		FOR BHF USE					

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0050765

Facility Name: Lake Shore Healthcare & Rehab

Address: 7200 North Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773)973-7200 **Fax #** (773)338-9373

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2010

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	42,892	3,734	9,131	55,757	8
9	SNF/PED					9
10	ICF	15,456		395	15,851	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,348	3,734	9,526	71,608	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.68%

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 [X]

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

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 [X] Date 1/1/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 313 and days of care provided 7,070

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	420,381	78,023	41,795	540,199		540,199		540,199			1
2	Food Purchase		411,280		411,280	(34,295)	376,985	(6,212)	370,772			2
3	Housekeeping	369,535	75,141		444,676		444,676	962	445,638			3
4	Laundry	171,270	13,826		185,096		185,096		185,096			4
5	Heat and Other Utilities			369,220	369,220		369,220	(2,472)	366,748			5
6	Maintenance	81,769	41,065	90,156	212,990		212,990	16,404	229,394			6
7	Other (specify):*											7
8	TOTAL General Services	1,042,955	619,335	501,171	2,163,461	(34,295)	2,129,166	8,682	2,137,847			8
	B. Health Care and Programs											
9	Medical Director			35,032	35,032		35,032		35,032			9
10	Nursing and Medical Records	4,526,170	245,831	53,670	4,825,671		4,825,671	(60,211)	4,765,460			10
10a	Therapy	296,884	3,492	2,653	303,029		303,029		303,029			10a
11	Activities	113,761	11,509		125,270		125,270		125,270			11
12	Social Services	213,945		43	213,988		213,988		213,988			12
13	CNA Training											13
14	Program Transportation			310	310		310		310			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,150,760	260,832	91,708	5,503,300		5,503,300	(60,211)	5,443,089			16
	C. General Administration											
17	Administrative	236,261		90,000	326,261		326,261	(12,960)	313,301			17
18	Directors Fees											18
19	Professional Services			352,252	352,252		352,252	(304,004)	48,248			19
20	Dues, Fees, Subscriptions & Promotions			89,030	89,030		89,030	(48,772)	40,258			20
21	Clerical & General Office Expenses	168,699	56,909	503,402	729,010		729,010	(331,578)	397,432			21
22	Employee Benefits & Payroll Taxes			1,038,299	1,038,299	34,295	1,072,594		1,072,594			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,791	1,791		1,791	507	2,298			24
25	Other Admin. Staff Transportation			3,165	3,165		3,165	(912)	2,253			25
26	Insurance-Prop.Liab.Malpractice			190,576	190,576		190,576	27,357	217,933			26
27	Other (specify):*							52,407	52,407			27
28	TOTAL General Administration	404,960	56,909	2,268,515	2,730,384	34,295	2,764,679	(617,955)	2,146,724			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,598,675	937,076	2,861,394	10,397,145		10,397,145	(669,484)	9,727,661			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab #0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			311,919	311,919		311,919	79,171	391,090			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,806	30,806		30,806	1,100,616	1,131,422			32
33	Real Estate Taxes							351,945	351,945			33
34	Rent-Facility & Grounds			1,498,054	1,498,054		1,498,054	(1,498,054)	(0)			34
35	Rent-Equipment & Vehicles							22	22			35
36	Other (specify):*											36
37	TOTAL Ownership			1,840,779	1,840,779		1,840,779	33,699	1,874,478			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		533,691	658,887	1,192,578		1,192,578		1,192,578			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,368	171,368		171,368		171,368			42
43	Other (specify):*	162,492		563,727	726,219		726,219	(726,219)				43
44	TOTAL Special Cost Centers	162,492	533,691	1,393,982	2,090,165		2,090,165	(726,219)	1,363,946			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,761,167	1,470,767	6,096,155	14,328,089		14,328,089	(1,362,004)	12,966,085			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(6,076)	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	(56,686)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(212)	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	(25)	21		18
19	Entertainment				19
20	Contributions	(10,125)	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	(441,648)	21		24
25	Fund Raising, Advertising and Promotional	(28,183)	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	(843,671)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,386,627)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	24,623		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,623		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,362,004)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Lake Shore Healthcare & Rehab

