

Facility Name & ID Number The Mosaic Of Lakeshore

0050765 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	70,556	3,999	13,612	88,167	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,556	3,999	13,612	88,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.17%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2010 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 8,040

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number The Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	582,397	57,785	48,108	688,290		688,290	510	688,800		1
2	Food Purchase		613,294		613,294	(49,290)	564,004	(2,726)	561,278		2
3	Housekeeping		17,660	469,489	487,149		487,149	1,199	488,348		3
4	Laundry		36,394	286,227	322,621		322,621		322,621		4
5	Heat and Other Utilities			349,941	349,941		349,941	(3,400)	346,541		5
6	Maintenance	130,981	29,353	97,546	257,880		257,880	33,385	291,265		6
7	Other (specify):*										7
8	TOTAL General Services	713,378	754,486	1,251,311	2,719,175	(49,290)	2,669,885	28,967	2,698,852		8
	B. Health Care and Programs										
9	Medical Director			131,850	131,850		131,850		131,850		9
10	Nursing and Medical Records	6,535,689	412,657	80,942	7,029,288		7,029,288	(17,560)	7,011,728		10
10a	Therapy	184,991		18,972	203,963		203,963		203,963		10a
11	Activities	253,730	19,811	1,322	274,863		274,863		274,863		11
12	Social Services	276,406		8,297	284,703		284,703	12,204	296,907		12
13	CNA Training										13
14	Program Transportation			5,601	5,601		5,601		5,601		14
15	Other (specify):*							18,430	18,430		15
16	TOTAL Health Care and Programs	7,250,816	432,468	246,984	7,930,268		7,930,268	13,074	7,943,342		16
	C. General Administration										
17	Administrative	203,745		600,000	803,745		803,745	(244,384)	559,361		17
18	Directors Fees										18
19	Professional Services			674,406	674,406	(250)	674,156	(386,725)	287,431		19
20	Dues, Fees, Subscriptions & Promotions			66,969	66,969		66,969	(55,912)	11,057		20
21	Clerical & General Office Expenses	281,868	18,473	472,452	772,793		772,793	80,299	853,092		21
22	Employee Benefits & Payroll Taxes			1,321,792	1,321,792	49,290	1,371,082		1,371,082		22
23	Inservice Training & Education										23
24	Travel and Seminar							5,854	5,854		24
25	Other Admin. Staff Transportation			4,310	4,310		4,310	18,216	22,526		25
26	Insurance-Prop.Liab.Malpractice			333,631	333,631		333,631	7,039	340,670		26
27	Other (specify):*							170,027	170,027		27
28	TOTAL General Administration	485,613	18,473	3,473,560	3,977,646	49,040	4,026,686	(405,586)	3,621,100		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,449,807	1,205,427	4,971,855	14,627,089	(250)	14,626,839	(363,545)	14,263,294		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

The Mosaic Of Lakeshore

#0050765

Report Period Beginning:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			294,200	294,200		294,200	422,124	716,324			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,413	130,413		130,413	859,647	990,060			32
33	Real Estate Taxes					250	250	434,506	434,756			33
34	Rent-Facility & Grounds			2,200,098	2,200,098		2,200,098	(2,198,785)	1,313			34
35	Rent-Equipment & Vehicles			16,938	16,938		16,938	6,573	23,511			35
36	Other (specify):*			12,448	12,448		12,448	128,927	141,375			36
37	TOTAL Ownership			2,654,097	2,654,097	250	2,654,347	(347,007)	2,307,340			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		457,161	1,769,884	2,227,045		2,227,045		2,227,045			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			655,626	655,626		655,626		655,626			42
43	Other (specify):*	189,409		16,594	206,003		206,003	(206,003)				43
44	TOTAL Special Cost Centers	189,409	457,161	2,442,104	3,088,674		3,088,674	(206,003)	2,882,671			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,639,216	1,662,588	10,068,056	20,369,860		20,369,860	(916,555)	19,453,305			45

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

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	(15,021)	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	184,246	30		9
10	Interest and Other Investment Income	(26,846)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(276)	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	(2,113)	21		18
19	Entertainment				19
20	Contributions	(57,160)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,587)	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	(493,068)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (593,825)		\$	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)	(322,730)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (322,730)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (916,555)		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

