

		FOR BHF USE				

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

<p>I. IDPH License ID Number: <u>0054270</u></p> <p>Facility Name: <u>Bayside Terrace</u></p> <p>Address: <u>1100 South Lewis Ave</u> <u>Waukegan</u> <u>60085</u> Number City Zip Code</p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>(847) 244-8196</u> Fax # <u>(847) 244-7647</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>00/00/76</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td style="width:15%;">Paid Preparer</td> <td>(Signed) _____</td> <td><u>04/23/2021</u></td> </tr> <tr> <td></td> <td colspan="2"><i>* Subject to the attached Accountants' Consulting Report</i></td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u></td> <td>Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	<u>04/23/2021</u>		<i>* Subject to the attached Accountants' Consulting Report</i>			(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	(Date) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u>	Fax # <u>(847) 282-6301</u>
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Facility Name & ID Number Bayside Terrace

0054270 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	61,488	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	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	37,898	479		38,377	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,898	479		38,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.41%

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Bayside Terrace # 0054270 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	356,511	41,327	5,332	403,170		403,170		403,170		1
2	Food Purchase		276,238		276,238		276,238	(34)	276,204		2
3	Housekeeping	144,631	22,150		166,781		166,781		166,781		3
4	Laundry		48,226		48,226		48,226		48,226		4
5	Heat and Other Utilities			134,628	134,628		134,628	332	134,960		5
6	Maintenance	68,670	587	163,007	232,264		232,264	(41,181)	191,083		6
7	Other (specify):*										7
8	TOTAL General Services	569,812	388,528	302,967	1,261,307		1,261,307	(40,883)	1,220,424		8
	B. Health Care and Programs										
9	Medical Director			26,938	26,938		26,938		26,938		9
10	Nursing and Medical Records	1,486,878	88,464	9,757	1,585,099		1,585,099		1,585,099		10
10a	Therapy										10a
11	Activities	114,589	11,680		126,269		126,269		126,269		11
12	Social Services	330,542	4,398	1,885	336,825		336,825		336,825		12
13	CNA Training										13
14	Program Transportation			1,071	1,071		1,071		1,071		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,932,009	104,542	39,651	2,076,202		2,076,202		2,076,202		16
	C. General Administration										
17	Administrative	116,644		13,915	130,559		130,559	36,085	166,644		17
18	Directors Fees										18
19	Professional Services			218,004	218,004		218,004	(24,535)	193,469		19
20	Dues, Fees, Subscriptions & Promotions			57,603	57,603		57,603	(27,649)	29,954		20
21	Clerical & General Office Expenses	320,637	52,994	213,883	587,514		587,514	(194,382)	393,132		21
22	Employee Benefits & Payroll Taxes			517,727	517,727		517,727	(957)	516,770		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,271	3,271		3,271		3,271		24
25	Other Admin. Staff Transportation			6,368	6,368		6,368		6,368		25
26	Insurance-Prop.Liab.Malpractice			108,437	108,437		108,437		108,437		26
27	Other (specify):*							4,870	4,870		27
28	TOTAL General Administration	437,281	52,994	1,139,208	1,629,483		1,629,483	(206,568)	1,422,915		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,939,102	546,064	1,481,826	4,966,992		4,966,992	(247,451)	4,719,541		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:

01/01/20

Ending:

12/31/20

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			42,873	42,873		42,873	12,169	55,042			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,585	10,585		10,585	(3,920)	6,665			32
33	Real Estate Taxes			72,419	72,419		72,419		72,419			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(220,194)	19,806			34
35	Rent-Equipment & Vehicles			2,855	2,855		2,855	630	3,485			35
36	Other (specify):*											36
37	TOTAL Ownership			368,732	368,732		368,732	(211,315)	157,417			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			69,013	69,013		69,013	(69,013)				41
42	Provider Participation Fee											42
43	Other (specify):*			17,555	17,555		17,555	(17,555)	(0)			43
44	TOTAL Special Cost Centers			86,568	86,568		86,568	(86,568)	(0)			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,939,102	546,064	1,937,126	5,422,292		5,422,292	(545,334)	4,876,958			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:

01/01/20

Ending:

12/31/20

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	9,238	30		9
10	Interest and Other Investment Income	(3,920)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	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				19
20	Contributions	(6,300)	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	(193,153)	21		24
25	Fund Raising, Advertising and Promotional	(4,305)	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	(190,300)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (388,774)		\$	30

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)	(156,560)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (156,560)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (545,334)		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

BHF USE ONLY							
48		49		50		51	

Bayside Terrace

ID# 0054270

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (433)	21	1
2	Vending Expenses	(69,013)	41	2
3	Misc. Income	(5,708)	21	3
4	Partners' Life Insurance	(957)	22	4
5	Bldg Co - Annual Filing Fee	(75)	20	5
6	Bldg Co - Professional Fees	(11,280)	19	6
7	Bldg Co - State Replacement Taxes	(2,357)	21	7
8	Additional R&M	1,164	06	8
9	Capitalized R&M	(42,345)	06	9
10	Non Allowable Expense	(7,137)	43	10
11	PAC Dues	(17,044)	20	11
12	Non Allowable Expense	(10,418)	43	12
13	Non Allowable Legal	(24,697)	19	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
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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	(190,300)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	(34)											(34)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			332									332	5
6	Maintenance	(41,181)											(41,181)	6
7	Other (specify):*													7
8	TOTAL General Services	(41,215)		332									(40,883)	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				36,085								36,085	17
18	Directors Fees													18
19	Professional Services	(35,977)	11,280	162									(24,535)	19
20	Fees, Subscriptions & Promotions	(27,724)	75										(27,649)	20
21	Clerical & General Office Expenses	(201,651)	1,860	5,409									(194,382)	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													26
27	Other (specify):*				4,870								4,870	27
28	TOTAL General Administration	(266,309)	13,215	5,571	40,955								(206,568)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(307,524)	13,215	5,903	40,955								(247,451)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	9,238	2,896	35									12,169	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,920)											(3,920)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(240,000)	19,806									(220,194)	34
35	Rent-Equipment & Vehicles			630									630	35
36	Other (specify):*													36
37	TOTAL Ownership	5,318	(237,104)	20,471									(211,315)	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	(69,013)											(69,013)	41
42	Provider Participation Fee													42
43	Other (specify):*	(17,555)											(17,555)	43
44	TOTAL Special Cost Centers	(86,568)											(86,568)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(388,774)	(223,889)	26,374	40,955								(545,334)	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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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: 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		
1	V	34 Rental Income	\$ 240,000	Bayside Terrace Realty, LLC		\$	(240,000)	1
2	V	33 Real Estate Taxes	72,419	Bayside Terrace Realty, LLC		72,419		2
3	V	21 Other Income	497	Bayside Terrace Realty, LLC			(497)	3
4	V	20 Annual Filing Fee		Bayside Terrace Realty, LLC		75	75	4
5	V	19 Professional Fees		Bayside Terrace Realty, LLC		11,280	11,280	5
6	V	30 Depreciation		Bayside Terrace Realty, LLC		2,896	2,896	6
7	V	21 State Replacement Taxes		Bayside Terrace Realty, LLC		2,357	2,357	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 312,916			\$ 89,027	\$ * (223,889)	14

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

Facility Name & ID Number

Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending:

12/31/20

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:

01/01/20

Ending:

12/31/20

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	PERRI ROSE BERMAN GRANDCHILDS TRUST	1.35%						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

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		\$ 332	\$	332	15
16	V	19 Professional Fees		A.H.B. D/B/A ABH Management		162		162	16
17	V	21 Clerical & General		A.H.B. D/B/A ABH Management		5,409		5,409	17
18	V	30 Depreciation		A.H.B. D/B/A ABH Management		35		35	18
19	V	34 Rent		A.H.B. D/B/A ABH Management		19,806		19,806	19
20	V	35 Equipment Rental		A.H.B. D/B/A ABH Management		630		630	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		\$			\$ 26,374	\$ *	26,374	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.		\$ 50,000	\$ 50,000	15
16	V	27 Employee Benefits		Karla Bishop, Inc.		4,870	4,870	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V	17 Management Fees	13,915	Karla Bishop, Inc.			(13,915)	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		\$ 13,915			\$ 54,870	\$ * 40,955	39

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

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning: 01/01/20

Ending: 12/31/20

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: 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.

