

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	313	Skilled (SNF)	313	114,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	313	TOTALS	313	114,245	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	56,386	2,217	15,920	74,523	8
9	SNF/PED					9
10	ICF	14,874		281	15,155	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,260	2,217	16,201	89,678	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.50%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/1/2010 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 313 and days of care provided 10,466

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	443,700	75,027	49,100	567,827		567,827	36	567,863		1
2	Food Purchase		491,004		491,004	(39,011)	451,993	(1,871)	450,122		2
3	Housekeeping	4,134	68,847	397,053	470,034		470,034	2,185	472,219		3
4	Laundry	1,116	12,299	264,716	278,131		278,131		278,131		4
5	Heat and Other Utilities			328,481	328,481		328,481	(6,992)	321,489		5
6	Maintenance	142,682	34,423	115,172	292,277		292,277	30,459	322,736		6
7	Other (specify):*										7
8	TOTAL General Services	591,632	681,600	1,154,522	2,427,754	(39,011)	2,388,743	23,817	2,412,560		8
	B. Health Care and Programs										
9	Medical Director			125,175	125,175		125,175	24,720	149,895		9
10	Nursing and Medical Records	4,868,319	328,669	322,763	5,519,751		5,519,751	45,894	5,565,645		10
10a	Therapy	305,498		46,907	352,405		352,405		352,405		10a
11	Activities	159,704	26,114		185,818		185,818		185,818		11
12	Social Services	314,918			314,918		314,918	2,994	317,912		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							18,137	18,137		15
16	TOTAL Health Care and Programs	5,648,439	354,783	494,845	6,498,067		6,498,067	91,746	6,589,813		16
	C. General Administration										
17	Administrative	214,411		600,000	814,411		814,411	(421,786)	392,625		17
18	Directors Fees										18
19	Professional Services			481,329	481,329	(281)	481,048	(358,944)	122,104		19
20	Dues, Fees, Subscriptions & Promotions			181,870	181,870		181,870	(92,986)	88,884		20
21	Clerical & General Office Expenses	306,014	25,366	921,118	1,252,498		1,252,498	(605,874)	646,624		21
22	Employee Benefits & Payroll Taxes			1,222,664	1,222,664	39,011	1,261,675	15	1,261,690		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,385	6,385		6,385	4	6,389		24
25	Other Admin. Staff Transportation			4,561	4,561		4,561	2,410	6,971		25
26	Insurance-Prop.Liab.Malpractice			275,547	275,547		275,547	17,143	292,690		26
27	Other (specify):*							62,196	62,196		27
28	TOTAL General Administration	520,425	25,366	3,693,474	4,239,265	38,730	4,277,995	(1,397,821)	2,880,174		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,760,496	1,061,749	5,342,841	13,165,086	(281)	13,164,805	(1,282,259)	11,882,546		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lake Shore Hlthcare & Rehab

#0050765

Report Period Beginning:

01/01/13

Ending:

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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			580,917	580,917		580,917	328,099	909,016			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,285	89,285		89,285	1,160,475	1,249,760			32
33	Real Estate Taxes					281	281	320,310	320,591			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)	0			34
35	Rent-Equipment & Vehicles							6,330	6,330			35
36	Other (specify):*											36
37	TOTAL Ownership			2,530,202	2,530,202	281	2,530,483	(44,786)	2,485,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		409,098	1,666,326	2,075,424		2,075,424	(942)	2,074,482			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			652,652	652,652		652,652		652,652			42
43	Other (specify):*	134,156		5,189	139,345		139,345	(139,345)				43
44	TOTAL Special Cost Centers	134,156	409,098	2,324,167	2,867,421		2,867,421	(140,287)	2,727,134			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,894,652	1,470,847	10,197,210	18,562,709	(0)	18,562,709	(1,467,332)	17,095,377			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(10,509)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	168,781	30		9
10	Interest and Other Investment Income	(12,925)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(121)	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	(1,729)	21		18
19	Entertainment	(173)	21		19
20	Contributions	(67,150)	20		20
21	Owner or Key-Man Insurance	15	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(742,678)	21		24
25	Fund Raising, Advertising and Promotional	(40,682)	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	(398,825)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,105,995)		\$	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)	(361,337)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (361,337)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,467,332)		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
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Lake Shore Hlthcare & Rehab

