			16,226	14
15	Various	1983	17,495		20			17,495	15
16	Various	1984	15,752		20			15,752	16
17	Various	1985	11,170		20			11,170	17
18	Various	1986	16,463		20			16,463	18
19	Various	1987	22,247		20			22,247	19
20	Various	1988	21,019		20			21,019	20
21	Various	1989	26,162		20			26,162	21
22	Various	1990	9,005		20			9,005	22
23	Various	1991	47,502		20			47,502	23
24	Various	1992	13,226		20			13,226	24
25	Various	1993	39,155		20			39,155	25
26	Various	1994	11,363		20			11,363	26
27	Various	1995	3,826		20			3,826	27
28	Various	1996	53,988		20	2,699	2,699	53,986	28
29	Various	1997	5,344		20	267	267	5,076	29
30	Various	1998	1,050		20	53	53	948	30
31	Various	1999	33,029		20	1,651	1,651	28,072	31
32	Various	2001	40,914		20	2,046	2,046	30,687	32
33	Various	2002	4,806		20	240	240	3,360	33
34	TOTAL (lines 1 thru 33)		\$ 448,344	\$		\$ 6,956	\$ 6,956	\$ 431,342	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 448,344	\$		\$ 6,956	\$ 6,956	\$ 431,342	1
2	Various	2003	3,048		20	152	152	1,979	2
3	Fence	2005	2,550		20	128	128	1,405	3
4	Concrete	2006	14,000		20	700	700	7,000	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	TOTAL (lines 1 thru 33)		\$ 467,942	\$		\$ 7,936	\$ 7,936	\$ 441,726	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from ABH Management	2002	3,382	29	20	80	51	2,839	10
11	Allocated from ABH Management	2003	202		20			202	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,584	\$ 29		\$ 80	\$ 51	\$ 3,041	34

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

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	
1		\$ 3,584	\$ 29		\$ 80	\$ 51	\$ 3,041	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	TOTAL (lines 1 thru 33)	\$ 3,584	\$ 29		\$ 80	\$ 51	\$ 3,041	34

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 205,534	\$	\$ 7,975	\$ 7,975	10	\$ 179,096	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	472,033				10	472,033	73
74								74
75	TOTALS	\$ 677,567	\$	\$ 7,975	\$ 7,975		\$ 651,129	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		1990 DODGE VAN	1990	\$ 21,434	\$	\$	\$	5	\$ 21,434	76
77		2011 Lexus LS460	2011	30,000		4,998	4,998	5	27,501	77
78										78
79										79
80	TOTALS			\$ 51,434	\$	\$ 4,998	\$ 4,998		\$ 48,935	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,458,744	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,525	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,645	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 35,120	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,056,906	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	NON ALLOWABLE PORTION OF LI	\$ 59,109	\$ 1,177	\$ 14,898	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 59,109	\$ 1,177	\$ 14,898	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.

Facility Name & ID Number

Bayside Terrace

0023036

Report Period Beginning: 01/01/15

Ending: 12/31/15

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	Allocated from ABH				21,130			5
6								6
7	TOTAL				\$ 21,130			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: \$ 13,105

Description: See Attached Schedule

(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	TOTAL		\$	\$	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. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* 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>
--	---	--

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	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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		# 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): <u>See Supplemental</u>									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.

Facility Name & ID Number **Bayside Terrace**# **0023036**Report Period Beginning: **01/01/15**

Ending:

12/31/15**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(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	\$ 497,099	\$ 1,177,038	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	955,561	955,561	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,734	33,734	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	79,000	79,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,565,394	\$ 2,245,333	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,226,698	14
15	Leasehold Improvements, at Historical Cost	61,358	61,358	15
16	Equipment, at Historical Cost	877,089	877,089	16
17	Accumulated Depreciation (book methods)	(806,065)	(2,975,402)	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)	\$ 132,382	\$ 289,743	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,697,776	\$ 2,535,076	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 209,624	\$ 209,624	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	302,304	302,304	29
30	Accrued Salaries Payable	151,017	151,017	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,047	12,047	31
32	Accrued Real Estate Taxes(Sch.IX-B)	146,400	146,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	37,635	37,635	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 859,027	\$ 859,027	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	See Attached Schedule	302,753	2,119	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 302,753	\$ 2,119	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,161,780	\$ 861,146	46
47	TOTAL EQUITY(page 18, line 24)	\$ 535,996	\$ 1,673,930	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,697,776	\$ 2,535,076	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 578,679	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 578,678	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(42,682)	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)	\$ (42,682)	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)	\$ 535,996	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning: 01/01/15

Ending:

12/31/15

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,550,624	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,550,624	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	84,518	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)	\$ 84,518	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,354	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	5,663	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,663	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,645,159	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,264,518	31
32	Health Care	1,987,796	32
33	General Administration	1,948,202	33
B. Capital Expense			
34	Ownership	414,981	34
C. Ancillary Expense			
35	Special Cost Centers	72,344	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,687,841	40
41	Income before Income Taxes (line 30 minus line 40)**	(42,682)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (42,682)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,451,254	44
45	Private Pay - Net Inpatient Revenue	99,370	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,550,624	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

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

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

Facility Name & ID Number Bayside Terrace

0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,120	\$ 99,053	\$ 46.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,210	15,383	452,255	29.40	3
4	Licensed Practical Nurses	9,796	10,654	270,385	25.38	4
5	CNAs & Orderlies	45,556	50,059	574,560	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,452	12,428	198,344	15.96	10
11	Social Service Workers	12,021	13,054	276,581	21.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,117	23,172	337,270	14.56	15
16	Dishwashers					16
17	Maintenance Workers	1,166	1,390	59,380	42.72	17
18	Housekeepers	10,074	11,530	149,738	12.99	18
19	Laundry	1,807	2,168	26,357	12.16	19
20	Administrator	2,080	2,080	157,582	75.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,593	14,557	270,310	18.57	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,952	158,595	\$ 2,871,815 *	\$ 18.11	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	Monthly	\$ 8,196	01-03	35
36	Medical Director	Monthly	11,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,956	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	7,802	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,654		49

C. CONTRACT NURSES

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

Facility Name & ID Number Bayside Terrace# 0023036

Report Period Beginning:

01/01/15

Ending:

12/31/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Alliance for Living \$11,506
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line N/A
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ _____
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? 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. \$ _____ 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? Yes
- 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? 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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.