The Mosaic Of Lakeshore

ID# 0050765

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Building Company- Accounting Fees	\$ (17,510)	19	1
2	Building Company- Bank Charges	(553)	21	2
3	Building Company- Amortization	(10,190)	36	3
4	Building Company- Licenses & Permits	(250)	20	4
5	Vending Income	(2,450)	02	5
6	Veterans Medical Expense	(50,004)	10	6
7	Marketing Consultant	(16,594)	43	7
8	Bank Charges	(27,953)	21	8
9	Marketing Salaries	(189,409)	43	9
10	Theft and Loss	(5,467)	21	10
11	Medicare Sequesteraion	(87,270)	21	11
12	Amortization	(12,448)	36	12
13	Non - Allowable Legal	(95,160)	19	13
14	Additional R&M	22,190	06	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	(493,068)		49

The Mosaic Of Lakeshore

ID# 0050765
 Report Period Beginning: 01/01/17
 Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Mosaic Of Lakeshore# 0050765

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			510									510	1
2	Food Purchase	(2,726)											(2,726)	2
3	Housekeeping			1,199									1,199	3
4	Laundry													4
5	Heat and Other Utilities	(15,021)		10,552	1,069								(3,400)	5
6	Maintenance	22,190		7,871	3,148		175						33,385	6
7	Other (specify):*													7
8	TOTAL General Services	4,443		20,131	4,217		175						28,967	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(50,004)		32,444									(17,560)	10
10a	Therapy													10a
11	Activities													11
12	Social Services			12,204									12,204	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			18,430									18,430	15
16	TOTAL Health Care and Programs	(50,004)		63,078									13,074	16
	C. General Administration													
17	Administrative			208,786		(453,170)							(244,384)	17
18	Directors Fees													18
19	Professional Services	(112,670)	17,510	(170,538)	569	1,643	(123,239)						(386,725)	19
20	Fees, Subscriptions & Promotions	(60,997)	250	4,500	334								(55,912)	20
21	Clerical & General Office Expenses	(303,356)	553	342,993			40,108						80,299	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			5,404			450						5,854	24
25	Other Admin. Staff Transportation			11,804		4,219	2,194						18,216	25
26	Insurance-Prop.Liab.Malpractice		5,817	863	207		152						7,039	26
27	Other (specify):*			156,289		7,002	6,736						170,027	27
28	TOTAL General Administration	(477,023)	24,130	560,101	1,111	(440,306)	(73,599)						(405,586)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(522,584)	24,130	643,311	5,328	(440,306)	(73,424)						(363,545)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	184,246	213,914	23,964									422,124	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,846)	880,323	1,906	4,265								859,647	32
33	Real Estate Taxes		429,330		5,176								434,506	33
34	Rent-Facility & Grounds		(2,200,098)	49,938	(49,938)		1,313						(2,198,785)	34
35	Rent-Equipment & Vehicles			6,573									6,573	35
36	Other (specify):*	(22,638)	151,565										128,927	36
37	TOTAL Ownership	134,762	(524,966)	82,381	(40,497)		1,313						(347,007)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(206,003)											(206,003)	43
44	TOTAL Special Cost Centers	(206,003)											(206,003)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(593,825)	(500,836)	725,692	(35,169)	(440,306)	(72,111)						(916,555)	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	\$ 2,200,098	LSH Property LLC	100.00%	\$	(2,200,098)	1
2	V	32 Interest	727	LSH Property LLC	100.00%	881,050	880,323	2
3	V	30 Depreciation		LSH Property LLC	100.00%	213,914	213,914	3
4	V	26 Insurance		LSH Property LLC	100.00%	5,817	5,817	4
5	V	19 Accounting Fees		LSH Property LLC	100.00%	17,510	17,510	5
6	V	36 MIP Insurance		LSH Property LLC	100.00%	141,375	141,375	6
7	V	21 Bank Charges		LSH Property LLC	100.00%	553	553	7
8	V	36 Amortization		LSH Property LLC	100.00%	10,190	10,190	8
9	V	20 Licenses & Permits		LSH Property LLC	100.00%	250	250	9
10	V	33 Real Estate Tax Expense		LSH Property LLC	100.00%	429,330	429,330	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,200,825			\$ 1,699,989	\$ * (500,836)	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	<u>1</u> <u>DIETARY</u>	\$	<u>MOSAIC HEALTHCARE</u>	100.00%	\$ 510	\$	510	15
16	V	<u>3</u> <u>HOUSEKEEPING</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	1,199		1,199	16
17	V	<u>5</u> <u>UTILITIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	10,552		10,552	17
18	V	<u>6</u> <u>REPAIRS AND MAINT.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	7,871		7,871	18
