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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0050765

Facility Name: Lake Shore Healthcare & Rehabilitation Centre, Llc

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: 01/00/00

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 01/01/11 to 12/31/11 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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	48,950	3,299	12,560	64,809	8
9	SNF/PED					9
10	ICF	12,912		329	13,241	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,862	3,299	12,889	78,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.32%

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 8,581

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: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cen # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	384,228	94,125	38,366	516,719		516,719		516,719			1
2	Food Purchase		443,609		443,609	(39,946)	403,663	(3,986)	399,677			2
3	Housekeeping	320,453	94,848		415,301		415,301	1,050	416,351			3
4	Laundry	190,829	19,981		210,810		210,810		210,810			4
5	Heat and Other Utilities			353,908	353,908		353,908	(6,105)	347,803			5
6	Maintenance	102,284	39,218	107,060	248,562		248,562	34,066	282,628			6
7	Other (specify):*											7
8	TOTAL General Services	997,794	691,781	499,334	2,188,909	(39,946)	2,148,963	25,025	2,173,988			8
	B. Health Care and Programs											
9	Medical Director			58,620	58,620		58,620		58,620			9
10	Nursing and Medical Records	4,494,661	333,161	43,296	4,871,118		4,871,118	(80,240)	4,790,878			10
10a	Therapy	280,788	2,556	1,326	284,670		284,670		284,670			10a
11	Activities	130,043	17,352		147,395		147,395		147,395			11
12	Social Services	224,943			224,943		224,943		224,943			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,130,435	353,069	103,242	5,586,746		5,586,746	(80,240)	5,506,506			16
	C. General Administration											
17	Administrative	246,009		340,000	586,009		586,009	(238,438)	347,571			17
18	Directors Fees											18
19	Professional Services			385,086	385,086		385,086	(305,503)	79,583			19
20	Dues, Fees, Subscriptions & Promotions			128,532	128,532		128,532	(48,634)	79,898			20
21	Clerical & General Office Expenses	204,713	59,476	403,274	667,463		667,463	(184,010)	483,453			21
22	Employee Benefits & Payroll Taxes			1,150,846	1,150,846	39,946	1,190,792		1,190,792			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,216	2,216		2,216	394	2,610			24
25	Other Admin. Staff Transportation			7,485	7,485		7,485	(3,075)	4,410			25
26	Insurance-Prop.Liab.Malpractice			190,571	190,571		190,571	16,079	206,650			26
27	Other (specify):*							80,818	80,818			27
28	TOTAL General Administration	450,722	59,476	2,608,010	3,118,208	39,946	3,158,154	(682,368)	2,475,785			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,578,951	1,104,326	3,210,586	10,893,863		10,893,863	(737,583)	10,156,280			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 & Rehabilitation Centre, Llc #0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			374,748	374,748		374,748	(33,907)	340,841			30
31	Amortization of Pre-Op. & Org.							(0)	(0)			31
32	Interest			39,941	39,941		39,941	1,230,402	1,270,343			32
33	Real Estate Taxes							429,652	429,652			33
34	Rent-Facility & Grounds			1,596,000	1,596,000		1,596,000	(1,596,000)				34
35	Rent-Equipment & Vehicles							759	759			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,010,689	2,010,689		2,010,689	30,906	2,041,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		555,505	808,734	1,364,239		1,364,239		1,364,239			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			454,746	454,746		454,746		454,746			42
43	Other (specify):*	229,070		313,680	542,750		542,750	(542,750)				43
44	**TOTAL Special Cost Centers**	229,070	555,505	1,577,160	2,361,735		2,361,735	(542,750)	1,818,985			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,808,021	1,659,831	6,798,435	15,266,287		15,266,287	(1,249,427)	14,016,860			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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(9,529)	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	(175,308)	30		9
10	Interest and Other Investment Income	(3,981)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(9,210)	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	(342,385)	21		24
25	Fund Raising, Advertising and Promotional	(40,024)	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	(710,596)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,291,218)		$	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)	41,791		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,791		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,249,427)		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

