

Facility Name & ID Number Bayside Terrace

0054270 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	47,266	1,105		48,371	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,266	1,105		48,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.88%

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 11/31/1976

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Bayside Terrace # 0054270 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	374,137	44,781	8,532	427,450		427,450		427,450		1
2	Food Purchase		310,116		310,116		310,116	(70)	310,046		2
3	Housekeeping	150,414	30,052		180,466		180,466		180,466		3
4	Laundry	28,774	55,112		83,886		83,886		83,886		4
5	Heat and Other Utilities			123,678	123,678		123,678	501	124,179		5
6	Maintenance	59,550		103,624	163,174		163,174	1,068	164,242		6
7	Other (specify):*										7
8	TOTAL General Services	612,875	440,061	235,834	1,288,770		1,288,770	1,499	1,290,269		8
	B. Health Care and Programs										
9	Medical Director			29,644	29,644		29,644		29,644		9
10	Nursing and Medical Records	1,413,383	70,774	9,042	1,493,199		1,493,199		1,493,199		10
10a	Therapy										10a
11	Activities	185,000	17,875		202,875		202,875		202,875		11
12	Social Services	321,010	7,492	6,096	334,598		334,598		334,598		12
13	CNA Training										13
14	Program Transportation			4,471	4,471		4,471		4,471		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,919,393	96,141	49,253	2,064,787		2,064,787		2,064,787		16
	C. General Administration										
17	Administrative	157,224		91,727	248,951		248,951	54,106	303,057		17
18	Directors Fees										18
19	Professional Services			159,292	159,292		159,292	(1,188)	158,105		19
20	Dues, Fees, Subscriptions & Promotions			42,192	42,192		42,192	(20,481)	21,711		20
21	Clerical & General Office Expenses	380,141	30,570	201,371	612,082		612,082	(174,295)	437,787		21
22	Employee Benefits & Payroll Taxes			532,797	532,797		532,797		532,797		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,252	3,252		3,252	(2,480)	772		24
25	Other Admin. Staff Transportation			9,377	9,377		9,377		9,377		25
26	Insurance-Prop.Liab.Malpractice			129,196	129,196		129,196	280	129,476		26
27	Other (specify):*							13,127	13,127		27
28	TOTAL General Administration	537,365	30,570	1,169,204	1,737,139		1,737,139	(130,930)	1,606,209		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,069,633	566,772	1,454,291	5,090,696		5,090,696	(129,431)	4,961,265		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 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			17,763	17,763		17,763	20,531	38,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,688	4,688		4,688	(4,688)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(220,307)	19,693			34
35	Rent-Equipment & Vehicles			10,747	10,747		10,747	733	11,480			35
36	Other (specify):*											36
37	TOTAL Ownership			273,198	273,198		273,198	(203,731)	69,467			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			77,722	77,722		77,722	(77,722)	0			41
42	Provider Participation Fee											42
43	Other (specify):*			9,294	9,294		9,294	(9,294)				43
44	TOTAL Special Cost Centers			87,016	87,016		87,016	(87,016)	0			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,069,633	566,772	1,814,505	5,450,910		5,450,910	(420,178)	5,030,732			45

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,377	30		9
10	Interest and Other Investment Income	(4,688)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,603)	21		19
20	Contributions	(210)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(176,762)	21		24
25	Fund Raising, Advertising and Promotional	(8,495)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(110,365)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (284,816)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(135,362)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (135,362)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (420,178)		37

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

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

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

Bayside Terrace

ID# 0054270

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (1,035)	21	1
2	Miscellaneous Income	(221)	21	2
3	Vending Expenses	(77,722)	41	3
4	Bldg Co - Annual Filing Fee	(75)	20	4
5	Bldg Co - Accounting Fees	(4,480)	19	5
6	Bldg Co - State Replacement Tax	(3,163)	21	6
7	Additional R&M	1,068	06	7
8	Out of State Seminar	(2,480)	24	8
9	Non Allowable Legal	(1,188)	19	9
10	PAC Dues	(11,776)	20	10
11	Non Allowable Expense	(9,294)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(110,365)		49

Bayside Terrace

Report Period Beginning: ID# 0054270
 Ending: 01/01/18
 12/31/18

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:

01/01/18

Ending:

