

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc

0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>313</u>	Skilled (SNF)	<u>313</u>	<u>114,245</u>	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	<u>313</u>	TOTALS	<u>313</u>	<u>114,245</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>68,984</u>	<u>2,689</u>	<u>15,980</u>	<u>87,653</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,984</u>	<u>2,689</u>	<u>15,980</u>	<u>87,653</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.72%

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 10,430

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cen # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	507,900	145,068	47,639	700,607		700,607	104	700,711		1
2	Food Purchase		491,693		491,693	(39,712)	451,981	(3,999)	447,982		2
3	Housekeeping		34,729	440,855	475,584		475,584	2,047	477,631		3
4	Laundry		42,169	293,912	336,081		336,081		336,081		4
5	Heat and Other Utilities			369,008	369,008		369,008	(7,912)	361,096		5
6	Maintenance	110,267	33,582	149,226	293,075		293,075	48,610	341,685		6
7	Other (specify):*										7
8	TOTAL General Services	618,167	747,241	1,300,640	2,666,048	(39,712)	2,626,336	38,849	2,665,185		8
	B. Health Care and Programs										
9	Medical Director			144,400	144,400		144,400	561	144,961		9
10	Nursing and Medical Records	5,483,333	357,284	201,718	6,042,335		6,042,335	43,813	6,086,148		10
10a	Therapy	157,759		1,772	159,531		159,531		159,531		10a
11	Activities	171,292	15,028	638	186,958		186,958	17	186,975		11
12	Social Services	274,248		18,780	293,028		293,028	10,050	303,078		12
13	CNA Training										13
14	Program Transportation			8,166	8,166		8,166		8,166		14
15	Other (specify):*							16,331	16,331		15
16	TOTAL Health Care and Programs	6,086,632	372,312	375,474	6,834,418		6,834,418	70,771	6,905,189		16
	C. General Administration										
17	Administrative	340,929		150,000	490,929		490,929	(100,209)	390,720		17
18	Directors Fees										18
19	Professional Services			928,741	928,741	(9,056)	919,685	(684,935)	234,750		19
20	Dues, Fees, Subscriptions & Promotions			231,426	231,426		231,426	(139,924)	91,502		20
21	Clerical & General Office Expenses	402,157	32,178	1,169,285	1,603,620		1,603,620	(772,433)	831,187		21
22	Employee Benefits & Payroll Taxes			1,161,159	1,161,159	39,712	1,200,871		1,200,871		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,699	5,699		5,699	99	5,798		24
25	Other Admin. Staff Transportation			8,341	8,341		8,341	5,502	13,843		25
26	Insurance-Prop.Liab.Malpractice			501,263	501,263		501,263	15,967	517,230		26
27	Other (specify):*							100,462	100,462		27
28	TOTAL General Administration	743,086	32,178	4,155,914	4,931,178	30,656	4,961,834	(1,575,472)	3,386,362		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,447,885	1,151,731	5,832,028	14,431,644	(9,056)	14,422,588	(1,465,852)	12,956,736		29

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc #0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			331,308	331,308		331,308	394,444	725,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,459	102,459		102,459	965,384	1,067,843			32
33	Real Estate Taxes			12,586	12,586	9,056	21,642	322,762	344,404			33
34	Rent-Facility & Grounds			2,229,079	2,229,079		2,229,079	(2,225,340)	3,739			34
35	Rent-Equipment & Vehicles			10,126	10,126		10,126	1,223	11,349			35
36	Other (specify):*							154,750	154,750			36
37	TOTAL Ownership			2,685,558	2,685,558	9,056	2,694,614	(386,776)	2,307,838			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		648,155	1,893,598	2,541,753		2,541,753	(25)	2,541,728			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			625,046	625,046		625,046		625,046			42
43	Other (specify):*	98,874		128,840	227,714		227,714	(227,714)				43
44	TOTAL Special Cost Centers	98,874	648,155	2,647,484	3,394,513		3,394,513	(227,739)	3,166,774			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,546,759	1,799,886	11,165,070	20,511,715		20,511,715	(2,080,367)	18,431,348			45