STATE OF ILLINOIS

Lake Shore Healthcare & Rehabilitation Centre, Llc

ID# 0050765

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (3,800)	02	1
2	Veterans Expenses	(80,240)	10	2
3	Marketing Salaries	(229,070)	43	3
4	Bank Charges	(8,288)	21	4
5	Theft & Loss	(9,596)	21	5
6	Marketing Consultant	(53,680)	43	6
7	Building Company - Amortization	(67,437)	31	7
8	Building Company - Annual Fees	(300)	20	8
9	Building Company - Office Supplies & Expenses	(2)	21	9
10	Building Company - Bank Charges	(152)	21	10
11	Building Company - Accounting	(5,500)	19	11
12	Capitalized R&M	(2,600)	06	12
13	Additional R&M	21,984	06	13
14	Annual Fees	(300)	20	14
15	Non-Allowable Travel	(3,142)	25	15
16	Jury Duty Income	(52)	21	16
17	Non-Allowable Legal	(4,232)	19	17
18	Shareholder Loan	(1,771)	32	18
19	PPA - Non-Allowable Legal	(2,418)	19	19
20	Non-Allowable Expense	(260,000)	43	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**	(710,596)		49

Lake Shore Healthcare & Rehabilitation Centre, Llc

ID# 0050765

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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 & Rehabilitation Centre, Llc **#** 0050765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,986)											(3,986)	2
3	Housekeeping			1,007		43							1,050	3
4	Laundry													4
5	Heat and Other Utilities	(9,529)		1,882		1,542							(6,105)	5
6	Maintenance	19,384		13,652		1,030							34,066	6
7	Other (specify):*													7
8	**TOTAL General Services**	5,869		16,541		2,615							25,025	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(80,240)											(80,240)	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**	(80,240)											(80,240)	16
	C. General Administration													
17	Administrative			100,828	(340,000)	734							(238,438)	17
18	Directors Fees													18
19	Professional Services	(12,150)	5,500	(299,960)	1,000	107							(305,503)	19
20	Fees, Subscriptions & Promotions	(49,834)	300	900									(48,634)	20
21	Clerical & General Office Expenses	(360,475)	(12,148)	188,304	309								(184,010)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			394									394	24
25	Other Admin. Staff Transportation	(3,142)		67									(3,075)	25
26	Insurance-Prop.Liab.Malpractice		14,870	913		296							16,079	26
27	Other (specify):*			80,818									80,818	27
28	**TOTAL General Administration**	(425,600)	8,522	72,264	(338,691)	1,137							(682,368)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(499,971)	8,522	88,805	(338,691)	3,752							(737,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc **#** 0050765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	(175,308)	136,320	4,687		394							(33,907)	30
31	Amortization of Pre-Op. & Org.	(67,437)	67,437										(0)	31
32	Interest	(5,752)	1,232,741	323		3,090							1,230,402	32
33	Real Estate Taxes		425,855			3,797							429,652	33
34	Rent-Facility & Grounds		(1,596,000)	15,101		(15,101)							(1,596,000)	34
35	Rent-Equipment & Vehicles			759									759	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(248,497)	266,353	20,870		(7,820)							30,906	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):*	(542,750)											(542,750)	43
44	**TOTAL Special Cost Centers**	(542,750)											(542,750)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,291,218)	274,875	109,675	(338,691)	(4,068)							(1,249,427)	45