Facility Name & ID Number

Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	17-07	1	
2	Jack Bishop	Relative	Maintenance	0%	None	40	100.00%	Salary	62,638	06-01	2	
3											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	\$ 112,638		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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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	111,701	3	\$ 965	\$ 38,377	\$ 332	1
2	19	Professional Fees	Patient Days	111,701	3	471	38,377	162	2
3	21	Clerical & General	Patient Days	111,701	3	15,743	38,377	5,409	3
4	30	Depreciation	Patient Days	111,701	3	101	38,377	35	4
5	34	Rent	Patient Days	111,701	3	57,647	38,377	19,806	5
6	35	Equipment Rental	Patient Days	111,701	3	1,833	38,377	630	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					\$ 76,760	\$	\$ 26,374	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending: 12/31/20

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	Average Hours Worked	40	3	\$ 200,000	\$ 200,000	10	\$ 50,000	1
2	27	Employee Benefits	Average Hours Worked	40	3	19,479		10	4,870	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					\$ 219,479	\$ 200,000		\$ 54,870	25

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending: 12/31/20

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:

01/01/20

Ending:

12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Lake Forest Bank & Trust		X	Line of Credit				107,000		10,585										
7																				
8																				
9	TOTAL Facility Related							107,000		10,585										
B. Non-Facility Related*																				
10	Interest Income		X							(3,920)										
11																				
12																				
13																				
14	TOTAL Non-Facility Related									(3,920)										
15	TOTALS (line 9+line14)							107,000		6,665										

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:

01/01/20

Ending:

12/31/20

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 2019 report.		\$	70,000	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.)		\$	70,419	2
3. Under or (over) accrual (line 2 minus line 1).		\$	419	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	72,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	72,419	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	139,765	8
	2016	144,599	9
	2017	72,361	10
	2018	67,647	11
	2019	70,419	12

2020 Accrual = \$70,419 x 1.02 = \$72,000 (Rounded)

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bayside Terrace COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0054270

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>08-32-107-012</u>	<u>Long Term Care Property</u>	\$ <u>70,418.54</u>	\$ <u>70,418.54</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>70,418.54</u></u>	\$ <u><u>70,418.54</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bayside Terrace COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0054270

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

01/01/20 Ending:

12/31/20

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column. Row 1: Facility, 104,671, \$ 100,000, 1. Row 2: 2. Row 3: TOTALS, 104,671, \$ 100,000, 3.

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	\$		\$	\$	\$
5		1986	1986	630,167	2,896	35	18,005	15,109	624,200
6		1986	1986	121,200					
7									
8									
Improvement Type**									
9	Various	1986		2,654		20			2,654
10	Various	1994		1,255		20			1,255
11	Various	1997		13,727		20	509	509	4,091
12	Various	1998		12,230		20	612	612	612
13	Various	1999		21,922		20	850	850	3,426
14	Various	2000		18,159		20			18,159
15	Various	2001		38,470		20	1,924	1,924	15,832
16	Various	2002		7,035		20			7,035
17	Various	2003		5,358		20			5,358
18	Various	2004		13,804		20	25	25	13,329
19	Various	2005		1,634		20			1,634
20	Various	2007		67,925		20	305	305	66,045
21	Various	2008		29,876		20	622	622	24,956
22	Various	2009		3,490		20	175	175	2,025
23	Various	2010		8,707		20	340	340	7,245
24	Various	2011		26,433		20	1,322	1,322	15,491
25	Various	2013		36,974		20	1,849	1,849	25,294
26	Various	2014		7,743		20	387	387	2,537
27	Various	2015		7,088		20	354	354	1,801
28	Various	2016		6,806		20	341	341	1,489
29									
30									
31									
32									
33									
34									
35									
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:

01/01/20

Ending:

12/31/20

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			3,266	3,266	463,382	67
68		3,101	35		69	35	2,976	68
69			42,873			(42,873)		69
70		\$ 2,636,066	\$ 45,804		\$ 30,955	\$ (14,849)	\$ 1,310,826	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:

01/01/20

Ending:

12/31/20

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		\$ 2,636,066	\$ 45,804		\$ 30,955	\$ (14,849)	\$ 1,310,826	1
2	Carpeting - Entire Area	2017	26,730		20	1,337	1,337	4,456	2
3	Replace Heat Exchanger - Roof-Top Unit	2017	2,677		20	134	134	435	3
4	Air Conditioner	2018	3,200		20	160	160	846	4
5	Carpeting For 3 Rooms	2019	5,800		20	290	290	704	5
6	Concrete Cut To Repair Underground Pipes	2019	2,643		20	132	132	264	6
7	Sprinkler Repair	2019	5,708		20	285	285	570	7
8	Hvac - Install New Heat Exchanger	2019	3,366		20	168	168	336	8
9	Walk-In Cooler - Replace Compressor	2019	3,600		20	180	180	360	9
10	North & South Wing Roofing	2020	131,982		20	6,599	6,599	6,599	10
11	Water Main Valve Repair	2020	4,255		20	213	213	213	11
12	Parking Lot Paving With Asphalt	2020	34,318		20	1,716	1,716	1,716	12
13	Replace Heat Exchanger	2020	3,533		20	177	177	177	13
14	West Wing Plumbing Repair	2020	18,000		20	900	900	900	14
15	6 Bathrooms Vinyl Flooring	2020	2,933		20	147	147	147	15
16	Repair Heat Exchanger	2020	3,820		20	191	191	191	16
17	Replace Compressor	2020	2,620		20	131	131	131	17
18	New Ac 4 Tons	2020	4,500		20	225	225	225	18
19	New Compressor	2020	2,685		20	134	134	134	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)		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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:

01/01/20

Ending:

12/31/20

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		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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:

01/01/20

Ending:

12/31/20

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		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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:

01/01/20

Ending:

12/31/20

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		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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		\$ 2,898,435	\$ 45,804		\$ 44,073	\$ (1,730)	\$ 1,329,229	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:

01/01/20

Ending:

12/31/20

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			33,029	31
32	Various	2001	40,914		20	2,046	2,046	40,914	32
33	Various	2002	4,806		20	240	240	4,560	33
34	TOTAL (lines 1 thru 33)		\$ 448,344	\$		\$ 2,286	\$ 2,286	\$ 448,098	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	\$		\$ 2,286	\$ 2,286	\$ 448,098	1
2	Various	2003	3,048		20	152	152	2,739	2
3	Fence	2005	2,550		20	128	128	2,045	3
4	Concrete	2006	14,000		20	700	700	10,500	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	\$		\$ 3,266	\$ 3,266	\$ 463,382	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	Allocated from ABH Management	2002	2,926	35	20	69	35	2,802	9
10	Allocated from ABH Management	2003	175		20			175	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)		\$ 3,101	\$ 35		\$ 69	\$ 35	\$ 2,976	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,101	\$ 35		\$ 69	\$ 35	\$ 2,976	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)	\$ 3,101	\$ 35		\$ 69	\$ 35	\$ 2,976	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	\$ 165,632	\$	\$ 10,901	\$ 10,901	10	\$ 143,113	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	537,035		68	68	10	537,035	73
74								74
75	TOTALS	\$ 702,667	\$	\$ 10,969	\$ 10,969		\$ 680,148	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)	\$ 3,752,536	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,804	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,042	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,238	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,060,811	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				19,806			5
6								6
7	TOTAL				\$ 19,806			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>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</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: \$ 3,485 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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.