19	V	<u>10</u> <u>NURSING SALARIES</u>	12,445	<u>MOSAIC HEALTHCARE</u>	100.00%	44,889		32,444	19
20	V	<u>12</u> <u>SOCIAL SERVICE SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	12,204		12,204	20
21	V	<u>15</u> <u>NURSING EMP BENS & PR TAXES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	18,430		18,430	21
22	V	<u>17</u> <u>ADMINISTRATIVE SALARIES</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	208,786		208,786	22
23	V	<u>19</u> <u>PROFESSIONAL FEES</u>	34,393	<u>MOSAIC HEALTHCARE</u>	100.00%	77,233		42,840	23
24	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	4,500		4,500	24
25	V	<u>21</u> <u>CLERICAL AND GENERAL SALARIES</u>	33,191	<u>MOSAIC HEALTHCARE</u>	100.00%	275,389		242,198	25
26	V	<u>21</u> <u>CLERICAL AND GENERAL EXP</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	100,795		100,795	26
27	V	<u>24</u> <u>SEMINARS</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	5,404		5,404	27
28	V	<u>25</u> <u>ADMIN. STAFF TRANS.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	11,804		11,804	28
29	V	<u>26</u> <u>INSURANCE</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	863		863	29
30	V	<u>27</u> <u>GEN. ADMIN. EMP. BEN.</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	156,289		156,289	30
31	V	<u>30</u> <u>DEPRECIATION</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	23,964		23,964	31
32	V	<u>32</u> <u>INTEREST EXPENSE</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	1,906		1,906	32
33	V	<u>34</u> <u>RENT - BUILDING (RELATED)</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	49,938		49,938	33
34	V	<u>35</u> <u>EQUIPMENT RENTAL</u>		<u>MOSAIC HEALTHCARE</u>	100.00%	6,573		6,573	34
35	V	<u>19</u> <u>BOOKKEEPING FEES</u>	213,378	<u>MOSAIC HEALTHCARE</u>	100.00%			(213,378)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 293,407			\$ 1,019,099	\$ *	725,692	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	5 UTILITIES		4600 TOUHY, LLC	100.00%	1,069	\$	1,069	15
16	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	3,148		3,148	16
17	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	569		569	17
18	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	334		334	18
19	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	207		207	19
20	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	4,265		4,265	20
21	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	5,176		5,176	21
22	V	34 RENTAL INCOME	49,938	4600 TOUHY, LLC	100.00%			(49,938)	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		\$ 49,938			\$ 14,769	\$ *	(35,169)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 GUARANTEED PAYMENT - NATHAN DAVIS		Tetrad Management	100.00%	\$ 37,112	\$ 37,112
16	V	17 GUARANTEED PAYMENT - JOSH DAVIS		Tetrad Management	100.00%	53,538	53,538
17	V	17 GUARANTEED PAYMENT - MOSHE DAVIS		Tetrad Management	100.00%	46,784	46,784
18	V	17 GUARANTEED PAYMENT - ELI DAVIS		Tetrad Management	100.00%	9,396	9,396
19	V	19 PROFESSIONAL FEES		Tetrad Management	100.00%	1,643	1,643
20	V	25 TRAVEL		Tetrad Management	100.00%	4,219	4,219
21	V	27 EMPLOYEE BEENFITS		Tetrad Management	100.00%	7,002	7,002
22	V	17 MANAGEMENT FEES	600,000	Tetrad Management	100.00%		(600,000)
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		\$ 600,000			\$ 159,694	\$ * (440,306)

* 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	6 MAINTENANCE & REPAIR	\$	PLATINUM BILLING SOLUTIONS	30.00%	\$ 175	\$	175	15
16	V	19 PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	928		928	16
17	V	21 CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	6,207		6,207	17
18	V	21 CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	33,901		33,901	18
19	V	24 BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	450		450	19
20	V	25 AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	2,194		2,194	20
21	V	26 INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	152		152	21
22	V	27 EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	6,736		6,736	22
23	V	34 RENT		PLATINUM BILLING SOLUTIONS	30.00%	1,313		1,313	23
24	V	19 AR MANAGEMENT FEES	124,167	PLATINUM BILLING SOLUTIONS	30.00%			(124,167)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V	**Column 6 Percent of ownership was							30
31	V	30% from January - April &							31
32	V	0% from May - December							32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 124,167			\$ 52,056	\$ *	(72,111)	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.

