

Facility Name & ID Number Bayside Terrace

0054270 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	49,785	1,132		50,917	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,785	1,132		50,917	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.03%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 11/3/1976

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Bayside Terrace # 0054270 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	384,994	42,617	8,196	435,807		435,807		435,807		1
2	Food Purchase		317,536		317,536		317,536	(71)	317,465		2
3	Housekeeping	154,088	27,606		181,694		181,694		181,694		3
4	Laundry	27,952	52,288		80,240		80,240		80,240		4
5	Heat and Other Utilities			116,643	116,643		116,643	550	117,193		5
6	Maintenance	60,647		119,145	179,792		179,792	(1,545)	178,247		6
7	Other (specify):*										7
8	TOTAL General Services	627,681	440,047	243,984	1,311,712		1,311,712	(1,066)	1,310,646		8
	B. Health Care and Programs										
9	Medical Director			23,200	23,200		23,200		23,200		9
10	Nursing and Medical Records	1,384,397	65,717	13,443	1,463,557		1,463,557		1,463,557		10
10a	Therapy										10a
11	Activities	203,761	17,713		221,474		221,474		221,474		11
12	Social Services	314,104	7,668	11,164	332,936		332,936		332,936		12
13	CNA Training										13
14	Program Transportation			8,582	8,582		8,582		8,582		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,902,262	91,098	56,389	2,049,749		2,049,749		2,049,749		16
	C. General Administration										
17	Administrative	170,703		495,818	666,521		666,521	(379,151)	287,370		17
18	Directors Fees										18
19	Professional Services			140,702	140,702	(5,000)	135,702	297	135,999		19
20	Dues, Fees, Subscriptions & Promotions			60,787	60,787		60,787	(30,661)	30,126		20
21	Clerical & General Office Expenses	380,753	31,836	49,113	461,702		461,702	(39,447)	422,255		21
22	Employee Benefits & Payroll Taxes			587,307	587,307		587,307	(957)	586,350		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,120	3,120		3,120		3,120		24
25	Other Admin. Staff Transportation			2,620	2,620		2,620		2,620		25
26	Insurance-Prop.Liab.Malpractice			169,145	169,145		169,145	265	169,410		26
27	Other (specify):*							12,724	12,724		27
28	TOTAL General Administration	551,456	31,836	1,508,612	2,091,904	(5,000)	2,086,904	(436,930)	1,649,974		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,081,399	562,981	1,808,985	5,453,365	(5,000)	5,448,365	(437,996)	5,010,369		29

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

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

Facility Name & ID Number

Bayside Terrace

#0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			34,670	34,670		34,670	5,961	40,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,274	4,274		4,274	(4,274)				32
33	Real Estate Taxes			149,603	149,603	5,000	154,603		154,603			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(218,367)	21,633			34
35	Rent-Equipment & Vehicles			13,282	13,282		13,282	530	13,812			35
36	Other (specify):*											36
37	TOTAL Ownership			441,829	441,829	5,000	446,829	(216,150)	230,679			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			73,025	73,025		73,025	(73,025)	(0)			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			73,025	73,025		73,025	(73,025)	(0)			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,081,399	562,981	2,323,839	5,968,219		5,968,219	(727,171)	5,241,048			45

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

Bayside Terrace

ID# 0054270

Report Period Beginning: 01/01/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Expense	\$ (73,025)	41	1
2	Misc. Income	(317)	21	2
3	Bank Charges	(942)	21	3
4	Personal use of auto-reimbursement	(10,400)	21	4
5				5
6	Additional R&M	1,132	06	6
7	Capitalized R&M	(2,677)	06	7
8	Franchise Taxes - Bldg. Co	(250)	21	8
9	Accounting Fees - Bldg. Co	(4,480)	19	9
10	Sate Replacement Tax - Bldg. Co	(3,024)	21	10
11	PAC Dues	(9,109)	20	11
12	Non-allowable Expense	(13,177)	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	(116,269)		49