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 1,596,000	LSH Property LLC	100.00%	$	$ (1,596,000)	1
2	V	26	Insurance Expense		LSH Property LLC		14,870	14,870	2
3	V	32	Interest Expense	73	LSH Property LLC		1,232,814	1,232,741	3
4	V	30	Depreciation Expense		LSH Property LLC		136,320	136,320	4
5	V	31	Amortization Expense		LSH Property LLC		67,437	67,437	5
6	V	33	Real Estate Tax Expense		LSH Property LLC		425,855	425,855	6
7	V	20	Annual Fees		LSH Property LLC		300	300	7
8	V	21	Office Supplies & Expenses		LSH Property LLC		2	2	8
9	V	21	Bank Charges		LSH Property LLC		152	152	9
10	V	19	Accounting		LSH Property LLC		5,500	5,500	10
11	V	21	Adjustment of Prior Period		LSH Property LLC		(12,302)	(12,302)	11
12	V								12
13	V								13
14	Total			$ 1,596,073			$ 1,870,948	$ * 274,875	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 1,007	$ 1,007	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,882	1,882	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	13,652	13,652	17
18	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	100,828	100,828	18
19	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	520	520	19
20	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	900	900	20
21	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	188,304	188,304	21
22	V	24	SEMINARS		MANAGCARE, INC.	100.00%	394	394	22
23	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	67	67	23
24	V	26	INSURANCE		MANAGCARE, INC.	100.00%	913	913	24
25	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	80,818	80,818	25
26	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	4,687	4,687	26
27	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	323	323	27
28	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	15,101	15,101	28
29	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	759	759	29
30	V								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			$ 410,155	$ * 109,675	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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							$	15
16	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	1,000	1,000	16
17	V	21	OTHER EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	309	309	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	17	MANAGEMENT FEES	340,000	TETRAD MANAGEMENT, LLC			(340,000)	27
28	V								28
29	V		This company is only for Lake Shore Healthcare, therefore there is no applicable page 8						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			$ 340,000			$ 1,309	$ * (338,691)	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	3553 WEST PETERSON AVE BLDG. PTR.	100.00%	$ 43	$ 43	15
16	V	5	UTILITIES		3553 WEST PETERSON AVE BLDG. PTR.		1,542	1,542	16
17	V	6	REPAIRS & MAINT.		3553 WEST PETERSON AVE BLDG. PTR.		1,030	1,030	17
18	V	17	ADMIN.-M. WOLF		3553 WEST PETERSON AVE BLDG. PTR.		734	734	18
19	V	19	PROFESSIONAL FEES		3553 WEST PETERSON AVE BLDG. PTR.		107	107	19
20	V	26	INSURANCE		3553 WEST PETERSON AVE BLDG. PTR.		296	296	20
21	V	30	DEPRECIATION		3553 WEST PETERSON AVE BLDG. PTR.		394	394	21
22	V	32	INTEREST EXPENSE		3553 WEST PETERSON AVE BLDG. PTR.		3,090	3,090	22
23	V	33	REAL ESTATE TAXES		3553 WEST PETERSON AVE BLDG. PTR.		3,797	3,797	23
24	V								24
25	V	34	RENT	15,101	3553 WEST PETERSON AVE BLDG. PTR.			(15,101)	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			$ 15,101			$ 11,033	$ * (4,068)	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ESTATE CARE OPERATOR, LLC	50.000%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	LSH PROPERTY, LLC		BUILDING CO.	1
2	LAKE SHORE YD DELTA, LLC	50.000%	MAYFIELD CARE CENTER, INC.	CHICAGO	TETRAD MANAGEMENT, LLC		MANAGEMENT CO.	2
3			MID AMERICA CARE CENTER, L.L.C.	CHICAGO	3553 WEST PETERSON AVE BLD		BUILDING CO.	3
4					MANAGCARE, INC.		MANAGEMENT CO.	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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cer # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	34.90	72.71%	Salary	$ 131,347	17-1	1
2	Yisroel Davis	Relative	Asst. Admin	0.00%	See Attached	40.00	100.00%	Salary	37,788	17-1	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	$ 169,135		13