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Moshe Davis	Relative	Administrative	0.00%	See Attached	6.57	16.43%	Alloc Salary	\$ 46,784	17-7	1	
2	Yehoshua Davis	Relative	Administrative	0.00%	See Attached	6.57	16.43%	Alloc Salary	53,538	17-7	2	
3	Nesanel Davis	Relative	Administrative	0.00%	See Attached	26.28	65.70%	Alloc Salary	37,112	17-7	3	
4	Eli Davis	Relative	Administrative	0.00%	See Attached	6.57	16.43%	Alloc Salary	9,396	17-7	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	\$ 146,830		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 The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	134,181	4	\$ 776	\$ 88,167	\$ 510	1
2	3	HOUSEKEEPING	PATIENT DAYS	134,181	4	1,824	88,167	1,199	2
3	5	UTILITIES	PATIENT DAYS	134,181	4	16,059	88,167	10,552	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	134,181	4	11,979	88,167	7,871	4
5	10	NURSING SALARIES	PATIENT DAYS	134,181	4	68,317	68,317	44,889	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	134,181	4	18,573	18,573	12,204	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	134,181	4	28,048	88,167	18,430	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	134,181	4	317,750	317,750	208,786	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	134,181	4	117,541	88,167	77,233	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	134,181	4	6,849	88,167	4,500	10
11	21	CLERICAL AND GENERAL SA	PATIENT DAYS	134,181	4	419,113	419,113	275,389	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	134,181	4	153,400	88,167	100,795	12
13	24	SEMINARS	PATIENT DAYS	134,181	4	8,225	88,167	5,404	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	134,181	4	17,964	88,167	11,804	14
15	26	INSURANCE	PATIENT DAYS	134,181	4	1,313	88,167	863	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	134,181	4	237,856	88,167	156,289	16
17	30	DEPRECIATION	PATIENT DAYS	134,181	4	36,471	88,167	23,964	17
18	32	INTEREST EXPENSE	PATIENT DAYS	134,181	4	2,900	88,167	1,906	18
19	34	RENT - BUILDING (RELATED)	PATIENT DAYS	134,181	4	76,000	88,167	49,938	19
20	35	EQUIPMENT RENTAL	PATIENT DAYS	134,181	4	10,004	88,167	6,573	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,550,962	\$ 823,753	\$ 1,019,099	25

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	MOSAIC PATIENT DAYS	134,181	4	1,627	88,167	1,069	1
2	6	REPAIRS & MAINT.	MOSAIC PATIENT DAYS	134,181	4	4,791	88,167	3,148	2
3	19	PROFESSIONAL FEES	MOSAIC PATIENT DAYS	134,181	4	867	88,167	569	3
4	20	FEES, SUBSCRIPTIONS	MOSAIC PATIENT DAYS	134,181	4	509	88,167	334	4
5	26	INSURANCE	MOSAIC PATIENT DAYS	134,181	4	315	88,167	207	5
6	32	INTEREST EXPENSE	MOSAIC PATIENT DAYS	134,181	4	6,491	88,167	4,265	6
7	33	REAL ESTATE TAXES	MOSAIC PATIENT DAYS	134,181	4	7,878	88,167	5,176	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					\$ 22,477	\$	\$ 14,769	25

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization TETRAD MANAGEMENT
 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	17	GUAR PAYMENT - NATHAN DAVIS	CENSUS DAYS	134,181	4	\$ 56,480	\$ 88,167	\$ 37,112	1
2	17	GUAR PAYMENT - JOSH DAVIS	CENSUS DAYS	134,181	4	81,480	88,167	53,538	2
3	17	GUAR PAYMENT - MOSHE DAVIS	CENSUS DAYS	134,181	4	71,200	88,167	46,784	3
4	17	GUAR PAYMENT - ELI DAVIS	CENSUS DAYS	134,181	4	14,300	88,167	9,396	4
5	19	PROFESSIONAL FEES	CENSUS DAYS	134,181	4	2,500	88,167	1,643	5
6	25	TRAVEL	CENSUS DAYS	134,181	4	6,421	88,167	4,219	6
7	27	EMPLOYEE BEENFITS	CENSUS DAYS	134,181	4	10,656	88,167	7,002	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					\$ 243,037	\$ 223,460	\$ 159,694	25