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

Lake Shore Healthcare & Rehabilitation Centre, Llc

ID# 0050765

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (3,850)	02	1
2	Misc. Income	(400)	21	2
3	Veterans Expenses	(23,791)	10	3
4	Marketing Consultant	(128,840)	43	4
5	Bank Charges	(12,463)	21	5
6	Marketing Salaries	(98,874)	43	6
7	Theft and Loss	(1,926)	21	7
8	Medicare Sequestration	(110,922)	21	8
9	Capitalized R&M	(6,435)	06	9
10	Additional R&M	19,959	06	10
11	Non-Allowable Legal Services	(11,825)	19	11
12	Building Company - Professional Fees	(18,597)	19	12
13	Building Company - Amortization	(10,191)	31	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(408,154)		49

Lake Shore Healthcare & Rehabilitation Centre, Llc

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc# 0050765

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			104									104	1
2	Food Purchase	(3,999)											(3,999)	2
3	Housekeeping			2,028	19								2,047	3
4	Laundry													4
5	Heat and Other Utilities	(12,150)		3,601	636								(7,912)	5
6	Maintenance	13,524	12,242	21,162	925		757						48,610	6
7	Other (specify):*													7
8	TOTAL General Services	(2,625)	12,242	26,895	1,580		757						38,849	8
	B. Health Care and Programs													
9	Medical Director			561									561	9
10	Nursing and Medical Records	(23,791)		67,605									43,813	10
10a	Therapy													10a
11	Activities			17									17	11
12	Social Services			10,050									10,050	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			16,331									16,331	15
16	TOTAL Health Care and Programs	(23,791)		94,563									70,771	16
	C. General Administration													
17	Administrative			49,791		(150,000)							(100,209)	17
18	Directors Fees													18
19	Professional Services	(30,422)	21,347	(432,801)	223	834	(244,117)						(684,935)	19
20	Fees, Subscriptions & Promotions	(148,609)		8,673	11								(139,924)	20
21	Clerical & General Office Expenses	(1,071,258)		231,097	124		67,604						(772,433)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			99									99	24
25	Other Admin. Staff Transportation			768		4,734							5,502	25
26	Insurance-Prop.Liab.Malpractice		14,843	708	416								15,967	26
27	Other (specify):*			92,648			7,814						100,462	27
28	TOTAL General Administration	(1,250,289)	36,190	(49,017)	775	(144,432)	(168,699)						(1,575,472)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,276,705)	48,432	72,440	2,355	(144,432)	(167,942)						(1,465,852)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc# 0050765