Facility Name & ID Number Bayside Terrace

0054270

Report Period Beginning: 01/01/20

Ending:

12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20

(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	\$ 555,073	\$ 1,521,575	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,153,854	1,153,854	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,303	37,303	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	480,844	483,518	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,227,074	\$ 3,196,250	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	233,456	233,456	15
16	Equipment, at Historical Cost	943,756	943,756	16
17	Accumulated Depreciation (book methods)	(938,851)	(3,123,591)	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)	\$ 238,361	\$ 380,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,465,435	\$ 3,576,569	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 571,458	\$ 571,458	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	107,000	107,000	29
30	Accrued Salaries Payable	101,062	101,062	30
31	Accrued Taxes Payable (excluding real estate taxes)	45,181	45,181	31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,000	72,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached	650,090	650,090	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,546,791	\$ 1,546,791	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached	970,049	229,495	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 970,049	\$ 229,495	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,516,840	\$ 1,776,286	46
47	TOTAL EQUITY(page 18, line 24)	\$ (51,405)	\$ 1,800,283	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,465,435	\$ 3,576,569	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 134,911	1
2	Restatements (describe):		2
3	Pension Plan Contribution	6,249	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 141,160	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(192,565)	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)	\$ (192,565)	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)	\$ (51,405)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,747,024	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,747,024	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	85,063	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)	\$ 85,063	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,920	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,920	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	393,720	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 393,720	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,229,727	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,261,307	31
32	Health Care	2,076,202	32
33	General Administration	1,629,483	33
B. Capital Expense			
34	Ownership	368,732	34
C. Ancillary Expense			
35	Special Cost Centers	86,568	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)*	\$ 5,422,292	40
41	Income before Income Taxes (line 30 minus line 40)**	(192,565)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (192,565)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,652,790	44
45	Private Pay - Net Inpatient Revenue	94,234	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)	\$ 4,747,024	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: 01/01/20

Ending: 12/31/20

12/31/20

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	3,998	4,190	\$ 202,677	\$ 48.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,385	10,216	348,452	34.11	3
4	Licensed Practical Nurses	11,204	12,135	371,846	30.64	4
5	CNAs & Orderlies	34,937	38,775	545,877	14.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,909	6,507	114,589	17.61	10
11	Social Service Workers	12,507	13,389	330,542	24.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,710	20,640	356,511	17.27	15
16	Dishwashers					16
17	Maintenance Workers	1,384	1,652	68,670	41.57	17
18	Housekeepers	8,649	10,069	144,631	14.36	18
19	Laundry					19
20	Administrator	2,104	2,112	116,644	55.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,538	13,938	320,637	23.00	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) <u>See Attached</u>	554	682	18,026	26.43	33
34	TOTAL (lines 1 - 33)	121,879	134,305	\$ 2,939,102 *	\$ 21.88	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	\$ 5,332	01-03	35
36	Medical Director	Monthly	26,938	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,757	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	1,885	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,912		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Bayside Terrace**

0054270

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

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	0	\$ 36,292	Workers' Compensation Insurance	\$ 43,913	IDPH License Fee	\$		
Daniel Parker	Administrator	0	80,352	Unemployment Compensation Insurance	14,688	Advertising: Employee Recruitment			
				FICA Taxes	224,841	Health Care Worker Background Check			
				Employee Health Insurance	111,638	(Indicate # of checks performed <u>148.3</u>)	7,415		
				Employee Meals	48	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	15,149		
				Union Pension Contribution	75,517	Licenses & Fees	7,390		
				Pension plan contribution	36,000				
				Christmas Expense	7,099				
				Employee Benefits	3,026				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,644	TOTAL (agree to Schedule V, line 22, col.8)		\$ 516,770			
B. Administrative - Other									
Description			Amount						
Karla Bishop, Inc. - Administrative			\$ 13,915						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 13,915						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Marcum LLP	Accounting		\$ 96,930			\$	Out-of-State Travel	\$	
Alpha Data	Data Processing		20,241						
Point Click Care	Computer Support		44,090						
Profit Planners	Pension Administration Fee		2,678				In-State Travel		
Stout Risius Ross	Financial Services		5,546						
							Seminar Expense	3,271	
See Attached	Legal		48,519						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 218,004	TOTAL		\$	Entertainment Expense ()		
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 3,271	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bayside Terrace# 0054270Report Period Beginning: 01/01/20Ending: 12/31/20**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 \$27,240
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (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 benefits on Schedule V. \$ 48 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.