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	\$ 962	\$ 88,126	\$ 175	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	5,087	88,126	928	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	34,032	88,126	6,207	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	185,874	185,874	33,901	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	2,467	88,126	450	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	12,027	88,126	2,194	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	836	88,126	152	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	36,930	88,126	6,736	8
9	34	RENT	PATIENT DAYS	483,176	10	7,200	88,126	1,313	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					\$ 285,413	\$ 185,874	\$ 52,056	25

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

Facility Name & ID Number

The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Capital One Bank		X	Mortgage			\$	\$ 21,545,792			\$	881,050						
2																		
3																		
4																		
5																		
Working Capital																		
6	First Midwest Bank		X	Line of Credit				2,543,308				130,413						
7	Allocated From Mosaic		X									1,906						
8	See Supplemental Schedule											4,265						
9	TOTAL Facility Related						\$	\$ 24,089,100			\$	1,017,634						
B. Non-Facility Related*																		
10	Interest Income		X									(26,846)						
11	Interest Income - Building Co		X									(727)						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(27,573)						
15	TOTALS (line 9+line14)						\$	\$ 24,089,100			\$	990,061						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 141,375 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Mosaic Of Lakeshore COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0050765
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
2.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
3.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
		TOTALS	\$ <hr/> <hr/>	\$ <hr/> <hr/>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765 Report Period Beginning:

01/01/17 Ending:

12/31/17

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for index. Rows include Facility, Allocated From 4600 Touhy, and TOTALS.

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	\$ 213,914	39	\$ 443,940	\$ 230,026	\$ 3,551,520	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2010	178,413		20	8,246	8,246	91,868	9
10	Various		2011	153,487		20	3,701	3,701	128,169	10
11	Various		2012	875,445		20	43,772	43,772	222,509	11
12	Various		2013	213,316		20	20,580	20,580	93,388	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		593,635			29,682	29,682	95,225	67
68		198,869			8,819	8,819	51,942	68
69			294,200			(294,200)		69
70		\$ 19,526,822	\$ 508,114		\$ 558,740	\$ 50,626	\$ 4,234,621	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 19,526,822	\$ 508,114		\$ 558,740	\$ 50,626	\$ 4,234,621	1
2	Patient Monitoring Cabling	2014	4,484		20	897	897	3,064	2
3	Fire Alarm Wiring	2014	3,747		20	187	187	609	3
4	Water Heater	2014	13,900		20	695	695	2,664	4
5	Call Light Sysyem	2015	3,092		20	618	618	1,804	5
6	Installation Of 2 New Annunciators For Call Lights With New Co	2015	6,184		20	309	309	850	6
7	Heat Pump	2015	4,600		20	920	920	2,453	7
8	2 Sump Pump Basins	2015	5,600		20	1,120	1,120	2,707	8
9	4 Wall Ac Wall	2015	2,723		20	545	545	1,362	9
10	4 Wall Ac Units	2015	2,701		20	540	540	1,306	10
11	Water Pump	2015	3,700		20	740	740	2,220	11
12	Elevator - Install Life Safety Repairs	2015	32,000		20	1,600	1,600	4,267	12
13	Kitchen Cabinets And Sink	2015	17,769		20	888	888	2,665	13
14	Carpet Flooring In Theater	2015	4,001		20	200	200	600	14
15	Water Chiller	2015	3,885		20	194	194	502	15
16	Storeroom Door Lever Added To Staff Washroom 1St Flr, Locks-	2015	2,550		20	128	128	383	16
17	Dayroom - Walls / Floors / Rails	2016	2,787		20	139	139	267	17
18	Fire Alarm System	2017	5,894		20	295	295	29	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)		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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		\$ 19,646,440	\$ 508,114		\$ 568,756	\$ 60,642	\$ 4,262,372	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									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	21,107	9
10	Install New Aluminum Windows	2014	223,605		20	11,180	11,180	44,721	10
11	Ceiling Improvements and Window Treatments	2014	4,450		20	223	223	891	11
12	Renovation of 2nd floor nurses station	2015	56,023		20	2,801	2,801	8,403	12
13	Elevator Replacement	2015	66,000		20	3,300	3,300	9,900	13
14	Elevator Drilling	2015	33,021		20	1,651	1,651	4,953	14
15	Elevator Repairs/Renovation	2017	105,000		20	5,250	5,250	5,250	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)		\$ 593,635	\$		\$ 29,682	\$ 29,682	\$ 95,225	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		\$ 593,635	\$		\$ 29,682	\$	\$ 95,225	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)	\$ 593,635	\$		\$ 29,682	\$	\$ 95,225	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	2012	67,476		30	2,249	2,249	13,495	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Mosaic	2013	5,664		20	283	283	1,416	9
10	Allocated From Mosaic	2012	70,440		20	3,522	3,522	21,132	10
11									11
12	Allocated From 4600 Touhy	2012	43,454		20	2,173	2,173	13,036	12
13	Allocated From 4600 Touhy	2013	10,574		20	529	529	2,643	13
14	Allocated From 4600 Touhy	2014	1,051		20	53	53	210	14
15	Allocated From 4600 Touhy	2017	210		20	10	10	10	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)		\$ 198,869	\$		\$ 8,819	\$ 8,819	\$ 51,942	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		\$ 198,869	\$		\$ 8,819	\$ 8,819	\$ 51,942	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)	\$ 198,869	\$		\$ 8,819	\$ 8,819	\$ 51,942	34