ID# 0050765

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (6,000)	02	1
2	Veterans Expenses	(60,142)	10	2
3	Marketing Salaries	(162,492)	43	3
4	Bank Charges	(2,712)	21	4
5	Theft & Loss	(769)	21	5
6	Marketing Consultant	(53,727)	43	6
7	Amortization- Building Company	(17,794)	31	7
8	Licenses & Permits- Building Company	(18,038)	20	8
9	Office Supplies & Expenses- Building Company	(755)	21	9
10	Other Expenses- Building Company	(400)	21	10
11	Capitalized R&M	(4,500)	06	11
12	COPE Dues	(11,249)	20	12
13	Additional R&M	15,984	06	13
14	Annual Fees	(250)	20	14
15	Non-Allowable Travel	(2,296)	25	15
16	Jury Duty Income	(69)	10	16
17	Jury Duty Income	(17)	21	17
18	Non-Allowable Expense	(510,000)	43	18
19	Non-Allowable Legal	(7,195)	19	19
20	Non-Allowable Appraisal Fee	(1,250)	19	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**	(843,671)		49

Lake Shore Healthcare & Rehab

ID# 0050765

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(6,212)											(6,212)	2
3	Housekeeping			945		17							962	3
4	Laundry													4
5	Heat and Other Utilities	(6,076)		1,677		1,927							(2,472)	5
6	Maintenance	11,484		4,101		819							16,404	6
7	Other (specify):*													7
8	**TOTAL General Services**	(804)		6,723		2,763							8,682	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(60,211)											(60,211)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(60,211)											(60,211)	16
	C. General Administration													
17	Administrative			76,393	(90,000)	647							(12,960)	17
18	Directors Fees													18
19	Professional Services	(8,445)		(298,753)	3,099	95							(304,004)	19
20	Fees, Subscriptions & Promotions	(67,845)	18,038	980		55							(48,772)	20
21	Clerical & General Office Expenses	(446,326)	1,155	113,164	404	25							(331,578)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			507									507	24
25	Other Admin. Staff Transportation	(2,296)		6	1,378								(912)	25
26	Insurance-Prop.Liab.Malpractice		26,726	372		259							27,357	26
27	Other (specify):*			52,407									52,407	27
28	**TOTAL General Administration**	(524,912)	45,919	(54,924)	(85,119)	1,081							(617,955)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(585,927)	45,919	(48,201)	(85,119)	3,844							(669,484)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(56,686)	130,634	4,946		277							79,171	30
31	Amortization of Pre-Op. & Org.	(17,794)	17,794											31
32	Interest		1,097,202	422		2,992							1,100,616	32
33	Real Estate Taxes		348,700			3,245							351,945	33
34	Rent-Facility & Grounds		(1,498,054)	14,176		(14,176)							(1,498,054)	34
35	Rent-Equipment & Vehicles			22									22	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(74,480)	96,276	19,566		(7,662)							33,699	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):*	(726,219)											(726,219)	43
44	**TOTAL Special Cost Centers**	(726,219)											(726,219)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,386,627)	142,195	(28,635)	(85,119)	(3,818)							(1,362,004)	45

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Lake Shore YD Delta Trust	50.00%	See Attached		See Attached		
Estate Core Operation LLC	50.00%					
				Lake Shore Healthcare Property LLC		Building Co.