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

ID# 0050765

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,750)	02	1
2	Discounts	(238)	21	2
3	Veterans Expenses	(58,479)	10	3
4	Bank Charges	(11,663)	21	4
5	Marketing Salaries	(134,156)	43	5
6	Prior Period Expenses	(13,136)	21	6
7	Theft & Loss	(5,862)	21	7
8	Medicare Sequestration	(70,451)	21	8
9	Building Company Amortization	(67,437)	31	9
10	Building Company Office Expense	(6)	21	10
11	Building Company Bank Charges	(36)	21	11
12	Building Company Professional Fees	(21,630)	19	12
13	Marketing Consultant	(5,189)	43	13
14	Non-Allowable Legal	(5,870)	19	14
15	Out of State/Marketing Travel	(382)	25	15
16	Non-Allowable Seminar	(1,053)	24	16
17	Misc. Income	(13,541)	21	17
18	Additional R&M	22,063	06	18
19	COPE Dues	(10,009)	20	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(398,825)	49

Lake Shore Hlthcare & Rehab

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Report Period Beginning: 01/01/13

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Hlthcare & Rehab# 0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			36									36	1
2	Food Purchase	(1,871)											(1,871)	2
3	Housekeeping			2,185									2,185	3
4	Laundry													4
5	Heat and Other Utilities	(10,509)		2,650		866							(6,992)	5
6	Maintenance	22,063		6,809		1,587							30,459	6
7	Other (specify):*													7
8	TOTAL General Services	9,683		11,681		2,453							23,817	8
	B. Health Care and Programs													
9	Medical Director			24,720									24,720	9
10	Nursing and Medical Records	(58,479)		104,373									45,894	10
10a	Therapy													10a
11	Activities													11
12	Social Services			2,994									2,994	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			18,137									18,137	15
16	TOTAL Health Care and Programs	(58,479)		150,225									91,746	16
	C. General Administration													
17	Administrative			65,110	(486,896)								(421,786)	17
18	Directors Fees													18
19	Professional Services	(27,500)	21,630	(354,464)	276	1,114							(358,944)	19
20	Fees, Subscriptions & Promotions	(117,841)		24,671		184							(92,986)	20
21	Clerical & General Office Expenses	(859,513)	42	253,495	47	55							(605,874)	21
22	Employee Benefits & Payroll Taxes	15											15	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,053)		1,057									4	24
25	Other Admin. Staff Transportation	(382)		2,788	4								2,410	25
26	Insurance-Prop.Liab.Malpractice		16,008	710		425							17,143	26
27	Other (specify):*			51,865	10,330								62,196	27
28	TOTAL General Administration	(1,006,274)	37,680	45,232	(476,238)	1,779							(1,397,821)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,055,069)	37,680	207,137	(476,238)	4,232							(1,282,259)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	168,781	136,313	17,828		5,177							328,099	30
31	Amortization of Pre-Op. & Org.	(67,437)	67,437											31
32	Interest	(12,925)	1,163,755	64		9,581							1,160,475	32
33	Real Estate Taxes		315,572			4,738							320,310	33
34	Rent-Facility & Grounds		(1,860,000)	28,011		(28,011)							(1,860,000)	34
35	Rent-Equipment & Vehicles			294	6,035								6,330	35
36	Other (specify):*													36
37	TOTAL Ownership	88,419	(176,923)	46,197	6,035	(8,515)							(44,786)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(942)						(942)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(139,345)											(139,345)	43
44	TOTAL Special Cost Centers	(139,345)					(942)						(140,287)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,105,995)	(139,243)	253,334	(470,203)	(4,284)	(942)						(1,467,332)	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,860,000	LSH Property LLC	100.00%	\$	\$ (1,860,000)	1
2	V	26 Insurance Expense		LSH Property LLC	100.00%	16,008	16,008	2
3	V	32 Interest	491	LSH Property LLC	100.00%	1,164,246	1,163,755	3
4	V	30 Depreciation Expense		LSH Property LLC	100.00%	136,313	136,313	4
5	V	31 Amortization Expense		LSH Property LLC	100.00%	67,437	67,437	5
6	V	33 Real Estate Tax Expense		LSH Property LLC	100.00%	315,572	315,572	6
7	V	19 Legal & Professional		LSH Property LLC	100.00%	21,630	21,630	7
8	V	21 Office Supplies & Expenses		LSH Property LLC	100.00%	6	6	8
9	V	21 Bank Charges		LSH Property LLC	100.00%	36	36	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,860,491			\$ 1,721,248	\$ * (139,243)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1 <u>DIETARY</u>	\$	<u>MANAGCARE, INC.</u>	100.00%	\$ 36	\$	36	15
16	V	3 <u>HOUSEKEEPING</u>		<u>MANAGCARE, INC.</u>	100.00%	2,185		2,185	16