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

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,018,713	\$	\$ 141,414	\$ 141,414	10	\$ 688,041	71
72	Current Year Purchases	51,660	23,964	5,166	(18,798)	10	2,390	72
73	Fully Depreciated Assets	1,712,731				10	1,712,731	73
74								74
75	TOTALS	\$ 2,783,104	\$ 23,964	\$ 146,580	\$ 122,616		\$ 2,403,162	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	Facility	Allocated From Mosaic	2017	\$ 67,361	\$	\$ 988	\$ 988	5	\$ 63,407	76
77										77
78										78
79										79
80	TOTALS			\$ 67,361	\$	\$ 988	\$ 988		\$ 63,407	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)	\$ 23,729,707	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 532,078	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 716,324	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 184,246	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,728,941	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.

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

Report Period Beginning: 01/01/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated From Platinum</u>				<u>1,313</u>			5
6								6
7	TOTAL				\$ 1,313			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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 7,064

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</u>	\$ <u>16,447</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 1,265	\$ 16,447	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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				\$ 559,623				\$ 559,623	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				336,408				336,408	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				749,596				749,596	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					402,155			402,155	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						124,257	55,006			179,263	13
14	TOTAL						\$ 1,769,884	\$ 457,161			\$ 2,227,045	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 340,557	\$ 559,272	1
2	Cash-Patient Deposits	31,305	31,305	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,784,464	7,784,464	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,476	113,497	6
7	Other Prepaid Expenses	48,331	48,331	7
8	Accounts Receivable (owners or related parties)	638,806	638,806	8
9	Other(specify): <u>See Attached Schedule</u>	346,743	1,311,295	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,252,682	\$ 10,486,970	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	1,228,775	1,830,438	15
16	Equipment, at Historical Cost	2,724,575	2,870,098	16
17	Accumulated Depreciation (book methods)	(3,318,829)	(4,634,246)	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): <u>See Attached Schedule</u>	602,224	18,124,909	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,236,745	\$ 24,706,244	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,489,427	\$ 35,193,214	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,325,388	\$ 4,351,867	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,106	32,106	28
29	Short-Term Notes Payable	2,543,308	3,013,614	29
30	Accrued Salaries Payable	270,115	270,115	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,346	6,346	31
32	Accrued Real Estate Taxes(Sch.IX-B)		406,624	32
33	Accrued Interest Payable	16,575	89,292	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	764,186	764,186	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,958,024	\$ 8,934,150	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,075,485	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	4,152,705	6,252,624	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,152,705	\$ 27,328,109	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,110,729	\$ 36,262,259	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,621,302)	\$ (1,069,045)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,489,427	\$ 35,193,214	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,765,273)	1
2	Restatements (describe):		2
3	Equity Adjustment	479	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,764,794)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	143,492	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)	\$ 143,492	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)	\$ (1,621,302)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Mosaic Of Lakeshore