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	265,143	4	$ 3,420	$	78,050	$ 1,007	1
2	5	UTILITIES	PATIENT DAYS	265,143	4	6,395		78,050	1,882	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	265,143	4	46,378		78,050	13,652	3
4	17	ADMINISTRATIVE	PATIENT DAYS	265,143	4	342,522	342,522	78,050	100,828	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	265,143	4	1,765		78,050	520	5
6	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	265,143	4	3,059		78,050	900	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	265,143	4	639,686	395,180	78,050	188,304	7
8	24	SEMINARS	PATIENT DAYS	265,143	4	1,339		78,050	394	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	265,143	4	229		78,050	67	9
10	26	INSURANCE	PATIENT DAYS	265,143	4	3,101		78,050	913	10
11	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	265,143	4	274,547		78,050	80,818	11
12	30	DEPRECIATION	PATIENT DAYS	265,143	4	15,921		78,050	4,687	12
13	32	INTEREST EXPENSE	PATIENT DAYS	265,143	4	1,096		78,050	323	13
14	34	RENT - BUILDING (RELATED)	PATIENT DAYS	265,143	4	51,300		78,050	15,101	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	265,143	4	2,577		78,050	759	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,393,335	$ 737,703		$ 410,155	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 COMPANY
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	265,143	4	$ 147	$	78,050	$ 43	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	265,143	4	5,239		78,050	1,542	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	265,143	4	3,498		78,050	1,030	3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	265,143	4	2,492		78,050	734	4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	265,143	4	363		78,050	107	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	265,143	4	1,007		78,050	296	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	265,143	4	1,338		78,050	394	7
8	31	INTEREST EXPENSE	MNGCR. PATIENT DAYS	265,143	4	10,498		78,050	3,090	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	265,143	4	12,899		78,050	3,797	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					$ 37,481	$		$ 11,033	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Cent # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage - Purchase of Facility			$	$ 16,677,375			$ 1,193,359	1
2	Capex		X					754,835			39,455	2
3	Private Bank		X					2,000,000		6.0000	38,170	3
4	Loan to Members	X						4,900,000				4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholder Loan		X	Line of Credit				750,000			1,771	6
7	Allocated from Managcare		X								323	7
8	See Supplemental Schedule										3,090	8
9	TOTAL Facility Related						$	$ 25,082,210			$ 1,276,168	9
	B. Non-Facility Related*											
10	Miscellaneous Interest		X								(3,981)	10
11	Non-Allowable Interest		X								(1,771)	11
12	Bldg. Interest Income		X								(73)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (5,825)	14
15	TOTALS (line 9+line14)						$	$ 25,082,210			$ 1,270,343	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 & Rehabilitation Cent # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 3553 WEST PETERSO		X				$	$			$ 3,090	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,090	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 & Rehabilitation Centre, Llc **#** 0050765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 348,700	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.)		$ 387,252	2
3. Under or (over) accrual (line 2 minus line 1).		$ 38,552	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 391,100	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.		$ 429,652	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	356,758	8
	2007	352,949	9
	2008	356,490	10
	2009	367,458	11
	2010	383,455	12

2011 Accrual= $383,455 x 1.02 = $391,100 (rounded)

Allocation from 3553 WEST PETERSON AVE BLDG. PTR.: $3,797

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehabilitation Centre, Llc 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 2010 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 2010.

	(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	$ 23,761.65	$ 23,761.65
2.	11-29-320-036-0000	Long Term Care Property	$ 83,855.40	$ 83,855.40
3.	11-29-320-037-0000	Long Term Care Property	$ 84,194.01	$ 84,194.01
4.	11-29-320-038-0000	Long Term Care Property	$ 84,194.01	$ 84,194.01
5.	11-29-320-039-0000	Long Term Care Property	$ 84,060.09	$ 84,060.09
6.	11-29-320-040-0000	Long Term Care Property	$ 23,389.46	$ 23,389.46
7.	See Attached	Allocated from 3553 WEST PETERS(	$ 53,964.18	$ 3,641.94
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 437,418.80	$ 387,096.56