17	V	5 <u>UTILITIES</u>		<u>MANAGCARE, INC.</u>	100.00%	2,650		2,650	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>MANAGCARE, INC.</u>	100.00%	6,809		6,809	18
19	V	9 <u>MEDICAL DIRECTOR</u>		<u>MANAGCARE, INC.</u>	100.00%	24,720		24,720	19
20	V	10 <u>NURSING SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	104,373		104,373	20
21	V	12 <u>SOCIAL SERVICE SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	2,994		2,994	21
22	V	15 <u>NURSING EMP BENS & PR TAXES</u>		<u>MANAGCARE, INC.</u>	100.00%	18,137		18,137	22
23	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	65,110		65,110	23
24	V	19 <u>PROFESSIONAL FEES</u>		<u>MANAGCARE, INC.</u>	100.00%	2,356		2,356	24
25	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>MANAGCARE, INC.</u>	100.00%	24,671		24,671	25
26	V	21 <u>CLERICAL AND GENERAL SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	190,769		190,769	26
27	V	21 <u>CLERICAL AND GENERAL EXP</u>		<u>MANAGCARE, INC.</u>	100.00%	62,726		62,726	27
28	V	24 <u>SEMINARS</u>		<u>MANAGCARE, INC.</u>	100.00%	1,057		1,057	28
29	V	25 <u>ADMIN. STAFF TRANS.</u>		<u>MANAGCARE, INC.</u>	100.00%	2,788		2,788	29
30	V	26 <u>INSURANCE</u>		<u>MANAGCARE, INC.</u>	100.00%	710		710	30
31	V	27 <u>GEN. ADMIN. EMP. BEN.</u>		<u>MANAGCARE, INC.</u>	100.00%	51,865		51,865	31
32	V	30 <u>DEPRECIATION</u>		<u>MANAGCARE, INC.</u>	100.00%	17,828		17,828	32
33	V	32 <u>INTEREST EXPENSE</u>		<u>MANAGCARE, INC.</u>	100.00%	64		64	33
34	V	34 <u>RENT - BUILDING (RELATED)</u>		<u>MANAGCARE, INC.</u>	100.00%	28,011		28,011	34
35	V	35 <u>EQUIPMENT RENTAL</u>		<u>MANAGCARE, INC.</u>	100.00%	294		294	35
36	V								36
37	V	19 <u>BOOKKEEPING FEES</u>	356,820	<u>BOOKKEEPING</u>	100.00%			(356,820)	37
38	V								38
39	Total		\$ 356,820			\$ 610,154	\$ *	253,334	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 ADMINISTRATIVE SALARY - NATHAN	\$	TETRAD MANAGEMENT, LLC	100.00%	\$ 35,098	\$ 35,098
16	V	17 ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	12,063	12,063
17	V	17 ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	35,098	35,098
18	V	17 ADMINISTRATIVE FEES - YOSEF DAVIS		TETRAD MANAGEMENT, LLC	100.00%	30,845	30,845
19	V	17 TOTAL MANAGEMENT FEES		TETRAD MANAGEMENT, LLC	100.00%		
20	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	276	276
21	V	21 OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	47	47
22	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	4	4
23	V	27 EMPLOYEE BEENFITS- PAYROLL TAXES		TETRAD MANAGEMENT, LLC	100.00%	10,330	10,330
24	V	35 AUTO LEASE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	6,035	6,035
25	V						
26	V	17 MANAGEMENT FEES	600,000	TETRAD MANAGEMENT, LLC	100.00%		(600,000)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 600,000			\$ 129,797	\$ * (470,203)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	4600 TOUHY, LLC	100.00%	\$ 866	\$	866	15
16	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	1,587		1,587	16
17	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	1,114		1,114	17
18	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	184		184	18
19	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	55		55	19
20	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	425		425	20
21	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	5,177		5,177	21
22	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	9,581		9,581	22
23	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	4,738		4,738	23
24	V								24
25	V	34 RENT	28,011	4600 TOUHY, LLC	100.00%			(28,011)	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		\$ 28,011			\$ 23,727	\$ *	(4,284)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	39 Ambulance	\$ 5,388	Lifeline Ambulance	100.00%	\$ 4,446	\$ (942)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 5,388			\$ 4,446	\$ * (942)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ESTATE CARE OPERATOR, LLC	0.520%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	LSH PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	LAKE SHORE YD DELTA, LLC	99.480%	MAYFIELD CARE CENTER, INC.	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO	2
3			MID AMERICA CARE CENTER, L.L.C.	CHICAGO	4600 TOUHY LLC	LINCOLNWOOD	BUILDING CO.	3
4			CAPITOL HEALTHCARE & REHABILITATION CENTRE	SPRINGFIELD, IL	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO	4
5			COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL	LIFELINE AMBULANCE,LLC	CHICAGO	AMBULANCE	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL				6
7			MORTON VILLA HEALTHCARE & REHABILITATION CENTRE	MORTON, IL				7