0050765

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 19,884,275	1
2	Discounts and Allowances for all Levels	(2,386,843)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,497,432	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,747,098	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,747,098	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	238,806	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	720	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 239,526	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	26,846	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,846	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,450	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,450	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,513,352	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,719,175	31
32	Health Care	7,930,268	32
33	General Administration	3,977,646	33
B. Capital Expense			
34	Ownership	2,654,097	34
C. Ancillary Expense			
35	Special Cost Centers	2,433,048	35
36	Provider Participation Fee	655,626	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,369,860	40
41	Income before Income Taxes (line 30 minus line 40)**	143,492	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 143,492	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 12,459,239	44
45	Private Pay - Net Inpatient Revenue	812,371	45
46	Medicare - Net Inpatient Revenue	3,330,897	46
47	Other-(specify) <u>Veterans/Hospice</u>	805,266	47
48	Other-(specify) <u>Insurance</u>	89,659	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 17,497,432	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 The Mosaic Of Lakeshore

0050765

Report Period Beginning:

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Ending:

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,144	\$ 121,603	\$ 56.72	1
2	Assistant Director of Nursing	1,632	1,696	80,134	47.26	2
3	Registered Nurses	26,694	31,652	1,099,472	34.74	3
4	Licensed Practical Nurses	88,135	94,944	2,624,589	27.64	4
5	CNAs & Orderlies	178,850	194,492	2,537,683	13.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,616	10,551	184,991	17.53	8
9	Activity Director	2,808	3,244	65,813	20.29	9
10	Activity Assistants	8,334	8,976	102,207	11.39	10
11	Social Service Workers	10,012	13,971	276,406	19.78	11
12	Dietician					12
13	Food Service Supervisor	2,928	3,928	71,860	18.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,240	42,002	510,537	12.16	15
16	Dishwashers					16
17	Maintenance Workers	6,132	6,901	130,981	18.98	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,096	2,421	134,463	55.55	20
21	Assistant Administrator	1,960	2,111	69,282	32.82	21
22	Other Administrative					22
23	Office Manager	1,924	2,056	54,941	26.72	23
24	Clerical	15,352	16,366	226,927	13.87	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	3,641	4,102	72,208	17.60	31
32	Other Health Care(specify)					32
33	Other(specify)	9,506	10,612	275,119	25.93	33
34	TOTAL (lines 1 - 33)	407,812	452,167	\$ 8,639,216 *	\$ 19.11	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	\$ 48,108	01-03	35
36	Medical Director	Monthly	131,850	09-03	36
37	Medical Records Consultant	Monthly	4,000	10-03	37
38	Nurse Consultant	Monthly	40,967	10-03	38
39	Pharmacist Consultant	Monthly	23,530	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Weekly	18,972	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,322	11-03	44
45	Social Service Consultant	Monthly	8,297	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	12,445	10-03	47
48					48
49	TOTAL (lines 35 - 48)	19	\$ 289,491		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shannon Jones	Administrator	0	\$ 134,463	Workers' Compensation Insurance	\$ 127,629	IDPH License Fee	\$	
Suddy Salgado-Silva	Assist. Admin.	0	69,282	Unemployment Compensation Insurance	86,340	Advertising: Employee Recruitment		
				FICA Taxes	645,394	Health Care Worker Background Check		
				Employee Health Insurance	326,326	(Indicate # of checks performed)		
				Employee Meals	49,290	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	921	
				Employee Life Insurance	5,143	License and Permits	5,301	
				Union Pension	54,704	Allocated From Mosaic	4,500	
				401K Match	52,500	Allocated From 4600 Touhy	334	
				Disability Insurance	9,496			
				Other Employee Benefits	14,260	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 203,745	TOTAL (agree to Schedule V, line 22, col.8)		\$ 11,056		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Tetrad			\$ 600,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 600,000	TOTAL				
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule	Legal Fees		\$ 214,049					
Marcum LLP	Accounting Fees		13,905					
Cukierski & Cochrane, LLC	Accounting Fees		2,225					
Mosaic HC	Bookkeeping Fees		213,378					
Mosaic HC	Administrative Consultant		20,742					
Mosaic HC	Insurance Consultant		9,201					
Achieve Accreditation, LLC	Accreditation Services		6,835					
Mosaic HC	Management Consultant		4,450					
Legat Architects	Architecture		5,225					
Platinum Billing Solutions	AR Management		124,167					
MTS Consulting, LLC	Tax Credits		5,667					
See Supplemental Schedule			54,562					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 674,406	TOTAL			\$	

* Attach copy of IMRF notifications

**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? No
If YES, give association name and amount. N/A
- (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. \$ 51,058 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. \$ 655,626
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. \$ 49,290 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