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehabilitation Centre, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	313		2010	1972	$ 5,316,218	$ 136,320	39	$ 136,313	$ (7)	$ 265,266	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		85,857	632		2,013	1,381	74,437	68
69	Financial Statement Depreciation			374,748			(374,748)		69
70	TOTAL (lines 4 thru 69)		$ 5,402,075	$ 511,700		$ 138,326	$ (373,374)	$ 339,703	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,402,075	$ 511,700		$ 138,326	$ (373,374)	$ 339,703	1
2	Asphalt, Tile Paving, Curbs, Walls, Sidewalk, Railings, Fence	2010	181,254		20	9,063	9,063	81,393	2
3	24 Color Cameras	2010	10,000		20	500	500	1,810	3
4	Cameras	2010	5,000		20	250	250	845	4
5	Repiping	2010	7,600		20	380	380	887	5
6	Stone Decking	2010	9,250		20	463	463	771	6
7	Asphalt Repairs	2010	12,450		20	623	623	1,038	7
8	Boiler	2010	12,800		20	640	640	2,347	8
9	Bumper Guards, Signage	2010	5,282		20	264	264	440	9
10	Reception Cabinetry With Granite Top	2010	7,500		20	375	375	469	10
11	Exterior Signage, Awning	2010	17,320		20	866	866	938	11
12	Elevator Controller	2010	59,711		20	2,986	2,986	3,981	12
13	Elevator Repair- Pump/Starter/Wiring	2010	4,500		20	225	225	450	13
14	Electrical Service To West Elevator	2011	4,200		20	315	315	315	14
15	New Doors - Econocare	2011	5,171		20	302	302	302	15
16	Custom Baseboard Covers	2011	5,706		20	475	475	475	16
17	Custom Baseboard Covers	2011	8,929		20	595	595	595	17
18	Generator Toggle Switch	2011	2,501		20	208	208	208	18
19	Waterproofing Membrane And Drain North Patio	2011	11,150		20	186	186	186	19
20	Telephone System	2011	27,000		20	2,025	2,025	2,025	20
21	Elevator Motor Starter & Maxton Valve	2011	5,500		20	115	115	115	21
22	Flooring For Shower Room	2011	6,400		20	53	53	53	22
23	Foorling For Shower Room	2011	5,650		20	47	47	47	23
24	Econocare - Blinds, Wallcovering, Vinyl Flooring	2011	87,478		20	10,206	10,206	10,206	24
25	Activity Room - Wall, Ceiling, Light Fixtures	2011	4,603		20	230	230	230	25
26	Dons & Book Office - Chairs, Filling Cabinet, File Pedastal Tables	2011	6,992		20	350	350	350	26
27	1St Flr Nurse Station - Furniture & Fixture	2011	12,470		20	623	623	623	27
28	Tub Room #3 & 4 - Bathroom Wall, Tile, Sink, & Fixtures	2011	13,914		20	696	696	696	28
29	Therapy Bathroom - Bathroom Wall, Tile, Sink, & Fixtures	2011	5,908		20	295	295	295	29
30	Therapy Room - Walls,Tile, Millwork, Wallcovering Cabinets	2011	63,094		20	3,155	3,155	3,155	30
31	Therapy & Speech Office - Carpet, Millwork, Wallcovering, Custo	2011	6,835		20	342	342	342	31
32	Repaint Bathroom Doors	2011	2,600		20	130	130	130	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,020,842	$ 511,700		$ 175,307	$ (336,393)	$ 455,418	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1985	30,370		35	1,012	1,012	26,573	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2011	1,391	99	20	92	(7)	92	9
10	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2007	1,787	46	20	89	43	406	10
11	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2006	958	25	20	48	23	264	11
12	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2005	716	64	20	72	8	464	12
13	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2001	638	16	20	32	16	334	13
14	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2000	322	8	20	16	8	181	14
15	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1998	1,136	37	20	57	20	779	15
16	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1997	1,059	27	20	53	26	759	16
17	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1996	722	8	20	36	28	562	17
18	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1995	163	4	20	8	4	135	18
19	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1994	645	12	20	32	20	531	19
20	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1993	381	11	20	19	8	351	20
21	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1991	285	9	20	13	4	278	21
22	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1990	443	9	20		(9)	436	22
23	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1989	277	6	20	8	2	254	23
24	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1987	630	12	20		(12)	630	24
25	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1986	2,546		20			2,546	25
26	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1985	177		20			177	26
27									27
28	Allocated from Managcare, Inc.	2008	4,116	225	20	412	187	1,612	28
29	Allocated from Managcare, Inc.	1997	3,540		20			3,540	29
30	Allocated from Managcare, Inc.	1993	278		20	14	14	258	30
31	Allocated from Managcare, Inc.	1988	433	14	20		(14)	433	31
32	Allocated from Managcare, Inc.	1986	32,844		20			32,842	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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)		$ 85,857	$ 632		$ 2,013	$ 1,381	$ 74,437	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,479,328	$ 223	$ 148,070	$ 147,847	10	$ 321,280	71
72	Current Year Purchases	101,546	2,034	11,925	9,891	10	11,925	72
73	Fully Depreciated Assets	77,197		104	104	10	77,033	73
74								74
75	TOTALS	$ 1,658,071	$ 2,257	$ 160,099	$ 157,842		$ 410,238	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Managcare, Inc.	1900	$ 33,589	$ 2,191	$ 5,434	$ 3,243	5	$ 22,189	76
77										77
78										78
79										79
80	TOTALS			$ 33,589	$ 2,191	$ 5,434	$ 3,243		$ 22,189	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)	$ 8,933,478	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 516,148	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 340,840	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (175,308)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 887,845	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	Therapy&Gym Windows	$ 3,600	92
93	Madison Specs & Architecs	3,705	93
94	1st Flr Corridor & Resident Rooms	278,301	94
95		$ 285,606	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 759 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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 340,180	$		$ 340,180	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			157,191			157,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			303,839			303,839	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				416,028		416,028	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					7,524	139,477		147,001	13