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES	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	184,692	193,295	12,219	4,238								394,444	30
31	Amortization of Pre-Op. & Org.	(10,191)	10,191											31
32	Interest	(1,493)	958,427		8,450								965,384	32
33	Real Estate Taxes		314,839		7,923								322,762	33
34	Rent-Facility & Grounds		(2,229,079)	17,949	(17,949)		3,739						(2,225,340)	34
35	Rent-Equipment & Vehicles			1,223									1,223	35
36	Other (specify):*		154,750										154,750	36
37	TOTAL Ownership	173,008	(597,577)	31,390	2,662		3,739						(386,776)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(25)					(25)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(227,714)											(227,714)	43
44	TOTAL Special Cost Centers	(227,714)						(25)					(227,739)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,331,411)	(549,145)	103,831	5,017	(144,432)	(164,203)	(25)					(2,080,367)	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	\$ 2,229,079	LSH Property LLC	100.00%	\$	\$ (2,229,079)	1
2	V	26 Insurance Expense		LSH Property LLC	100.00%	14,843	14,843	2
3	V	32 Interest	314	LSH Property LLC	100.00%	958,741	958,427	3
4	V	30 Depreciation Expense		LSH Property LLC	100.00%	193,295	193,295	4
5	V	31 Amortization Expense		LSH Property LLC	100.00%	10,191	10,191	5
6	V	33 Real Estate Tax Expense		LSH Property LLC	100.00%	314,839	314,839	6
7	V	19 Legal & Professional		LSH Property LLC	100.00%	18,597	18,597	7
8	V	36 Mortgage Insurance		LSH Property LLC	100.00%	154,750	154,750	8
9	V	06 R&M		LSH Property LLC	100.00%	12,242	12,242	9
10	V	19 Appraisal (RE Tax Appeal)		LSH Property LLC	100.00%	2,750	2,750	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,229,393			\$ 1,680,248	\$ * (549,145)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>DIETARY</u>	\$	<u>MOSAIC HEALTHCARE</u>	100.00%	\$ 104	\$	104	15
16	V	3 <u>HOUSEKEEPING</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	2,028		2,028	16
17	V	5 <u>UTILITIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	3,601		3,601	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	21,162		21,162	18
19	V	9 <u>MEDICAL DIRECTOR</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	561		561	19
20	V	10 <u>NURSING SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	105,165		105,165	20
21	V	11 <u>ACTIVITIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	17		17	21
22	V	12 <u>SOCIAL SERVICE SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	10,050		10,050	22
23	V	15 <u>NURSING EMP BENS & PR TAXES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	16,331		16,331	23
24	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	49,791		49,791	24
25	V	19 <u>PROFESSIONAL FEES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	(5,801)		(5,801)	25
26	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	8,673		8,673	26
27	V	21 <u>CLERICAL AND GENERAL SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	327,594		327,594	27
28	V	21 <u>CLERICAL AND GENERAL EXP</u>	131,460	<u>MOSAIC HEALTHCARE</u>	100.00%	34,962		(96,498)	28
29	V	24 <u>SEMINARS</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	99		99	29
30	V	25 <u>ADMIN. STAFF TRANS.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	768		768	30
31	V	26 <u>INSURANCE</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	708		708	31
32	V	27 <u>GEN. ADMIN. EMP. BEN.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	92,648		92,648	32
33	V	30 <u>DEPRECIATION</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	12,219		12,219	33
34	V	34 <u>RENT - BUILDING (RELATED)</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	17,949		17,949	34
35	V	35 <u>EQUIPMENT RENTAL</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	1,223		1,223	35
36	V	19 <u>BOOKKEEPING FEES</u>	351,880	<u>MOSAIC HEALTHCARE</u>	100.00%			(351,880)	36
37	V	19 <u>ADMINISTRATIVE CONSULTANT</u>	75,120	<u>MOSAIC HEALTHCARE</u>	100.00%			(75,120)	37
38	V	10 <u>MDS CONSULTANT</u>	37,560					(37,560)	38
39	Total		\$ 596,020			\$ 699,851	\$ *	103,831	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSKEEPING	\$	4600 TOUHY, LLC	100.00%	\$ 19	\$	19	15
16	V	5 UTILITIES		4600 TOUHY, LLC	100.00%	636		636	16
17	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	925		925	17
18	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	223		223	18
19	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	11		11	19
20	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	124		124	20
21	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	416		416	21
22	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	4,238		4,238	22
23	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	8,450		8,450	23
24	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	7,923		7,923	24
25	V								25
26	V	34 RENT	17,949	4600 TOUHY, LLC	100.00%			(17,949)	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		\$ 17,949			\$ 22,966	\$ *	5,017	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	834	\$	834	15
16	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	4,734		4,734	16
17	V	17 MANAGEMENT FEES	150,000	TETRAD MANAGEMENT, LLC	100.00%			(150,000)	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		\$ 150,000			\$ 5,568	\$ *	(144,432)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 LEGAL & PROFESSIONAL		PLATINUM BILLING SOLUTIONS	30.00%	4,968	\$ 4,968
16	V	6 REPAIRS & MAINTENANCE		PLATINUM BILLING SOLUTIONS	30.00%	757	757
17	V	21 CLERICAL & GENERAL EXPENSE		PLATINUM BILLING SOLUTIONS	30.00%	14,830	14,830
18	V	21 CLERICAL & GENERAL SALARY		PLATINUM BILLING SOLUTIONS	30.00%	52,774	52,774
19	V	27 EMPLOYEE BENEFITS		PLATINUM BILLING SOLUTIONS	30.00%	7,814	7,814
20	V	34 RENT EXPENSE		PLATINUM BILLING SOLUTIONS	30.00%	3,739	3,739
21	V	19 PROFESSIONAL FEES	249,085	PLATINUM BILLING SOLUTIONS	30.00%		(249,085)
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		\$ 249,085			\$ 84,882	\$ * (164,203)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 AMBULANCE	\$ 325	Lifeline Ambulance	100.00%	\$ 300	\$ (25)
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		\$ 325			\$ 300	\$ * (25)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ce # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$	13	