Bayside Terrace

Report Period Beginning: ID# 0054270
 Ending: 01/01/17
 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bayside Terrace# 0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17**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	(71)											(71)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			550									550	5
6	Maintenance	(1,545)											(1,545)	6
7	Other (specify):*													7
8	TOTAL General Services	(1,616)		550									(1,066)	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			(21,630)	(219,229)	(138,292)							(379,151)	17
18	Directors Fees													18
19	Professional Services	(4,480)	4,480	297									297	19
20	Fees, Subscriptions & Promotions	(30,661)											(30,661)	20
21	Clerical & General Office Expenses	(44,376)	3,274	1,655									(39,447)	21
22	Employee Benefits & Payroll Taxes	(957)											(957)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			265									265	26
27	Other (specify):*				5,454	7,270							12,724	27
28	TOTAL General Administration	(80,474)	7,754	(19,413)	(213,775)	(131,022)							(436,930)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,090)	7,754	(18,863)	(213,775)	(131,022)							(437,996)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	2,806	3,127	28									5,961	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,274)											(4,274)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(240,000)	21,633									(218,367)	34
35	Rent-Equipment & Vehicles			530									530	35
36	Other (specify):*													36
37	TOTAL Ownership	(1,468)	(236,873)	22,191									(216,150)	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	(73,025)											(73,025)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(73,025)											(73,025)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(156,583)	(229,119)	3,328	(213,775)	(131,022)							(727,171)	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	149,603	Bayside Terrace Realty, LLC	100.00%		(149,603)	2
3	V	33 R/E Taxes		Bayside Terrace Realty, LLC	100.00%	149,004	149,004	3
4	V	33 R/E Taxes - Prior Year		Bayside Terrace Realty, LLC	100.00%	599	599	4
5	V	21 Franchise Taxes		Bayside Terrace Realty, LLC	100.00%	250	250	5
6	V	19 Accounting Fees		Bayside Terrace Realty, LLC	100.00%	4,480	4,480	6
7	V	30 Depreciation		Bayside Terrace Realty, LLC	100.00%	3,127	3,127	7
8	V	21 State Replacement Tax		Bayside Terrace Realty, LLC	100.00%	3,024	3,024	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 389,603			\$ 160,484	\$ * (229,119)	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%	\$ 550	\$	550	15
16	V	19 PROFESSIONAL FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	297		297	16
17	V	21 CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,655		1,655	17
18	V	26 INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	265		265	18
19	V	30 DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	28		28	19
20	V	34 RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	21,633		21,633	20
21	V	35 EQUIPMENT RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	530		530	21
22	V								22
23	V	17 HOME OFFICE	21,630	A.H.B. D/B/A ABH MANAGEMENT	100.00%			(21,630)	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		\$ 21,630			\$ 24,958	\$ *	3,328	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	17 ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 50,000	\$ 50,000
16	V	27 EMPLOYEE BENEFITS		KARLA BISHOP, INC.	100.00%	5,454	5,454
17	V						
18	V	17 MANAGEMENT FEES	269,229	KARLA BISHOP, INC.	100.00%		(269,229)
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 269,229			\$ 55,454	\$ * (213,775)

* 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%	\$ 66,667	\$ 66,667
16	V	27 EMPLOYEE BENEFITS		HEALTH RESOURCE, INC.	100.00%	7,270	7,270
17	V						
18	V						
19	V	17 MANAGEMENT FEES	204,959	HEALTH RESOURCE, INC.	100.00%		(204,959)
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		\$ 204,959			\$ 73,937	\$ * (131,022)