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,498,054	Lake Shore Healthcare Property LLC	100.00%	$	$ (1,498,054)	1
2	V	26	Insurance Expense		Lake Shore Healthcare Property LLC	100.00%	26,726	26,726	2
3	V	32	Interest Expense		Lake Shore Healthcare Property LLC	100.00%	1,097,202	1,097,202	3
4	V	30	Depreciation Expense		Lake Shore Healthcare Property LLC	100.00%	130,634	130,634	4
5	V	31	Amortization Expense		Lake Shore Healthcare Property LLC	100.00%	17,794	17,794	5
6	V	33	Real Estate Tax Expense		Lake Shore Healthcare Property LLC	100.00%	348,700	348,700	6
7	V	20	Licenses & Permits		Lake Shore Healthcare Property LLC	100.00%	18,038	18,038	7
8	V	21	Office Supplies & Expenses		Lake Shore Healthcare Property LLC	100.00%	755	755	8
9	V	21	Other Expenses		Lake Shore Healthcare Property LLC	100.00%	400	400	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,498,054			$ 1,640,249	$ * 142,195	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 945	$ 945	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,677	1,677	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	4,101	4,101	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	76,393	76,393	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,727	1,727	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	980	980	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	113,164	113,164	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	507	507	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	6	6	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	372	372	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	52,407	52,407	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	4,946	4,946	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	422	422	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	14,176	14,176	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	22	22	30
31	V	19	HOME OFFICE	300,480	MANAGCARE, INC.	100.00%		(300,480)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 300,480			$ 271,845	$ * (28,635)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 30,000	Tryko Holdings, LLC	33.00%	$	$ (30,000)	15
16	V	19	Professional Fees		Tryko Holdings, LLC	33.00%	3,099	3,099	16
17	V	21	Office Supplies		Tryko Holdings, LLC	33.00%	404	404	17
18	V	25	Travel Expenses		Tryko Holdings, LLC	33.00%	1,378	1,378	18
19	V				Tryko Holdings, LLC	33.00%			19
20	V					33.00%			20
21	V								21
22	V	17	Management Fees	60,000	Tedrad	67.00%		(60,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V		These companies are only for Lake Shore Healthcare, therefore there is no applicable page 8						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			$ 90,000			$ 4,881	$ * (85,119)	39

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MAZEL MANAGEMENT	100.00%	$ 17	$ 17	15
16	V	5	UTILITIES		MAZEL MANAGEMENT		1,927	1,927	16
17	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		819	819	17
18	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		647	647	19
20	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		95	95	20
21	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		55	55	21
22	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		25	25	22
23	V	26	INSURANCE		MAZEL MANAGEMENT		259	259	23
24	V	30	DEPRECIATION		MAZEL MANAGEMENT		277	277	24
25	V	31	AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,992	2,992	26
27	V	33	REAL ESTATE TAXES				3,245	3,245	27
28	V								28
29	V	34	RENT	14,176				(14,176)	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			$ 14,176			$ 10,358	$ * (3,818)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nesanel Davis	Relative	Administrator	0.00%	See Attached	42.00	87.50%	Salary	$ 150,000	17-1	1
2											2
3											3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 150,000		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 & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	259,131	3	$ 3,420	$	98,488	$ 945	1
2	5	UTILITIES	PATIENT DAYS	259,131	3	6,068		98,488	1,677	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	259,131	3	14,839		98,488	4,101	3
4	10	NURSING SALARIES	PATIENT DAYS	259,131	3			98,488		4
5	17	ADMINISTRATIVE	PATIENT DAYS	259,131	3	276,447	276,447	98,488	76,393	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	259,131	3	6,250		98,488	1,727	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	259,131	3	3,547		98,488	980	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	259,131	3	409,513	341,493	98,488	113,164	8
9	24	SEMINARS	PATIENT DAYS	259,131	3	1,835		98,488	507	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	259,131	3	22		98,488	6	10
11	26	INSURANCE	PATIENT DAYS	259,131	3	1,347		98,488	372	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	259,131	3	200,550		98,488	52,407	12
13	30	DEPRECIATION	PATIENT DAYS	259,131	3	17,897		98,488	4,946	13
14	32	INTEREST EXPENSE	PATIENT DAYS	259,131	3	1,526		98,488	422	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	259,131	3	51,300		98,488	14,176	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	259,131	3	81		98,488	22	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 994,642	$ 617,940		$ 271,845	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	259,131	3	$ 62	$	98,488	$ 17	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	259,131	3	6,974		98,488	1,927	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	259,131	3	2,962		98,488	819	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	259,131	3			98,488		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	259,131	3	2,340		98,488	647	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	259,131	3	344		98,488	95	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	259,131	3	198		98,488	55	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	259,131	3	90		98,488	25	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	259,131	3	938		98,488	259	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	259,131	3	1,002		98,488	277	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	259,131	3			98,488		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	259,131	3	10,826		98,488	2,992	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	259,131	3	11,741		98,488	3,245	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					$ 37,477	$		$ 10,358	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Private Bank		X	Mortgage- Purchase of Facility			$	$ 17,023,581			$ 1,097,202	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Bank		X	Line of Credit							25,118	6
7	Allocated From Managcare		X								422	7
8	See Supplemental Schedule										2,992	8
9	TOTAL Facility Related						$	$ 17,023,581			$ 1,125,734	9
	B. Non-Facility Related*											
10	Miscellaneous Interest		X								5,688	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 5,688	14
15	TOTALS (line 9+line14)						$	$ 17,023,581			$ 1,131,422	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From Mazel		X				$	$			$ 2,992	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,992	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	367,458	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.)	$	370,703	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,245	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	348,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	351,945	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	402,783	8
	2006	356,758	9
	2007	352,949	10
	2008	356,490	11
	2009	367,458	12