12/31/18

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	(70)											(70)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			501									501	5
6	Maintenance	1,068											1,068	6
7	Other (specify):*													7
8	TOTAL General Services	998		501									1,499	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			(2,722)	17,372	39,456							54,106	17
18	Directors Fees													18
19	Professional Services	(5,668)	4,480										(1,188)	19
20	Fees, Subscriptions & Promotions	(20,556)	75										(20,481)	20
21	Clerical & General Office Expenses	(182,784)	3,163	5,326									(174,295)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,480)											(2,480)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			280									280	26
27	Other (specify):*				5,633	7,494							13,127	27
28	TOTAL General Administration	(211,487)	7,718	2,884	23,005	46,950							(130,930)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(210,489)	7,718	3,385	23,005	46,950							(129,431)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	17,377	3,127	27									20,531	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,688)											(4,688)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(240,000)	19,693									(220,307)	34
35	Rent-Equipment & Vehicles			733									733	35
36	Other (specify):*													36
37	TOTAL Ownership	12,689	(236,873)	20,453									(203,731)	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	(77,722)											(77,722)	41
42	Provider Participation Fee													42
43	Other (specify):*	(9,294)											(9,294)	43
44	TOTAL Special Cost Centers	(87,016)											(87,016)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(284,816)	(229,155)	23,838	23,005	46,950							(420,178)	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		\$	\$ (240,000)	1
2	V	33 Rental Income- R/E Tax Reimburseme	75,000	Bayside Terrace Realty, LLC			(75,000)	2
3	V	33 Real Estate Taxes		Bayside Terrace Realty, LLC		75,000	75,000	3
4	V	20 Annual Filing Fee		Bayside Terrace Realty, LLC		75	75	4
5	V	19 Accounting Fees		Bayside Terrace Realty, LLC		4,480	4,480	5
6	V	30 Depreciation		Bayside Terrace Realty, LLC		3,127	3,127	6
7	V	21 State Replacement Taxes		Bayside Terrace Realty, LLC		3,163	3,163	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 315,000			\$ 85,845	\$ * (229,155)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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		\$ 501	\$ 501	15
16	V	21 CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT		5,326	5,326	16
17	V	26 INSURANCE		A.H.B. D/B/A ABH MANAGEMENT		280	280	17
18	V	30 DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT		27	27	18
19	V	34 RENT		A.H.B. D/B/A ABH MANAGEMENT		19,693	19,693	19
20	V	35 EQUIPMENT RENT		A.H.B. D/B/A ABH MANAGEMENT		733	733	20
21	V							21
22	V	17 HOME OFFICE	2,722	A.H.B. D/B/A ABH MANAGEMENT			(2,722)	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		\$ 2,722			\$ 26,560	\$ * 23,838	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.		\$ 62,500	\$ 62,500	15
16	V	27 EMPLOYEE BENEFITS		KARLA BISHOP, INC.		5,633	5,633	16
17	V							17
18	V	17 MANAGEMENT FEES	45,128	KARLA BISHOP, INC.			(45,128)	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		\$ 45,128			\$ 68,133	\$ * 23,005	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. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.		\$ 83,333	\$ 83,333	15
16	V	27 EMPLOYEE BENEFITS		HEALTH RESOURCE, INC.		7,494	7,494	16
17	V							17
18	V	17 MANAGEMENT FEES	43,877	HEALTH RESOURCE, INC.			(43,877)	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		\$ 43,877			\$ 90,827	\$ * 46,950	39

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

Facility Name & ID Number

Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending:

12/31/18

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 (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:

01/01/18

Ending:

12/31/18

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	\$ 62,500	17-07	1	
2	Earl Rosenbaum	Gen. Partner	Administrative	0%	See Attached	15	33.33%	Alloc. Salary	83,333	17-07	2	
3	Jack Bishop	Relative	Maintenance	0%	none	40	100.00%	Salary	58,694	06-01	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	\$ 204,527		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:

01/01/18

Ending: 12/31/18

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:

01/01/18

Ending: 12/31/18

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 AVENEUE
 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	130,126	3	\$ 1,347	\$ 48,371	\$ 501	1
2	21	CLERICAL AND GENERAL	PATIENT DAYS	130,126	3	14,327	48,371	5,326	2
3	26	INSURANCE	PATIENT DAYS	130,126	3	753	48,371	280	3
4	30	DEPRECIATION	PATIENT DAYS	130,126	3	72	48,371	27	4
5	34	RENT	PATIENT DAYS	130,126	3	52,978	48,371	19,693	5
6	35	EQUIPMENT RENT	PATIENT DAYS	130,126	3	1,973	48,371	733	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					\$ 71,450	\$	\$ 26,560	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	\$ 250,000	\$ 250,000	10	\$ 62,500	1
2	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 40	3	22,530		10	5,633	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				\$ 272,530	\$ 250,000		\$ 68,133	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED 45	3	\$ 250,000	\$ 250,000	15	\$ 83,333	1
2	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 45	3	22,481		15	7,494	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				\$ 272,481	\$ 250,000		\$ 90,827	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending: 12/31/18

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:

01/01/18

Ending: 12/31/18

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:

01/01/18

Ending: 12/31/18

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:

01/01/18

Ending: 12/31/18

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: **01/01/18** Ending: **12/31/18**

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:

01/01/18

Ending: 12/31/18

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:

01/01/18

Ending:

12/31/18

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								4,688	6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$			\$	4,688	9					
B. Non-Facility Related*																		
10	Interest Income		X									(4,688)	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(4,688)	14					
15	TOTALS (line 9+line14)						\$	\$			\$		15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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

0054270

Report Period Beginning:

01/01/18

Ending:

12/31/18

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 2017 report.	\$	<u>147,361</u>	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.)	\$	<u>72,361</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(75,000)</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>75,000</u>	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.	\$	<u>0</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>133,054</u>	8
	2014	<u>142,217</u>	9
	2015	<u>139,765</u>	10
	2016	<u>144,599</u>	11
	2017	<u>72,361</u>	12

2018 Accrual = 72,361 x 1.036 = \$75,000 (Rounded)

Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bayside Terrace COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0054270
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>08-32-107-012</u>	<u>Long Term Care Property</u>	\$ <u>72,361.48</u>	\$ <u>72,361.48</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>72,361.48</u>	\$ <u>72,361.48</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bayside Terrace COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0054270
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

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 _____ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

0054270 Report Period Beginning:

01/01/18 Ending:

12/31/18

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			\$ 100,000	3

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	588,190	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	2,454	13
14	Various		2000		18,159		20			18,159	14
15	Various		2001		38,470		20	732	732	13,176	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	65,435	20
21	Various		2008		29,876		20	622	622	23,712	21
22	Various		2009		3,490		20	175	175	1,676	22
23	Various		2010		8,707		20	721	721	6,184	23
24	Various		2011		26,433		20	1,634	1,634	12,535	24
25	Various		2013		36,974		20	3,698	3,698	19,747	25
26	Various		2014		7,743		20	387	387	1,763	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:

01/01/18

Ending:

12/31/18

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			4,917	4,917	456,849	67
68		3,355	27		75	48	3,071	68
69			17,763			(17,763)		69
70		\$ 2,622,426	\$ 20,917		\$ 31,393	\$ 10,476	\$ 2,451,337	70

**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:

01/01/18

Ending:

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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	Totals from Page 12A, Carried Forward	\$ 2,622,426	\$ 20,917		\$ 31,393	\$ 10,476	\$ 2,451,337		1
2	Hot Water Heater	7,088		20	354	354	1,093		2
3	Generator Repairs	3,374		20	169	169	422		3
4	Replaced Coil On Walk-In Cooler	3,432		20	172	172	386		4
5	Carpeting - Entire Area	26,730		20	1,337	1,337	1,782		5
6	Replace Heat Exchanger - Roof-Top Unit	2,677		20	134	134	167		6
7	Air Conditioner	3,200		20	229	229	229		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)	\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416		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:

01/01/18

Ending:

12/31/18

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		\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416	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)	\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416	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:

01/01/18

Ending:

12/31/18

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		\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416	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)	\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416	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		\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416	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)	\$ 2,668,927	\$ 20,917		\$ 33,788	\$ 12,871	\$ 2,455,416	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:

01/01/18

Ending:

12/31/18

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			1,050	30
31	Various	1999	33,029		20	1,651	1,651	33,025	31
32	Various	2001	40,914		20	2,046	2,046	36,825	32
33	Various	2002	4,806		20	240	240	4,080	33
34	TOTAL (lines 1 thru 33)		\$ 448,344	\$		\$ 3,937	\$ 3,937	\$ 443,525	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	\$		\$ 3,937	\$ 3,937	\$ 443,525	1
2	Various	2003	3,048		20	152	152	2,435	2
3	Fence	2005	2,550		20	128	128	1,789	3
4	Concrete	2006	14,000		20	700	700	9,100	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	\$		\$ 4,917	\$	\$ 456,849	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	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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ABH Management	2002	3,166	27	20	75	48	2,882	9
10	Allocated from ABH Management	2003	189		20			189	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)		\$ 3,355	\$ 27		\$ 75	\$ 48	\$ 3,071	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:

01/01/18

Ending:

12/31/18

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		\$ 3,355	\$ 27		\$ 75	\$ 48	\$ 3,071	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)	\$ 3,355	\$ 27		\$ 75	\$ 48	\$ 3,071	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 187,792	\$	\$ 4,293	\$ 4,293	10	\$ 161,822	71
72	Current Year Purchases	2,978		213	213	10	213	72
73	Fully Depreciated Assets	505,788				10	505,788	73
74								74
75	TOTALS	\$ 696,557	\$	\$ 4,506	\$ 4,506		\$ 667,823	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)	\$ 3,516,918	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,917	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,293	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,377	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,174,673	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.

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 Mgmt				19,693			5
6								6
7	TOTAL				\$ 19,693			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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 11,480 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist		hrs	\$				\$								1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# 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.

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	\$ 74,805	\$ 551,877	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,309,365	1,309,365	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,137	36,137	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	257,769	258,509	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,678,076	\$ 2,155,888	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	931,367	931,367	16
17	Accumulated Depreciation (book methods)	(867,362)	(3,046,079)	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)	\$ 125,363	\$ 273,344	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,803,439	\$ 2,429,232	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 472,114	\$ 472,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,965	72,965	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,893	7,893	31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,000	75,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	200,000	200,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 827,972	\$ 827,972	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>	898,834		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 898,834	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,726,806	\$ 827,972	46
47	TOTAL EQUITY(page 18, line 24)	\$ 76,633	\$ 1,601,260	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,803,439	\$ 2,429,232	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 71,139	1
2	Restatements (describe):		2
3	Pension Plan Contribution	(6,661)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 64,478	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	12,155	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)	\$ 12,155	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)	\$ 76,633	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bayside Terrace# 0054270Report Period Beginning: 01/01/18Ending: 12/31/18**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	\$ 5,370,290	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,370,290	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	82,466	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)	\$ 82,466	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,088	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,088	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	221	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 221	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,463,065	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,288,770	31
32	Health Care	2,064,787	32
33	General Administration	1,737,139	33
B. Capital Expense			
34	Ownership	273,198	34
C. Ancillary Expense			
35	Special Cost Centers	87,016	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)*	\$ 5,450,910	40
41	Income before Income Taxes (line 30 minus line 40)**	12,155	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 12,155	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,147,083	44
45	Private Pay - Net Inpatient Revenue	223,207	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)	\$ 5,370,290	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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: 01/01/18

Ending: 12/31/18

12/31/18

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	2,080	\$ 82,623	\$ 39.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,590	14,587	418,656	28.70	3
4	Licensed Practical Nurses	12,677	14,149	370,115	26.16	4
5	CNAs & Orderlies	37,772	41,521	541,989	13.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,133	11,013	185,000	16.80	10
11	Social Service Workers	12,869	13,893	321,010	23.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,177	23,385	374,137	16.00	15
16	Dishwashers					16
17	Maintenance Workers	937	1,281	59,550	46.49	17
18	Housekeepers	9,845	10,837	150,414	13.88	18
19	Laundry	1,884	2,228	28,774	12.91	19
20	Administrator	2,080	2,080	157,224	75.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,638	18,384	380,141	20.68	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)	141,682	155,438	\$ 3,069,633 *	\$ 19.75	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	\$ 8,532	01-03	35
36	Medical Director	Monthly	29,644	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,042	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	6,096	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 53,314		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