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning: 01/01/17

Ending: 12/31/17

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 (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 (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	1.27%	ABBOTT HOUSE LLC	HIGHLAND PARK	BAYSIDE TERRACE REALTY, LLC		BUILDING CO.	1
2	BARBARA STILLMAN	1.35%	HILLCREST RETIREMENT VILLAGE, LTD.	ROUND LAKE BEACH	KARLA BISHOP, INC.	LAKE BLUFF	MANAGEMENT CO.	2
3	BETTE C. HORSTMAN TRUST	0.85%			A.H.B. D/B/A ABH MANAGEMEN	HIGHLAND PARK	HOME OFFICE	3
4	CAROL F. GUTSTEIN TRUST	2.86%			HEALTH RESOURCE, INC.	HIGHLAND PARK	MANAGEMENT CO.	4
5	CAROL SPIELMAN TRUST	3.60%						5
6	CHRISTINE G. GARBER REV. TRUST	1.80%						6
7	EARL L ROSENBAUM DECLARATION TRUST	40.11%						7
8	EDWARD F. VLACK III	0.85%						8
9	ELEANOR SINGLETON	0.85%						9
10	ELIEZER SILVER	0.90%						10
11	ELIZABETH O'LAVIN	0.85%						11
12	HEALTH RESOURCE, INC.	1.00%						12
13	HOWARD M. SILBERMAN REVOCABLE TRUST	3.60%						13
14	ILA ROSENBAUM	0.34%						14
15	IVY FISHMAN FAMILY TRUST	1.27%						15
16	JOYCE L. MAZUREK TRUST	4.50%						16
17	JUDY ROSENBAUM	2.70%						17
18	KARLA BISHOP, INC.	13.45%						18
19	KATHLEEN HANKS	0.85%						19
20	LAWRENCE JUTOVSKY RESIDUARY TRUST	1.80%						20
21	MARY LYNN KAULFERS	0.85%						21
22	MICHAEL HARRIS	2.70%						22
23	MITCHELL ROSENBAUM	0.34%						23
24	PAUL ROSENBAUM	0.34%						24
25	RALPH ROSENBAUM	0.34%						25
26	MINDY RYAN	2.70%						26
27	SOLOMON GUTSTEIN TRUST	2.54%						27
28	SONDRA GOLD	1.35%						28
29	YEHUDAH SILVER	0.90%						29
30	JUDITH JUTOVSKY TRUST DTD 10/02/02	1.80%						30

Facility Name & ID Number

Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	33.33%	Alloc. Salary	66,667	17 - 7	2	
3	Jack Bishop	Relative	Maintenance	0%		40	100.00%	Salary	52,867	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	\$ 169,534		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

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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

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	131,578	3	\$ 1,421	\$ 50,917	\$ 550	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	131,578	3	767	50,917	297	2
3	21	CLERICAL AND GENERAL	PATIENT DAYS	131,578	3	4,277	50,917	1,655	3
4	26	INSURANCE	PATIENT DAYS	131,578	3	685	50,917	265	4
5	30	DEPRECIATION	PATIENT DAYS	131,578	3	72	50,917	28	5
6	34	RENT	PATIENT DAYS	131,578	3	55,904	50,917	21,633	6
7	35	EQUIPMENT RENT	PATIENT DAYS	131,578	3	1,371	50,917	530	7
8									8
9	17	ADM. COMP.- IVY FISHMAN	AVG. HOURS WORKED	40	1	2,500			9
10	27	EMP. BEN.-DIRECT ALLOC.	DIRECT		1	7,459			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					\$ 74,456	\$	\$ 24,958	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 40	3	21,818		10	5,454	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				\$ 221,818	\$ 200,000		\$ 55,454	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 45	3	\$ 200,000	\$ 200,000	15	\$ 66,667	1
2	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 45	3	21,810		15	7,270	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				\$ 221,810	\$ 200,000		\$ 73,937	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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**

0054270 Report Period Beginning: **01/01/17** Ending: **12/31/17**

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

0054270

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Lake Forest Bank & Trust		X	Line of Credit								4,275	6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$			\$	4,275	9					
B. Non-Facility Related*																		
10	Interest Income		X									(4,275)	10					
11	Other Interest		X										11					
12	Allocated from Karla Bishop Inc.		X										12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(4,275)	14					
15	TOTALS (line 9+line14)						\$	\$			\$	(0)	15					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	144,000	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.)		\$	144,599	2
3. Under or (over) accrual (line 2 minus line 1).		\$	599	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	149,004	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.)		\$	5,000	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.		\$	154,603	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	135,573	8
	2013	133,054	9
	2014	142,217	10
	2015	139,765	11
	2016	144,599	12

2017 Accrual = \$144,599 x 1.0305 = \$149,004

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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.