Beginning Accrual Adjusted For 2009 Taxes
2010 Accrual= $367,458 X 0.95 = $348,700 (Rounded)
Allocation from Mazel Management: $3,245

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-320-035-0000	Long Term Care Property	$ 22,770.35	$ 22,770.35
2.	11-29-320-036-0000	Long Term Care Property	$ 80,357.11	$ 80,357.11
3.	11-29-320-037-0000	Long Term Care Property	$ 80,681.60	$ 80,681.60
4.	11-29-320-038-0000	Long Term Care Property	$ 80,681.60	$ 80,681.60
5.	11-29-320-039-0000	Long Term Care Property	$ 80,553.29	$ 80,553.29
6.	11-29-320-040-0000	Long Term Care Property	$ 22,413.70	$ 22,413.70
7.	See Attached	Allocated From Mazel Management	$ 51,712.83	$ 3,276.23
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 419,170.48	$ 370,733.88

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2010	$ 1,220,975	1
2					2
3	TOTALS			$ 1,220,975	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		5,316,218	130,634		136,313	5,679	128,953	67
68	Related Party Allocations (Pages 12H & 12I)		79,298	586		1,809	1,223	67,990	68
69	Financial Statement Depreciation			16,531			(16,531)		69
70	TOTAL (lines 4 thru 69)		$ 5,395,516	$ 147,751		$ 138,122	$ (9,629)	$ 196,943	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 5,395,516	$ 147,751		$ 138,122	$ (9,629)	$ 196,943	1
2	Asphalt/Tile Paving, Curbs, Walls, Sidewalk, Railings, Fence	2010	181,254		20	72,330	72,330	72,330	2
3	24 Color Cameras	2010	10,000		20	1,310	1,310	1,310	3
4	Cameras	2010	5,000		20	595	595	595	4
5	Repiping	2010	7,600		20	507	507	507	5
6	Stone Decking	2010	9,250		20	308	308	308	6
7	Asphalt Repairs	2010	12,450		20	415	415	415	7
8	Boiler	2010	12,800		20	1,707	1,707	1,707	8
9	Bumper Guards, Signage	2010	5,282		20	176	176	176	9
10	Reception Cabinetry With Granite Top	2010	7,500		20	94	94	94	10
11	Exterior Signage, Awning	2010	17,320		20	72	72	72	11
12	Elevator Controller	2010	59,711		20	995	995	995	12
13	Elevator Repair- Pump/Starter/Wiring	2010	4,500		20	225	225	225	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)		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	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
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15									15
16									16
17									17
18									18
19									19
20									20
21									21
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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)		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12C, Carried Forward		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	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)		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12D, Carried Forward		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,728,183	$ 147,751		$ 216,856	$ 69,105	$ 275,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	LSH Property- 313 Beds- Purchased in 2010	1972	5,316,218	130,634	39	136,313	5,679	128,953	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 5,316,218	$ 130,634		$ 136,313	$ 5,679	$ 128,953	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Mazel Management	1985	28,509		30	950	950	23,995	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Mazel Management	2007	1,678	43	20	84	41	298	9
10	Allocated From Mazel Management	2006	900	23	20	45	22	202	10
11	Allocated From Mazel Management	2005	673	60	20	67	7	368	11
12	Allocated From Mazel Management	2001	599	15	20	30	15	284	12
13	Allocated From Mazel Management	2000	303	8	20	15	7	155	13
14	Allocated From Mazel Management	1998	1,067	34	20	53	19	678	14
15	Allocated From Mazel Management	1997	995	26	20	50	24	663	15
16	Allocated From Mazel Management	1996	678	8	20	34	26	494	16
17	Allocated From Mazel Management	1995	153	4	20	8	4	119	17
18	Allocated From Mazel Management	1994	605	11	20	30	19	468	18
19	Allocated From Mazel Management	1993	358	10	20	18	8	312	19
20	Allocated From Mazel Management	1991	268	8	20	13	5	249	20
21	Allocated From Mazel Management	1990	416	9	20	6	(3)	409	21
22	Allocated From Mazel Management	1989	260	6	20	7	1	231	22
23	Allocated From Mazel Management	1987	592	12	20		(12)	592	23
24	Allocated From Mazel Management	1986	2,390		20			2,390	24
25	Allocated From Mazel Management	1985	166		20			166	25
26									26
27	Allocated From Managcare	2008	3,864	296	20	386	90	1,127	27
28	Allocated From Managcare	1997	3,324		20			3,324	28
29	Allocated From Managcare	1993	261		20	13	13	229	29
30	Allocated From Managcare	1988	407	13	20		(13)	407	30
31	Allocated From Managcare	1986	30,832		20			30,830	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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 (12H & 12I lines 1 thru 33)		$ 79,298	$ 586		$ 1,809	$ 1,223	$ 67,990	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 6,774	$ 377	$ 1,034	$ 657	10	$ 5,198	71