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization MOSAIC HEALTHCARE
 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	491,775	10	\$ 583	\$ 87,653	\$ 104	1	
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376	87,653	2,028	2	
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206	87,653	3,601	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728	87,653	21,162	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145	87,653	561	5	
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	87,653	105,165	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95	87,653	17	7	
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	87,653	10,050	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625	87,653	16,331	9	
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	87,653	49,791	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)	87,653	(5,801)	11	
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662	87,653	8,673	12	
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	491,775	10	1,837,959	1,837,959	87,653	327,594	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155	87,653	34,962	14	
15	24	SEMINARS	PATIENT DAYS	491,775	10	556	87,653	99	15	
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308	87,653	768	16	
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971	87,653	708	17	
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798	87,653	92,648	18	
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552	87,653	12,219	19	
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10		87,653		20	
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700	87,653	17,949	21	
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863	87,653	1,223	22	
23									23	
24									24	
25	TOTALS					\$ 3,926,495	\$ 2,763,717	\$ 699,851	25	

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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	3	HOUSKEEPING	MNGCR. PATIENT DAYS 491,775	10	\$ 107	\$	87,653	\$ 19	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 491,775	10	3,569		87,653	636	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 491,775	10	5,190		87,653	925	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 491,775	10	1,250		87,653	223	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 491,775	10	63		87,653	11	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 491,775	10	698		87,653	124	6
7	26	INSURANCE	MNGCR. PATIENT DAYS 491,775	10	2,336		87,653	416	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS 491,775	10	23,779		87,653	4,238	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 491,775	10	47,406		87,653	8,450	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 491,775	10	44,453		87,653	7,923	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				\$ 128,850	\$		\$ 22,966	25

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682	87,653	834	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559	87,653	4,734	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					\$ 31,241	\$	\$ 5,568	25

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PLATINUM BILLING SOLUTIONS
 Street Address 1100 TOWBIN AVENUE, UNIT C
 City / State / Zip Code LAKEWOOD, NJ 08701
 Phone Number ()
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	LEGAL & PROFESSIONAL	PATIENT DAYS	188,403	3	9,965	93,928	4,968	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	188,403	3	1,518	93,928	757	2
3	21	CLERICAL & GENERAL EXP	PATIENT DAYS	188,403	3	29,745	93,928	14,830	3
4	21	CLERICAL & GENERAL SALA	PATIENT DAYS	188,403	3	105,856	105,856	52,774	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	188,403	3	15,673	93,928	7,814	5
6	34	RENT EXPENSE	PATIENT DAYS	188,403	3	7,500	93,928	3,739	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					\$ 170,257	\$ 105,856	\$ 84,882	25

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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) 949-9262

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ambulance	Direct Allocation		\$	\$		\$ 300	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				\$	\$		\$ 300	25

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cent # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Private Bank		X	Mortgage			\$	\$ 22,425,663		\$ 958,741	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	Private Bank		X	Loan Payable				1,415,000		102,459	6								
7	Allocated from 4600 Touhy		X							8,450	7								
8											8								
9	TOTAL Facility Related						\$	\$ 23,840,663		\$ 1,069,649	9								
B. Non-Facility Related*																			
10	Interest Income		X							(1,493)	10								
11	Bldg. Co. Interest Income		X							(314)	11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (1,807)	14								
15	TOTALS (line 9+line14)						\$	\$ 23,840,663		\$ 1,067,842	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 154,750 Line # 36

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cent # 0050765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2014 report.	\$	368,477	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	350,732	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(17,745)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	353,093	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	9,056	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 18,892 For 2012 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	344,404	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2010	383,455	8
	2011	381,860	9
	2012	352,968	10
	2013	357,745	11
	2014	342,809	12