Facility Name & ID Number Bayside Terrace

0054270 Report Period Beginning:

01/01/17 Ending:

12/31/17

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	104,671		\$ 100,000	1
2					2
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		18,005	14,878	570,185	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			3,582	11
12	Various		1998	12,230		20				12
13	Various		1999	21,922		20	123	123	2,331	13
14	Various		2000	18,159		20			18,159	14
15	Various		2001	38,470		20	732	732	12,444	15
16	Various		2002	7,035		20			7,035	16
17	Various		2003	5,358		20			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	65,130	20
21	Various		2008	29,876		20	622	622	23,090	21
22	Various		2009	3,490		20	175	175	1,501	22
23	Various		2010	8,707		20	721	721	5,463	23
24	Various		2011	26,433		20	1,634	1,634	10,901	24
25	Various		2013	36,974		20	3,697	3,697	16,050	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

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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			4,966	4,966	451,932	67
68		3,493	28		78	50	3,119	68
69			34,670			(34,670)		69
70		\$ 2,614,820	\$ 37,825		\$ 31,058	\$ (6,767)	\$ 2,418,692	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		\$ 2,614,820	\$ 37,825		\$ 31,058	\$ (6,767)	\$ 2,418,692	1
2	Walk-In Freezer Compressor	2014	2,545		20	127	127	467	2
3	Ac Unit Condenser	2014	2,580		20	129	129	473	3
4	Reinstall Annunciator	2014	2,618		20	131	131	436	4
5	Hot Water Heater	2015	7,088		20	354	354	738	5
6	Generator Repairs	2016	3,374		20	169	169	253	6
7	Replaced Coil On Walk-In Cooler	2016	3,432		20	172	172	215	7
8	Carpeting - Entire Area	2017	26,730		20	1,023	1,023	1,023	8
9	Replaced A Heat Exhanger - Roof-Top Hvac	2017	2,677		20	134	134	2,677	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)		\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	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		\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	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		\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	34

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	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		\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	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		\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	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)	\$ 2,665,864	\$ 37,825		\$ 33,296	\$ (4,529)	\$ 2,424,973	34

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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									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			53,988	28
29	Various	1997	5,344		20			5,344	29
30	Various	1998	1,050		20	49	49	1,050	30
31	Various	1999	33,029		20	1,651	1,651	31,374	31
32	Various	2001	40,914		20	2,046	2,046	34,779	32
33	Various	2002	4,806		20	240	240	3,840	33
34	TOTAL (lines 1 thru 33)		\$ 448,344	\$		\$ 3,986	\$ 3,986	\$ 439,588	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	\$		\$ 3,986	\$	\$ 439,588	1
2	Various	2003	3,048		20	152	152	2,283	2
3	Fence	2005	2,550		20	128	128	1,661	3
4	Concrete	2006	14,000		20	700	700	8,400	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	\$		\$ 4,966	\$ 980	\$ 451,932	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	3,296	28	20	78	50	2,922	10
11	Allocated from ABH Management	2003	197					197	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)		\$ 3,493	\$ 28		\$ 78	\$ 50	\$ 3,119	34

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		\$ 3,493	\$ 28		\$ 78	\$ 50	\$ 3,119	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		\$ 3,493	\$ 28		\$ 78	\$ 50	\$ 3,119	34

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 190,252	\$	\$ 6,687	\$ 6,687	10	\$ 177,556	71
72	Current Year Purchases	18,081		648	648	10	648	72
73	Fully Depreciated Assets	486,492				10	486,492	73
74								74
75	TOTALS	\$ 694,824	\$	\$ 7,335	\$ 7,335		\$ 664,696	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				5	30,000	77
78										78
79										79
80	TOTALS			\$ 51,434	\$	\$	\$		\$ 51,434	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,512,123	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,631	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,806	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,141,103	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 L	\$ 59,109	\$	\$ 59,109	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 59,109	\$	\$ 59,109	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