72	Current Year Purchases	1,473,644	295,388	169,003	(126,385)	10	169,003	72
73	Fully Depreciated Assets	71,030				10	71,030	73
74								74
75	TOTALS	$ 1,551,448	$ 295,765	$ 170,037	$ (125,728)		$ 245,231	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Managcare	2010	$ 31,532	$ 4,260	$ 4,197	$ (63)	5	$ 15,728	76
77										77
78										78
79										79
80	TOTALS			$ 31,532	$ 4,260	$ 4,197	$ (63)		$ 15,728	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)	$ 8,532,137	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 447,776	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 391,090	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (56,686)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 536,635	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	Phone System, Boiler,	$ 86,920	92
93	Awnings, Furniture, Heating,		93
94	Elevator, Remodeling		94
95		$ 86,920	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 Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 22 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 299,149	$		$ 299,149	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,707			119,707	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			239,572			239,572	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				342,868		342,868	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					459	190,823		191,282	13
14	TOTAL			$		$ 658,887	$ 533,691		$ 1,192,578	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lake Shore Healthcare & Rehab **#** 0050765 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(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	$ 233,903	$ 247,155	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,134,820	1,134,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,681	122,693	6
7	Other Prepaid Expenses	10,692	10,692	7
8	Accounts Receivable (owners or related parties)		1,179,975	8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,493,096	$ 2,698,335	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	303,625	303,625	15
16	Equipment, at Historical Cost	1,514,169	1,514,169	16
17	Accumulated Depreciation (book methods)	(311,919)	(442,553)	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): See Attached Schedule	86,920	14,547,115	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,592,795	$ 22,437,401	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,085,891	$ 25,135,736	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 347,853	$ 360,154	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,410	46,410	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	544,679	544,679	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,331	31,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)		348,700	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,912,862	1,912,862	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,883,135	$ 3,244,136	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,023,581	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 17,023,581	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,883,135	$ 20,267,717	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 202,756	$ 4,868,019	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,085,891	$ 25,135,736	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,192,542	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,192,542	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(989,786)	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)**	$ (989,786)	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)**	$ 202,756	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,044,138	1
2	Discounts and Allowances for all Levels	(1,631,173)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,412,965	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,337,000	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,337,000	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	309,569	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,406	19
20	Radiology and X-Ray	3,650	20
21	Other Medical Services	57,127	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 398,752	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	189,586	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 189,586	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,338,303	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,163,461	31
32	Health Care	5,503,300	32
33	General Administration	2,730,384	33
	B. Capital Expense		
34	Ownership	1,840,779	34
	C. Ancillary Expense		
35	Special Cost Centers	1,918,797	35
36	Provider Participation Fee	171,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,328,089	40
41	**Income before Income Taxes (line 30 minus line 40)****	(989,786)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (989,786)	43