2015 Accrual = \$342,809 x 1.03 = 353,093 (Rounded)

Allocation from 4600 Touhy LLC: \$7,923

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2014	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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>	<u>1</u>
2	<u>Allocated from 4600 Touhy, LLC</u>			<u>16,041</u>	<u>2</u>
3	TOTALS			\$ 1,237,016	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	313	2010	1972	\$ 17,313,657	\$ 193,295	39	\$ 443,940	\$ 250,645	\$ 2,663,640	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2010	178,413		20	11,885	11,885	73,471	9
10	Various		2011	153,487		20	24,623	24,623	111,330	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

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		488,635			24,432	24,432	41,111	67
68		186,864	5,376		7,818	2,442	30,333	68
69			331,308			(331,308)		69
70		\$ 18,321,056	\$ 529,979		\$ 512,698	\$ (17,281)	\$ 2,919,884	70

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc

0050765

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 18,321,056	\$ 529,979		\$ 512,698	\$ (17,281)	\$ 2,919,884	1
2	4Th Floor Exit Door Magnetic Locks	2012	4,746		20	237	237	732	2
3	2Nd Floor Staircase Exit Door Locks	2012	5,721		20	286	286	882	3
4	Sprinkler System Heads And Pipe Fittings	2012	19,153		20	958	958	2,953	4
5	Epoxy Quartz Surface And Durock On 2Nd And 4Th Floor Showe	2012	3,200		20	160	160	493	5
6	Baseboard Covers	2012	3,547		20	177	177	547	6
7	Flooring In Resident Rooms	2012	8,551		20	428	428	1,318	7
8	Hvac - Sas Architects	2012	39,873		20	1,994	1,994	6,147	8
9	Idph Plan Review For Remodeling Project	2012	3,540		20	177	177	546	9
10	Walls, Floors, Cove Base, Carpet, Lighting, Tiling, Carpeting, Sco	2012	688,743		20	34,437	34,437	106,181	10
11	Walls, Flooring, Cove Base, Cornices, Plumbing, Ceiling, Locks	2012	79,588		20	3,979	3,979	12,270	11
12	Cubicle Tracks And Curtains, Cornices, Window Panels, Window	2012	2,643		20	132	132	407	12
13	Work On Doors And Door Jams	2012	2,910		20	146	146	449	13
14	Piping And Shut Off Valve	2012	4,900		20	245	245	755	14
15	Blower Motor And Temperature Control	2012	2,640		20	132	132	407	15
16	Ball Valves, Pipes, Couplings	2012	2,950		20	148	148	455	16
17	Recessed Flourescent Lighting	2012	2,740		20	137	137	422	17
18	Patio Stone Surfacing	2013	8,000		20	1,600	1,600	4,133	18
19	2Nd Floor Resident Rooms & Bathrooms-Floor, Wallcovering, Lig	2013	154,358		20	15,436	15,436	39,876	19
20	A/C Wall Sleeve Units	2013	10,727		20	1,532	1,532	3,959	20
21	Pipes For Utility Room	2013	4,200		20	210	210	508	21
22	Bathroom - Drain Covers, Smoke Detectors, Locksets, Grab Bars	2013	36,031		20	1,802	1,802	3,753	22
23	Patient Monitoring Cabling	2014	4,484		20	897	897	1,270	23
24	Fire Alarm Wiring	2014	3,747		20	187	187	234	24
25	Water Heater	2014	13,900		20	695	695	1,274	25
26	Call Light Sysyem	2015	3,092		20	567	567	567	26
27	Intallation Of 2 New Annunciators For Call Lights With New Con	2015	6,184		20	103	103	103	27
28	Heat Pump	2015	4,600		20	613	613	613	28
29	2 Sump Pump Basins	2015	5,600		20	467	467	467	29
30	4 Wall Ac Units	2015	2,723		20	272	272	272	30
31	4 Wall Ac Units	2015	2,701		20	225	225	225	31
32	Water Pump	2015	3,700		20	740	740	740	32
33	Elevator - Install Life Safety Repairs	2015	32,000		20	400	400	400	33