0054270

Report Period Beginning: 01/01/17

Ending: 12/31/17

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				21,633			5
6								6
7	TOTAL				\$ 21,633			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</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: \$ 13,812 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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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): _____									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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(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	\$ 86,524	\$ 252,614	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,266,351	1,266,351	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,638	31,638	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	89,111	89,111	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,473,624	\$ 1,639,714	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	924,121	924,121	16
17	Accumulated Depreciation (book methods)	(849,599)	(3,025,189)	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)	\$ 135,880	\$ 286,988	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,609,504	\$ 1,926,702	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 339,185	\$ 339,185	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,137	66,137	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,505	6,505	31
32	Accrued Real Estate Taxes(Sch.IX-B)	149,004	149,004	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 560,831	\$ 560,831	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	<u>See Attached Schedule</u>	977,534		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 977,534	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,538,365	\$ 560,831	46
47	TOTAL EQUITY(page 18, line 24)	\$ 71,139	\$ 1,365,871	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,609,504	\$ 1,926,702	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 493,816	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 493,814	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(422,675)	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)	\$ (422,675)	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)	\$ 71,139	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning: 01/01/17

Ending:

12/31/17

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,456,236	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,456,236	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	73,248	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)	\$ 73,248	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,343	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,343	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,717	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,717	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,545,544	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,311,712	31
32	Health Care	2,049,749	32
33	General Administration	2,091,904	33
B. Capital Expense			
34	Ownership	441,829	34
C. Ancillary Expense			
35	Special Cost Centers	73,025	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)*	\$ 5,968,219	40
41	Income before Income Taxes (line 30 minus line 40)**	(422,675)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (422,675)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,221,802	44
45	Private Pay - Net Inpatient Revenue	234,434	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)	\$ 5,456,236	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

0054270

Report Period Beginning:

01/01/17

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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	1,960	2,080	\$ 80,473	\$ 38.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,914	14,951	479,243	32.05	3
4	Licensed Practical Nurses	11,024	11,925	311,906	26.16	4
5	CNAs & Orderlies	39,520	42,439	512,775	12.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,420	12,389	203,761	16.45	10
11	Social Service Workers	12,899	13,835	314,104	22.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,382	24,266	384,994	15.87	15
16	Dishwashers					16
17	Maintenance Workers	1,295	1,477	60,647	41.06	17
18	Housekeepers	10,036	11,244	154,088	13.70	18
19	Laundry	1,919	2,199	27,952	12.71	19
20	Administrator	2,080	2,080	170,703	82.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,666	19,126	380,753	19.91	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)	146,115	158,011	\$ 3,081,399 *	\$ 19.50	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	23,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,443	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	11,164	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,003		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

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	
Demetria Rafael	Administrator		\$ 170,703	Workers' Compensation Insurance	\$ 65,892	IDPH License Fee	\$	
				Unemployment Compensation Insurance	10,120	Advertising: Employee Recruitment		
				FICA Taxes	226,487	Health Care Worker Background Check		
				Employee Health Insurance	159,913	(Indicate # of checks performed <u>379</u>)	3,790	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,719	
				Union Pension Contribution	78,964	Alliance for Living	7,235	
				Other Employee Benefits	455	Licenses & Fees	10,382	
				Holiday Expense	10,464			
				Pension Plan Contributions	34,000			
				Employee Meals	55			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 170,703	TOTAL (agree to Schedule V, line 22, col.8)		\$ 30,126		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ABH Management - Home Office			\$ 21,630				Out-of-State Travel	\$
Health Resources, Inc. - Management/Bookkeeping			204,959					
Karla Bishop, Inc. - Administrative			269,229				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 495,817				Seminar Expense	3,120
C. Professional Services								
Vendor/Payee	Type		Amount					
Marcum LLP	Accounting		\$ 82,393					
See Attached	Legal		9,080					
Alpha Data	Data Processing		5,387					
Westcom Solutions	Computer Services		34,724					
Vikkex	Computer Services		1,300					
Profit Planners	Pension Admin Fee		2,818					
Real Estate Analysis Corporation	Appraisal Report		5,000					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 140,702	TOTAL			\$ 3,120	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bayside Terrace# 0054270

Report Period Beginning:

01/01/17

Ending:

12/31/17**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 \$21,792
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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 benefit 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