* **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.** SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,195	$ 89,014	$ 40.55	1
2	Assistant Director of Nursing	2,736	2,856	93,311	32.67	2
3	Registered Nurses	51,908	54,546	1,635,208	29.98	3
4	Licensed Practical Nurses	30,502	31,754	796,330	25.08	4
5	CNAs & Orderlies	157,992	166,475	1,862,787	11.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,871	19,041	296,884	15.59	8
9	Activity Director	3,750	4,227	59,795	14.15	9
10	Activity Assistants	5,375	5,445	53,966	9.91	10
11	Social Service Workers	12,970	13,691	213,945	15.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,764	38,498	420,381	10.92	15
16	Dishwashers					16
17	Maintenance Workers	4,950	5,259	81,769	15.55	17
18	Housekeepers	29,199	31,188	369,535	11.85	18
19	Laundry	14,044	14,979	171,270	11.43	19
20	Administrator	2,184	2,184	150,000	68.68	20
21	Assistant Administrator	1,816	2,270	86,261	38.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,068	12,716	168,699	13.27	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	2,060	2,206	41,871	18.98	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,456	4,756	170,141	35.77	33
34	TOTAL (lines 1 - 33)	392,645	414,286	$ 6,761,167 *	$ 16.32	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	968	$ 41,795	01-03	35
36	Medical Director	Monthly	35,032	09-03	36
37	Medical Records Consultant	96	4,416	10-03	37
38	Nurse Consultant	16	2,145	10-03	38
39	Pharmacist Consultant	2,443	13,437	10-03	39
40	Physical Therapy Consultant	30	318	10a-03	40
41	Occupational Therapy Consultant	38	403	10a-03	41
42	Respiratory Therapy Consultant	27	1,465	10a-03	42
43	Speech Therapy Consultant	44	467	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	1	43	12-03	45
46	Other(specify) QA Director	Monthly	26,400	10-03	46
47	Psychiatric Medical Director	Monthly	2,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	3,663	$ 127,921		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	118	5,272	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	118	$ 5,272		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nesanel Davis	Administrator	0.00%	$ 150,000
Benjamin Silverstein	Asst. Admin.	0.00%	86,261
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 236,261

B. Administrative - Other

Description	Amount
Management Fee- Tedrad	$ 60,000
Management Fee- Tryko Holdings	30,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 90,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Managcare, Inc	Bookkeeping	$ 300,480
Accumed	Computer Services	420
RH Positive	Computer Services	642
Kronos, Inc	Computer Services	380
Kipp Computer Solutions	Computer Services	3,000
PVS	Appraisal (Adj Pg 5A)	1,250
Cimpar Consulting	Quality Assurance	2,975
Personnel Planners	Unemployment Tax Consult	2,464
E-Health Data Solutions	Computer Services	9,971
See Attached	Legal	13,279
IIT/Sourcetech	Purchasing Consulting	1,150
See Supplemetal Schedule		16,241
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 352,252

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,973
Unemployment Compensation Insurance	65,510
FICA Taxes	517,229
Employee Health Insurance	274,879
Employee Meals	34,295
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	10,080
Other Employee Benefits	2,579
Holiday Expense	6,464
Pension Expense	58,305
Disability Insurance	5,280
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,072,594

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	13,025
Health Care Worker Background Check	
(Indicate # of checks performed 107)	1,070
Patient Background Checks 178	1,780
Licenses & Permits	3,673
Advertising & Promotion	28,183
Dues & Subscriptions	18,680
See Supplemental Schedule	1,035
Less: Public Relations Expense	( )
Non-allowable advertising	(28,183)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,258

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,791
Allocated From Managcare	507
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,298

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab # 0050765 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehab **#** 0050765 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 $29,929**

(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. $ **59,189** Line **10-2**

(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. $ **171,368**
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. $ **34,295** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.