8			MORTON TERRACE HEALTHCARE & REHABILITATION CENTRE	MORTON, IL				8
9			RIVERSHORES HEALTHCARE 7 REHABILITATION CENTRE	MASEILLES, IL				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nesanel Davis	Relative	Administrative	0.00	See Attached	8.85	18.44%	Alloc Salary	\$ 35,098	17-7	1
2	Moshe Davis	Relative	Administrative	0.00	See Attached	8.11	18.43%	Alloc Salary	35,098	17-7	2
3	Yehoshua Davis	Relative	Administrative	0.00	See Attached	8.85	18%	Alloc Salary	12,063	17-7	3
4	Yosef Davis	Relative	Administrative	0.00	See Attached	3.32	11%	Alloc Salary	30,845	17-7	4
5	Eli Davis	Relative	Administrative	0.00	See Attached	7.37	18%	Alloc Salary	1,290	17-7	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	\$ 114,394		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization MANAGCARE, INC.
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	486,626	10	\$ 198	\$ 89,678	\$ 36	1	
2	3	HOUSEKEEPING	PATIENT DAYS	486,626	10	11,856	89,678	2,185	2	
3	5	UTILITIES	PATIENT DAYS	486,626	10	14,381	89,678	2,650	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	486,626	10	36,948	89,678	6,809	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	486,626	10	134,142	89,678	24,720	5	
6	10	NURSING SALARIES	PATIENT DAYS	486,626	10	566,366	566,366	89,678	104,373	6
7	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	486,626	10	16,247	16,247	89,678	2,994	7
8	15	NURSING EMP BENS & PR TA	PATIENT DAYS	486,626	10	98,421	89,678	18,137	8	
9	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	486,626	10	353,309	353,309	89,678	65,110	9
10	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	12,785	89,678	2,356	10	
11	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	486,626	10	133,874	89,678	24,671	11	
12	21	CLERICAL AND GENERAL SA	PATIENT DAYS	486,626	10	1,035,183	1,035,183	89,678	190,769	12
13	21	CLERICAL AND GENERAL EX	PATIENT DAYS	486,626	10	340,374	89,678	62,726	13	
14	24	SEMINARS	PATIENT DAYS	486,626	10	5,737	89,678	1,057	14	
15	25	ADMIN. STAFF TRANS.	PATIENT DAYS	486,626	10	15,128	89,678	2,788	15	
16	26	INSURANCE	PATIENT DAYS	486,626	10	3,851	89,678	710	16	
17	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	486,626	10	281,440	89,678	51,865	17	
18	30	DEPRECIATION	PATIENT DAYS	486,626	10	96,741	89,678	17,828	18	
19	32	INTEREST EXPENSE	PATIENT DAYS	486,626	10	346	89,678	64	19	
20	34	RENT - BUILDING (RELATED)	PATIENT DAYS	486,626	10	152,000	89,678	28,011	20	
21	35	EQUIPMENT RENTAL	PATIENT DAYS	486,626	10	1,597	89,678	294	21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 3,310,923	\$ 1,971,105		\$ 610,154	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization TETRAD MANAGEMENT, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARY - PATIENT DAYS	486,626	10	\$ 190,457	\$ 190,457	89,678	\$ 35,098	1
2	17	ADMINISTRATIVE SALARY - PATIENT DAYS	486,626	10	65,457	65,457	89,678	12,063	2
3	17	ADMINISTRATIVE SALARY - PATIENT DAYS	486,626	10	190,457	190,457	89,678	35,098	3
4	17	ADMINISTRATIVE FEES - YO PATIENT DAYS	486,626	10	167,375		89,678	30,845	4
5	17	TOTAL MANAGEMENT FEES PATIENT DAYS	486,626	10			89,678		5
6	19	PROFESSIONAL FEES PATIENT DAYS	486,626	10	1,500		89,678	276	6
7	21	OFFICE EXPENSE PATIENT DAYS	486,626	10	253		89,678	47	7
8	25	TRAVEL PATIENT DAYS	486,626	10	23		89,678	4	8
9	27	EMPLOYEE BEENFITS- PAY PATIENT DAYS	486,626	10	56,057		89,678	10,330	9
10	35	AUTO LEASE EXPENSE PATIENT DAYS	486,626	10	32,750		89,678	6,035	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				\$ 704,328	\$ 446,371		\$ 129,797	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization 4600 TOUHY, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	486,626	10	\$ 4,702	\$ 89,678	\$ 866	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	486,626	10	8,610	89,678	1,587	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	486,626	10	6,043	89,678	1,114	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	486,626	10	1,001	89,678	184	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	486,626	10	300	89,678	55	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	486,626	10	2,308	89,678	425	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	486,626	10	28,092	89,678	5,177	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	486,626	10	51,990	89,678	9,581	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	486,626	10	25,708	89,678	4,738	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				\$ 128,752	\$		\$ 23,727	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Lifeline Ambulance LLC
 Street Address 2424 S. Wabash Ave
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 9499262