14	TOTAL			$		$ 808,734	$ 555,505		$ 1,364,239	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 214,178	$ 382,801	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,135,637	4,135,637	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	162,917	395,522	6
7	Other Prepaid Expenses	9,094	9,094	7
8	Accounts Receivable (owners or related parties)		1,472,041	8
9	Other(specify): See Attached Schedule	1,368	1,368	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,526,194	$ 6,399,463	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	599,078	599,078	15
16	Equipment, at Historical Cost	1,902,016	1,902,016	16
17	Accumulated Depreciation (book methods)	(686,667)	(953,621)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(67,437)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	7,305	14,467,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,821,732	$ 22,462,581	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,347,926	$ 28,862,044	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 769,182	$ 771,683	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,322	45,322	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,665	255,665	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,108	11,108	31
32	Accrued Real Estate Taxes(Sch.IX-B)		391,100	32
33	Accrued Interest Payable	9,718	114,795	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,625,148	2,625,148	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,716,143	$ 4,214,821	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,750,000	25,082,210	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		300	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,750,000	$ 25,082,510	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,466,143	$ 29,297,331	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (118,217)	$ (435,287)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,347,926	$ 28,862,044	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc **#** 0050765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 202,757	1
2	Restatements (describe):		2
3	**Loan Payable - Members**	(750,000)	3
4	**Due to LSH Property**	(192,542)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (739,785)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	621,568	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)**	$ 621,568	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)**	$ (118,217)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Ll # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 15,653,361	1
2	Discounts and Allowances for all Levels	(2,231,005)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,422,356	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,793,552	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,793,552	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	389,730	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,933	19
20	Radiology and X-Ray	13,525	20
21	Other Medical Services	63,631	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 501,819	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,981	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,981	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	166,147	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 166,147	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,887,855	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,188,909	31
32	Health Care	5,586,746	32
33	General Administration	3,118,208	33
	B. Capital Expense		
34	Ownership	2,010,689	34
	C. Ancillary Expense		
35	Special Cost Centers	1,906,989	35
36	Provider Participation Fee	454,746	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,266,287	40
41	**Income before Income Taxes (line 30 minus line 40)****	621,568	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 621,568	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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,920	2,072	$ 85,982	$ 41.50	1
2	Assistant Director of Nursing	1,944	2,088	70,407	33.72	2
3	Registered Nurses	43,695	46,503	1,376,765	29.61	3
4	Licensed Practical Nurses	41,159	43,538	1,041,821	23.93	4
5	CNAs & Orderlies	166,335	178,242	1,880,239	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,566	19,021	280,788	14.76	8
9	Activity Director	5,416	5,976	81,922	13.71	9
10	Activity Assistants	5,258	5,450	48,121	8.83	10
11	Social Service Workers	13,504	14,303	224,943	15.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,931	35,632	384,228	10.78	15
16	Dishwashers					16
17	Maintenance Workers	6,886	7,327	102,284	13.96	17
18	Housekeepers	25,687	28,351	320,453	11.30	18
19	Laundry	15,085	16,747	190,829	11.39	19
20	Administrator	1,936	2,084	150,999	72.46	20
21	Assistant Administrator	2,064	2,202	95,010	43.15	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,516	16,248	204,713	12.60	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	1,986	2,207	39,447	17.87	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,292	4,587	229,070	49.94	33
34	TOTAL (lines 1 - 33)	403,180	432,578	$ 6,808,021 *	$ 15.74	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	908	$ 38,366	01-03	35
36	Medical Director	Monthly	58,620	09-03	36
37	Medical Records Consultant	32	1,504	10-03	37
38	Nurse Consultant	36	5,030	10-03	38
39	Pharmacist Consultant	2,593	14,262	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	26	1,326	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Quality Assurance	Monthly	12,000	10-03	46
47	Psychiatric Medical Director	Monthly	10,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	3,595	$ 141,608		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		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 & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nesanel Davis	Administrator	0.00%	$ 131,347
Thomas Larey	Administrator	0.00%	19,651
Benjamin Silverstein	Asst. Admin.	0.00%	53,616
Yisroel Davis	Asst. Admin.	0.00%	37,788
Paven Rakalla	Asst. Admin.	0.00%	3,606
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 246,009