34	TOTAL (lines 1 thru 33)		\$ 19,492,549	\$ 529,979		\$ 582,216	\$ 52,237	\$ 3,113,244	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 19,492,549	\$ 529,979		\$ 582,216	\$ 52,237	\$ 3,113,244	1
2	Water Chiller	2015	3,885		20	194	194	194	2
3	Storeroom Door Lever Added To Staff Wshroom 1St Flr, Locks -	2015	2,550		20	128	128	128	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)		\$ 19,498,984	\$ 529,979		\$ 582,538	\$ 52,559	\$ 3,113,565	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,498,984	\$ 529,979		\$ 582,538	\$ 52,559	\$ 3,113,565	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)	\$ 19,498,984	\$ 529,979		\$ 582,538	\$ 52,559	\$ 3,113,565	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,498,984	\$ 529,979		\$ 582,538	\$ 52,559	\$ 3,113,565	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		\$ 19,498,984	\$ 529,979		\$ 582,538	\$ 52,559	\$ 3,113,565	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Wallcoverings, Flooring-Corridor, Lobby, Dayroom, kitchenette, c	2014	105,536		20	5,277	5,277	10,554	9
10	Install New Aluminum Windows	2014	223,605		20	11,180	11,180	22,361	10
11	Ceiling Improvements and Window Treatments	2014	4,450		20	223	223	445	11
12	Renovation of 2nd floor nurses station	2015	56,023		20	2,801	2,801	2,801	12
13	Elevator Replacement	2015	66,000		20	3,300	3,300	3,300	13
14	Elevator Drilling	2015	33,021		20	1,651	1,651	1,651	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)		\$ 488,635	\$		\$ 24,432	\$ 24,432	\$ 41,111	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 488,635	\$		\$ 24,432	\$ 24,432	\$ 41,111	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)	\$ 488,635	\$		\$ 24,432	\$ 24,432	\$ 41,111	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From 4600 Touhy LLC	2012	91,518	2,347	30	3,051	704	12,202	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From 4600 Touhy LLC	2012	58,937	1,518	20	2,947	1,429	11,787	9
10	Allocated From 4600 Touhy LLC	2013	14,341	337	20	717	380	2,151	10
11	Allocated From 4600 Touhy LLC	2014	1,425	37	20	71	34	142	11
12	Allocated From Mosaic	2013	1,536	295	20	77	(218)	230	12
13	Allocated From Mosaic	2012	19,107	842	20	955	113	3,821	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)		\$ 186,864	\$ 5,376		\$ 7,818	\$ 2,442	\$ 30,333	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 186,864	\$ 5,376		\$ 7,818	\$ 2,442	\$ 30,333	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)	\$ 186,864	\$ 5,376		\$ 7,818	\$ 2,442	\$ 30,333	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 760,039	\$ 10,481	\$ 130,042	\$ 119,561	10	\$ 440,074	71
72	Current Year Purchases	123,967		13,174	13,174	10	13,174	72
73	Fully Depreciated Assets	1,461,886				10	1,461,886	73
74								74
75	TOTALS	\$ 2,345,892	\$ 10,481	\$ 143,216	\$ 132,735		\$ 1,915,133	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 Mosaic	2015	\$ 16,932	\$ 601	\$	\$ (601)	5	\$ 16,932	76
77										77
78										78
79										79
80	TOTALS			\$ 16,932	\$ 601	\$	\$ (601)		\$ 16,932	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)	\$ 23,098,824	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 541,061	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 725,753	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 184,692	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,045,631	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.