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ambulance	Direct Allocation		\$	\$		\$ 4,446	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				\$	\$		\$ 4,446	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Private Bank		X	Mortgage- Purchase of Facility			\$	\$ 16,677,375			\$ 1,078,934	1				
2	Capex		X					1,350,000			85,312	2				
3	Private Bank		X					1,575,000			89,285	3				
4	Loan to Members	X						4,900,000				4				
5												5				
Working Capital																
6	Shareholder Loan		X					750,000				6				
7	Allocated From Managcare		X								64	7				
8	See Supplemental Schedule										9,581	8				
9	TOTAL Facility Related						\$	\$ 25,252,375			\$ 1,263,176	9				
B. Non-Facility Related*																
10	Bldg. Co. Interest Income		X								(491)	10				
11	Non-Allowable Interest		X								(12,925)	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (13,416)	14				
15	TOTALS (line 9+line14)						\$	\$ 25,252,375			\$ 1,249,760	15				

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from 4600 Touhy						\$	\$			\$ 9,581					
9																
10																
11																
12																
13																
14	TOTAL Working Capital										9,581					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Hlthcare & Rehab COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0050765
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-320-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>22,708.93</u>	\$ <u>22,708.93</u>
2. <u>11-29-320-036-0000</u>	<u>Long Term Care Property</u>	\$ <u>76,746.95</u>	\$ <u>76,746.95</u>
3. <u>11-29-320-037-0000</u>	<u>Long Term Care Property</u>	\$ <u>77,120.41</u>	\$ <u>77,120.41</u>
4. <u>11-29-320-038-0000</u>	<u>Long Term Care Property</u>	\$ <u>77,120.41</u>	\$ <u>77,120.41</u>
5. <u>11-29-320-039-0000</u>	<u>Long Term Care Property</u>	\$ <u>76,972.73</u>	\$ <u>76,972.73</u>
6. <u>11-29-320-040-0000</u>	<u>Long Term Care Property</u>	\$ <u>22,298.50</u>	\$ <u>22,298.50</u>
7. <u>See Attached</u>	<u>Allocated from 4600 Touhy LLC</u>	\$ <u>48,715.81</u>	\$ <u>4,488.80</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>401,683.74</u></u>	\$ <u><u>357,456.73</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? X 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2010</u>	<u>\$ 1,220,975</u>	1
2					2
3	TOTALS			\$ 1,220,975	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	313		2010	1972	\$ 17,313,657	\$ 136,313	39	\$ 443,940	\$ 307,627	\$ 1,775,760	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		191,732	8,199		8,009	(190)	15,198	68
69			580,917			(580,917)		69
70		\$ 17,505,389	\$ 725,429		\$ 451,949	\$ (273,480)	\$ 1,790,958	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	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		\$ 17,505,389	\$ 725,429		\$ 451,949	\$ (273,480)	\$ 1,790,958	1
2	24 Color Cameras	2010	10,000		20	1,429	1,429	5,595	2
3	Cameras	2010	5,000		20	714	714	2,738	3
4	Repiping	2010	7,600		20	760	760	2,787	4
5	Stone Decking	2010	9,250		20	617	617	2,158	5
6	Asphalt Repairs	2010	12,450		20	830	830	2,905	6
7	Boiler	2010	12,800		20	2,560	2,560	9,387	7
8	Bumper Guards, Signage	2010	5,282		20	1,056	1,056	3,345	8
9	Reception Cabinetry With Granite Top	2010	7,500		20	375	375	1,219	9
10	Exterior Signage, Awning	2010	17,320		20	866	866	2,670	10
11	Elevator Controller	2010	59,711		20	2,986	2,986	9,952	11
12	Telephone System	2010	27,000		20	2,700	2,700	7,425	12
13	Elevator Repair- Pump/Starter/Wiring	2010	4,500		20	225	225	900	13
14	Electrical Service To West Elevator	2011	4,200		20	420	420	1,155	14
15	New Doors- Econocare	2011	5,171		20	517	517	1,336	15
16	Custom Baseboard Covers	2011	5,706		20	1,141	1,141	2,758	16
17	Custom Baseboard Covers	2011	8,929		20	1,786	1,786	4,167	17
18	Generator Toggle Switch	2011	2,501		20	500	500	1,209	18
19	Waterproofing Membrane And Drain North Patio	2011	11,150		20	743	743	1,672	19
20	Elevator Motor Starter & Maxton Valve	2011	5,500		20	275	275	665	20
21	Flooring For Shower Room	2011	6,400		20	640	640	1,333	21
22	Flooring For Shower Room	2011	5,650		20	565	565	1,177	22
23	Econocare - Blinds, Wallcovering, Vinyl Flooring	2011	87,478		20	17,496	17,496	45,197	23
24	Activity Room - Wall, Ceiling, Light Fixtures	2011	4,603		20	230	230	671	24