B. Administrative - Other

Description	Amount
Management Fee- Tetrad Management, LLC	$ 340,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 340,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting Service	$ 23,250
Managcare, Inc	Bookkeeping	300,480
Kronos, Inc	Computer Services	18,911
Cimpar Consulting	Quality Assurance	8,628
Personnel Planners	Unemployment Tax Consult	2,793
See Attached	Legal	8,269
IIT/Sourcetech	Purchasing Consulting	230
Marquis Health Services	Management Fee	12,000
American Data	Data Processing	2,569
E Health Data Solutions	Data Processing	6,302
ADAR	Data Processing	1,654
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 385,085

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 148,565
Unemployment Compensation Insurance	103,585
FICA Taxes	520,814
Employee Health Insurance	289,386
Employee Meals	39,946
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	8,584
Other Employee Benefits	6,361
Holiday Expense	4,418
Pension Expense	62,191
Disability Insurance	6,618
Dental Insurance	324
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,190,792

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	$
Advertising: Employee Recruitment	23,031
Health Care Worker Background Check	
(Indicate # of checks performed 119)	3,380
Patient Background Checks 381	7,185
Patient Background Checks	
Licenses & Permits	4,030
Advertising & Promotion	40,024
Dues & Subscriptions	41,372
Allocated From Managcare	900
Less: Public Relations Expense	( )
Non-allowable advertising	(40,024)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,898

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,216
Allocated From Managcare	394
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,610

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc # 0050765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & Rehabilitation Centre, Llc **#** 0050765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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. **ICLTC $30,330**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **68,195** 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. $ **454,746**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **39,946** 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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.