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	<u>Allocated from Platinum Billing Solutions</u>				<u>3,739</u>			5
6								6
7	TOTAL				\$ 3,739			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 1,223 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>Facility</u>		\$ <u>1,265.13</u>	\$ <u>10,126</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 1,265.13	\$ 10,126	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 640,296	\$		\$ 640,296	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			288,695			288,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			799,496			799,496	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 prescripts				605,055		605,055	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>					165,111	43,100		208,211	13
14	TOTAL			\$		\$ 1,893,598	\$ 648,155		\$ 2,541,753	14

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc# 0050765Report Period Beginning: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 52,130	\$ 105,693	1
2	Cash-Patient Deposits	44,932	44,932	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,996,162	5,996,162	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	190,876	230,311	6
7	Other Prepaid Expenses	23,182	23,182	7
8	Accounts Receivable (owners or related parties)	59,625	2,567,185	8
9	Other(specify):	30,446	135,446	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,397,353	\$ 9,102,911	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	1,210,970	1,681,934	15
16	Equipment, at Historical Cost	2,614,185	2,759,708	16
17	Accumulated Depreciation (book methods)	(2,728,673)	(3,623,455)	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):		15,073,461	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,096,482	\$ 22,406,693	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,493,835	\$ 31,509,604	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,035,468	\$ 3,035,469	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,733	45,733	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	463,147	463,147	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,840	30,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)		353,093	32
33	Accrued Interest Payable	5,598	84,835	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	3,879,712	3,879,712	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,460,498	\$ 7,892,829	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,415,000	1,415,000	39
40	Mortgage Payable		22,425,663	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)	\$ 1,415,000	\$ 23,840,663	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,875,498	\$ 31,733,492	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,381,663)	\$ (223,888)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,493,835	\$ 31,509,604	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,226,268)	1
2	Restatements (describe):		2
3	<u>A/R Bad Debts</u>	(52,976)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,279,244)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(102,419)	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)	\$ (102,419)	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)	\$ (1,381,663)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/15Ending: 12/31/15**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 20,117,537	1
2	Discounts and Allowances for all Levels	(4,270,980)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,846,557	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,548,501	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,548,501	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	810,273	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	109,075	19
20	Radiology and X-Ray	70,255	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 989,603	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,493	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,493	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	23,142	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,142	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,409,296	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,666,048	31
32	Health Care	6,834,418	32
33	General Administration	4,931,178	33
B. Capital Expense			
34	Ownership	2,685,558	34
C. Ancillary Expense			
35	Special Cost Centers	2,769,467	35
36	Provider Participation Fee	625,046	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,511,715	40
41	Income before Income Taxes (line 30 minus line 40)**	(102,419)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (102,419)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 11,203,775	44
45	Private Pay - Net Inpatient Revenue	734,937	45
46	Medicare - Net Inpatient Revenue	3,460,659	46
47	Other-(specify) <u>Hospice, Veterans</u>	214,830	47
48	Other-(specify) <u>Insurance</u>	232,356	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,846,557	49

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

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

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc

0050765

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,080	\$ 121,450	\$ 58.39	1
2	Assistant Director of Nursing	1,928	2,080	89,874	43.21	2
3	Registered Nurses	46,348	50,893	1,507,634	29.62	3
4	Licensed Practical Nurses	59,241	64,784	1,613,243	24.90	4
5	CNAs & Orderlies	167,902	185,488	2,079,897	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,376	8,992	157,759	17.54	8
9	Activity Director	4,915	5,423	84,668	15.61	9
10	Activity Assistants	4,857	5,200	53,773	10.34	10
11	Social Service Workers	16,568	17,482	274,248	15.69	11
12	Dietician					12
13	Food Service Supervisor	3,856	4,160	75,405	18.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,405	38,994	432,495	11.09	15
16	Dishwashers					16
17	Maintenance Workers	5,719	6,070	110,267	18.17	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,016	2,120	176,624	83.31	20
21	Assistant Administrator	3,616	3,800	164,305	43.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,035	16,208	402,157	24.81	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	3,746	4,154	71,235	17.15	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,175	5,437	131,725	24.23	33
34	TOTAL (lines 1 - 33)	386,727	423,365	\$ 7,546,759 *	\$ 17.83	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	\$ 47,639	01-03	35
36	Medical Director	Monthly	144,400	09-03	36
37	Medical Records Consultant	Monthly	4,000	10-03	37
38	Nurse Consultant	Monthly	117,203	10-03	38
39	Pharmacist Consultant	Monthly	13,705	10-03	39
40	Physical Therapy Consultant	Visit	45	10a-03	40
41	Occupational Therapy Consultant	Monthly	440	10a-03	41
42	Respiratory Therapy Consultant	Weekly	1,287	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	638	11-03	44
45	Social Service Consultant	Monthly	18,780	12-03	45
46	Other(specify) <u>Quality Assurance</u>	Monthly	12,000	10-03	46
47	<u>MDS Consultant</u>	Monthly	37,560	10-03	47
48	<u>Psychiatric Medical Director</u>	Monthly	17,250	10-03	48
49	TOTAL (lines 35 - 48)	9	\$ 414,947		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

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 \$36,357
- (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. \$ 56,973 Line 10
- (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. \$ 625,046
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ 39,712 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.