25	Repaint Bathroom Doors	2011	2,600		20	130	130	368	25
26	4Th Floor Exit Door Magnetic Locks	2012	4,746		20	237	237	4,983	26
27	2Nd Floor Staircase Exit Door Locks	2012	5,721		20	286	286	6,007	27
28	Sprinkler System Heads And Pipe Fittings	2012	19,153		20	958	958	20,111	28
29	Epoxy Quartz Surface And Durock On 2Nd And 4Th Floor Showe	2012	3,200		20	160	160	3,360	29
30	Baseboard Covers	2012	3,547		20	177	177	3,724	30
31	Flooring In Resident Rooms	2012	8,551		20	428	428	8,979	31
32	Hvac - Sas Architects	2012	39,873		20	1,994	1,994	41,867	32
33	Idph Plan Review For Remodeling Project	2012	3,540		20	177	177	3,717	33
34	TOTAL (lines 1 thru 33)		\$ 17,922,020	\$ 725,429		\$ 495,926	\$ (229,503)	\$ 1,996,494	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 17,922,020	\$ 725,429		\$ 495,926	\$ (229,503)	\$ 1,996,494	1
2	Walls, Floors, Cove Base, Carpet, Lighting, Tiling, Carpeting, Scor	2012	688,743		20	34,437	34,437	723,181	2
3	Walls, Flooring, Cove Base, Cornices, Plumbing, Ceiling, Locks	2012	79,588		20	3,979	3,979	83,567	3
4	Cubicle Tracks And Curtains, Cornices, Window Panels, Window	2012	2,643		20	132	132	2,775	4
5	Work On Doors And Door Jams	2012	2,910		20	146	146	3,056	5
6	Piping And Shut Off Valve	2012	4,900		20	245	245	5,145	6
7	Blower Motor And Temperature Control	2012	2,640		20	132	132	2,772	7
8	Ball Valves, Pipes, Couplings	2012	2,950		20	148	148	3,098	8
9	Patio Stone Surfacing	2013	8,000		20	957	957	957	9
10	2Nd Floor Resident Rooms And Bathrooms-Floor, Wallcoverings,	2013	154,358		20	6,145	6,145	6,145	10
11	A/C Wall Sleeve Units	2013	10,727		20	894	894	894	11
12	Pipes For Utility Room	2013	4,200		20	88	88	88	12
13	Recessed Flourescent Lighting	2013	2,740		20	274	274	274	13
14	Windows	2013	3,600		20	360	360	360	14
15	Bathrooms-Drain Covers, Smoke Detectors, Locksets, Brab Bars	2013	36,031		20	1,802	1,802	1,802	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)		\$ 18,926,051	\$ 725,429		\$ 545,663	\$ (179,765)	\$ 2,830,606	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 18,926,051	\$ 725,429		\$ 545,663	\$ (179,765)	\$ 2,830,606	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)		\$ 18,926,051	\$ 725,429		\$ 545,663	\$ (179,765)	\$ 2,830,606	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 18,926,051	\$ 725,429		\$ 545,663	\$ (179,765)	\$ 2,830,606	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)		\$ 18,926,051	\$ 725,429		\$ 545,663	\$ (179,765)	\$ 2,830,606	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From 4600 Touhy LLC	2012	94,623	2,426	20	3,154	728	6,308	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From 4600 Touhy LLC	2012	60,937	1,593	20	3,047	1,454	6,094	9
10	Allocated From 4600 Touhy LLC	2013	14,827	1,157	20	741	(416)	741	10
11									11
12	Allocated From Managcare	2013	1,589	905	20	79	(826)	79	12
13	Allocated From Managcare	2012	19,756	2,118	20	988	(1,130)	1,976	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued		\$	\$		\$	\$	\$	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
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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 (12H & 12I lines 1 thru 33)		\$ 191,732	\$ 8,199		\$ 8,009	\$ (190)	\$ 15,198	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,980,527	\$ 4,296	\$ 348,689	\$ 344,393	10	\$ 1,610,395	71
72	Current Year Purchases	127,275	9,125	12,135	3,010	10	12,135	72
73	Fully Depreciated Assets	49,390				10	49,390	73
74								74
75	TOTALS	\$ 2,157,192	\$ 13,421	\$ 360,824	\$ 347,403		\$ 1,671,919	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		Allocated from Managcare	2013	\$ 22,272	\$ 1,384	\$ 2,528	\$ 1,144	5	\$ 17,838	76
77										77
78										78
79										79
80	TOTALS			\$ 22,272	\$ 1,384	\$ 2,528	\$ 1,144		\$ 17,838	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)	\$ 22,326,490	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 740,234	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 909,015	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 168,781	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,520,364	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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								5
6								6
7	TOTAL				\$			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 294

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Tetrad Mgmt</u>		\$	\$ <u>6,035</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>6,035</u>	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	462,550	\$		\$	462,550	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				214,562				214,562	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				664,969				664,969	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					367,847			367,847	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						324,245	41,251			365,496	13
14	TOTAL			\$		\$	1,666,326	\$	409,098	\$	2,075,424	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab# 0050765Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 265,539	\$ 608,529	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,809,329	3,809,329	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	239,407	253,591	6
7	Other Prepaid Expenses	35,257	35,257	7
8	Accounts Receivable (owners or related parties)	632,141	2,844,509	8
9	Other(specify): <u>See Attached Schedule</u>	66,427	938,415	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,048,100	\$ 8,489,630	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,198,827	13
14	Buildings, at Historical Cost		5,316,218	14
15	Leasehold Improvements, at Historical Cost	1,143,672	1,143,672	15
16	Equipment, at Historical Cost	2,523,504	2,523,504	16
17	Accumulated Depreciation (book methods)	(1,791,253)	(2,330,840)	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):		14,352,652	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,875,923	\$ 22,204,033	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,924,023	\$ 30,693,663	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,281,256	\$ 1,298,413	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,957	59,957	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,680	286,680	30
31	Accrued Taxes Payable (excluding real estate taxes)	146,987	146,987	31
32	Accrued Real Estate Taxes(Sch.IX-B)		363,557	32
33	Accrued Interest Payable	6,058	111,218	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,512,504	2,512,504	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,293,442	\$ 4,779,316	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,325,000	25,252,375	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,325,000	\$ 25,252,375	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,618,442	\$ 30,031,691	46
47	TOTAL EQUITY(page 18, line 24)	\$ 305,581	\$ 661,972	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,924,023	\$ 30,693,663	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 154,108	1
2	Restatements (describe):		2
3	Rounding	(7)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 154,101	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	151,480	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)	\$ 151,480	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)	\$ 305,581	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 20,699,571	1
2	Discounts and Allowances for all Levels	(5,589,989)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,109,582	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,088,883	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,088,883	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		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	411,427	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,326	19
20	Radiology and X-Ray	7,865	20
21	Other Medical Services	22,652	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 487,270	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,925	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,925	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	15,529	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,529	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,714,189	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,427,754	31
32	Health Care	6,498,067	32
33	General Administration	4,239,265	33
B. Capital Expense			
34	Ownership	2,530,202	34
C. Ancillary Expense			
35	Special Cost Centers	2,214,769	35
36	Provider Participation Fee	652,652	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,562,709	40
41	Income before Income Taxes (line 30 minus line 40)**	151,480	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 151,480	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,118,049	44
45	Private Pay - Net Inpatient Revenue	708,720	45
46	Medicare - Net Inpatient Revenue	3,543,461	46
47	Other-(specify)	739,352	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,109,582	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Hlthcare & Rehab

0050765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,880	2,163	\$ 100,252	\$ 46.35	1
2	Assistant Director of Nursing	1,744	1,923	68,537	35.64	2
3	Registered Nurses	31,548	35,463	1,057,012	29.81	3
4	Licensed Practical Nurses	65,582	70,376	1,623,386	23.07	4
5	CNAs & Orderlies	176,051	192,211	1,962,984	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,234	19,901	305,498	15.35	8
9	Activity Director	5,376	6,028	87,564	14.53	9
10	Activity Assistants	7,159	7,718	72,140	9.35	10
11	Social Service Workers	15,148	16,405	314,918	19.20	11
12	Dietician					12
13	Food Service Supervisor	3,804	4,233	71,543	16.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,198	36,292	372,157	10.25	15
16	Dishwashers					16
17	Maintenance Workers	8,418	9,370	142,682	15.23	17
18	Housekeepers	296	363	4,134	11.39	18
19	Laundry	87	103	1,116	10.83	19
20	Administrator	1,896	2,213	129,729	58.62	20
21	Assistant Administrator	1,744	2,107	84,682	40.19	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,977	17,211	306,014	17.78	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	3,668	4,050	56,148	13.86	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,824	4,116	134,156	32.59	33
34	TOTAL (lines 1 - 33)	394,634	432,246	\$ 6,894,652 *	\$ 15.95	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	\$ 49,100	01-03	35
36	Medical Director	Monthly	125,175	09-03	36
37	Medical Records Consultant	Monthly	1,552	10-03	37
38	Nurse Consultant	Monthly	250,197	10-03	38
39	Pharmacist Consultant	Monthly	10,186	10-03	39
40	Physical Therapy Consultant	Monthly	15,000	10a-03	40
41	Occupational Therapy Consultant	Monthly	20,231	10a-03	41
42	Respiratory Therapy Consultant	Weekly	11,676	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Quality Assurance</u>	Monthly	12,000	10-03	46
47	<u>MDS Consultant</u>	Monthly	48,828	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 543,945		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Konstantinos Stavropoulos	Administrator	0	\$ 47,150	Workers' Compensation Insurance	\$ 208,350	IDPH License Fee	\$ 1,990	
Paven Rakalla	Asst. Admin.	0	18,363	Unemployment Compensation Insurance	159,379	Advertising: Employee Recruitment	18,011	
Shai Berdugo	Administrator	0	81,854	FICA Taxes	515,940	Health Care Worker Background Check		
Eli Barnett	Asst. Admin.	0	67,044	Employee Health Insurance	283,946	(Indicate # of checks performed <u>48</u>)	1,370	
				Employee Meals	39,011	Patient Background Checks	<u>155</u> 2,913	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	40,682	
				Holiday Expense	2,951	Licenses & Permits	182	
				Chicago Head Tax	2,982	Dues & Subscriptions	39,563	
				Dental Insurance	238	Allocated From Managcare	24,671	
				Pension Expense	28,557	See Supplemental Schedule	184	
				Disability	4,852	Less: Public Relations Expense	()	
				Other Employee Benefits	15,484	Non-allowable advertising	(40,682)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 214,411			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,261,690	
Description				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Amount				Description			Amount	
Tetrad Management - Management Fees							Out-of-State Travel	
\$ 600,000							\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							In-State Travel	
\$ 600,000								
C. Professional Services							Seminar Expense	
Vendor/Payee				Description			5,332	
Type				Line #			Allocated From Managcare	
Amount				Amount			1,057	
Frost, Ruttenberg & Rothblatt								
Accounting								
\$ 27,272								
See Attached								
Legal								
27,027								
Personnel Planners								
Unemployment Consultant								
2,385								
Managcare, Inc.								
Bookkeeping								
356,820								
MPRO								
Conflict Resolution								
1,005								
CRS								
Reimbursement Consulting								
5,288								
Zimmet Healthcare Services								
Healthcare Consulting								
1,600								
Templin Healthcare Accounting								
Accounting								
835								
Provinet Solutions								
Computer Services								
1,100								
Prospect Resources								
Energy Procurement Services								
1,150								
Adar LLC								
Computer Services								
10,384								
See Supplemental Schedule								
46,464								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			Entertainment Expense	
							()	
\$ 481,329							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 6,389	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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. IL Council on LTC \$30,330
- (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. \$ 73,313 Line 10-02
- (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. \$ 652,652
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (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. \$ 39,011 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.